HOUSE OF ASSEMBLY

Tuesday 27 September 1983

ESTIMATES COMMITTEE B

Chairman:
Mr G.T. Whitten

Members:
The Hon. Jennifer Adamson
Mr E.S. Ashenden
Mr H. Becker
Mr R.J. Gregory
Mr G.A. Ingerson
Mr J.H.C. Klunder
Mr M.K. Mayes
Mr K.H. Plunkett

The Committee met at 11 a.m.

The **SECRETARY:** I table an extract from the Votes and Proceedings of the House of Assembly dated 22 September 1983, which records the reference of certain proposed expenditures to Estimates Committee B. It details a time table to be followed by the Committee. The extract also indicates the membership of the Committee. Further, I advise the receipt of the following letter:

Hon. T.M. McRae, M.P.
Speaker, House of Assembly,
Parliament House,
Adelaide 5000.

Dear Mr Speaker,
Pursuant to the Sessional Orders establishing the Estimates Committees, I nominate Mr G.T. Whitten as Chairman of Estimates Committee B.

Yours sincerely,
J.C. Bannon, Premier.

The CHAIRMAN: I wish to make a few brief remarks before the examination of the vote proceeds. First, I indicate that I will recognise the member for Coles as the lead speaker for the Opposition, and the member for Florey as the lead speaker for the Government. Any changes or substitution of members of the Committee may be made at the time of a change in the vote or at 1 o'clock or 6 o'clock. There can be no substitution at any other times. Questions should be directed to the Minister and not to his officers or advisers, but the Minister may refer the question to one of his officers or he may answer and ask the officer to supplement his answer. Also, I suggest that questions should relate to the vote, not as matters of general policy. By that I mean that I do not intend to allow a second reading speech or grievance debate to take place at any time. Next, I suggest that it may be useful if perhaps the member for Coles, the member for Florey, the Minister and myself meet at perhaps the first break to allocate times. We will be dealing with two votes, Minister of Health—Miscellaneous, found on page 92 and Health Commission which can be found on page 146. I expect that the first vote will take the majority of the Committee's time.

A quorum will be comprised of four members of the Committee and, at any time when there is not a quorum, the sitting will be suspended until such time as we have a quorum. In regard to honourable members who are not members of the Committee, I may see them but I suggest that if any of those members wishes to ask a question, he or she should give prior advice and plenty of warning of their desire. I will not be encouraging members who are not members of the Committee to ask questions. Further, I intend to allow the member for Coles, as the lead Opposition speaker, the opportunity to make a short statement of about 15 minutes. She will then be followed by the Minister, who will have the same time restriction.

After that, the first question will go to the member for Coles, who will be allowed to ask three successive questions. I will then call the member for Florey and will then subsequently alternate from one side to the other, with not more than three questions coming successively from either side. Finally, I am advised that the required notices of discharge and substitution of members of the Committee have been given as follows: Mr Becker replaces Mr Meier, and Mr Klunder replaces Mr Duncan.

Minister of Health, Miscellaneous, $267 590 000

Witness:

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

Departmental Advisers:

William Taylor McCoy, Executive Director, Central Sector, South Australian Health Commission.

Edward John Cooper, Deputy Chief Executive Officer, South Australian Health Commission.

Michael Court, Director, Corporate Finance and Administration, South Australian Health Commission.

Raymond James Sayers, Executive Director, Southern Sector, South Australian Health Commission.

Alan John Bansemer, Director, Policy and Projects, South Australian Health Commission.

Brian Shea, Director of Mental Health, South Australian Health Commission.

Keith John Wilson, Principal Health Commission Officer, Public Health Service, South Australian Health Commission.

The CHAIRMAN: I declare the proposed expenditure open for examination. It is my intention, as Chairman of this Committee, to allow members to stand or sit, as they desire, when speaking. I suggest that it may be more comfortable for members to remain sitting whilst speaking, but it is up to their own discretion. The honourable member for Coles.

The Hon. JENNIFER ADAMSON: I will stand to make my preliminary statement and remain seated when asking questions. I first express regret that we are today discussing the health budget and not the tourism budget, because if it were the latter it would give me an opportunity to ask what the South Australian Government is going to do to capitalise on the magnificent win this morning by the Australians in the America's Cup competition. Having put those remarks on record, together I am sure with the jubilation of all members of the Committee about that result, I turn to the health budget, the 'Miscellaneous' and 'Commission' lines.

The most important aspect of this Budget is the impact of Medicare on the State's finances, as acknowledged on page 6 of the yellow book, which identifies these issues and refers to the introduction of the national health insurance scheme in Australia and its impact on health services in South Australia. That impact, of course, is not only related to quality of care but also very much related to cost. Another important factor of the health budget which will affect the State's Budget is the impact at the end of cost-sharing on State finances. The Opposition will certainly want to know what guarantees the South Australian Government has been

able to obtain from the Federal Government in respect of this matter.

On page 7 of *Agency Overview* it states that the proposed total expenditure for the 1983-84 financial year will be $563.7 million, which represents an increase of 3.6 per cent on the 1982-83 actual expenditure of $544 million. I am assuming that the State Government endorses the forecast made by the Federal Treasurer, Mr Keating, that inflation in Australia this year will be running at a level of 7.5 per cent. It is well known that inflation in the health field far exceeds the c.p.i. because of the unique costs incurred in that field. Therefore, at the very minimum, this Budget represents a reduction in real terms of 3.9 per cent and is very likely to be considerably in excess of that figure because of the special costs incurred in the provision of health services.

Bearing that in mind, it is interesting to look further in this book and to note that at page 7 it states that the Commission can only pursue new initiatives if sufficient savings are obtained in 1983-84 from existing services to enable it to continue to reallocate resources to higher priority health programmes. I assume that the statement that the extent to which reallocation of resources is possible is heavily dependent upon the rate at which health costs rise, especially in areas such as workers compensation, general insurance and utilities being recognised by the Government when referring to that inflationary factor of 7.5 per cent plus to which I have referred.

I note, also, that the Commission recognises that the extent to which savings can be made depends on the ability of boards of management of incorporated health services and units to continue to achieve the level of savings achieved in recent years. I assume that the present Government recognises that savings achieved in past years were necessary to allow new initiatives to be undertaken and recognises that those savings need to continue to be undertaken, a view quite contrary to that expressed by the Minister while Opposition spokesman on health. The Opposition does not intend to take the time of the Committee in making statements: rather, we seek information, and I will be awaiting the Minister's statement and then proceeding to questions.

The Hon. J. R. Cornwall: First, I will respond immediately to a couple of the major points raised by the member for Coles. She stated that she presumed that we are accepting Paul Keating's prediction of a 7.5 per cent inflation rate, and if one considers raw figures, that represents a cut in real terms (according to the honourable member's figures) of about 3.5 per cent. The member for Coles, as Minister of Health for more than three years, would know that the way in which State Budgets are presented is different from the way in which the Federal Budget is presented. In fact, a very substantial sum is always held in what is called the round-sum allowances. It can, therefore, be very misleading to use the word 'figures'.

In fact, the amount in round-sum allowances that has been allocated to the health area is about $29 million, so if members re-do their sums, they will see that the statement that this is a standstill Budget is very close to entirely accurate. The new initiatives (and I will refer to them later) certainly come from anticipated savings; however, they will be modest in the 1983-84 financial year because, frankly, there is no fat left in the hospital or health systems. We have long since got into the muscle, it seems to me, particularly in regard to the policies of the previous Government, and on occasions I suspect that we get down to the bone, which is really starting to hurt. The new initiatives that we propose represent a modest cost in the overall Budget of about $1.6 million, and indeed that is a good deal less than the cost of the new initiatives that were proposed from savings in the 1982-83 Budget, which was introduced by the previous Government.

I repeat that I reject the bald statement that savings have to continue. In fact, the first major undertaking of this Government in late November, early December, 1982 was to supplement the budget to major teaching hospitals to the tune of $4.8 million. The alternative would have been to start losing staff rapidly by attrition to meet the stringent and sometimes inaccurate estimates of the 1982-83 Budget. Staff would have to go by attrition, or worse I suspect, possibly by sackings in the health area.

The primary document setting out the Government's Budget is the Estimates of Payments, which is supported by the programme estimates, the so-called yellow book. In the health area, we produced a third document called Information Supporting the 1983-84 Estimates, the so-called blue book. The programme estimates is a means of examining objectives and stategies of resources allocation related to programme of service for target populations. The allocation of resources to programmes is estimated using statistical and forecasting techniques.

This contrasts with the information provided in the blue book, which shows the allocation of resources to health units, against which a unit's budgetary performance can be assessed. Each document reflects the fact that the Government has a cash accounting system that gives rise to a number of apparent anomalies relating to the undue significance that is placed on 30 June 1983. For example, there can be apparent unexplained increases and decreases in a health unit's expenditure because of the occurrence of a 27th pay day in a particular financial year.

I am sure that the Committee recognises that the compilation of the Budget papers being considered today had to be finalised some considerable time ago. The time constraints within which the Government's Budget is finalised and presented place the Health Commission under considerable pressure. It is not possible for the Commission to finalise allocations to all health units between the time that the Government's allocation for health is known and the time that papers are required for printing. It should be remembered that there are, from memory, 178 separate health units that have to be administered or are the responsibility directly and indirectly, of the South Australian Health Commission.

The Commission itself functions as the treasury for a system within a system. For this reason the blue book presents preliminary allocations, many of which at the time of printing had not been agreed with the health unit concerned and, therefore, are obviously subject to some minor variations. As the health budget had to be finalised in late July, it does not reflect the introduction of Medicare. At this time all States have agreed in principle to co-operate with the Federal Government in relation to the introduction of Medicare, but a formal and detailed agreement has not yet been signed.

In general, for the information of members, at this stage I refer to the aspects of Medicare that particularly relate to State health services: first, the provision of public hospital accommodation and in-patient and out-patient treatment by hospital or sessional doctors without direct charge; secondly, the reduction of private bed day charges in public hospitals to $80 per day; thirdly, the development in conjunction with the Commonwealth of a classification of private hospitals as a precursor to a variable bed day subsidy and health benefit system to be administered by the State from 1 July 1985; and, fourthly, the redefinition of rights to private practice and facilities charges in respect of full-time and visiting diagnostic specialists, in the fields of pathology and radiology, in public hospitals as a condition of the Medicare grant.

In addition, the Commonwealth is providing $1.58 million in a full year or $630 000 in 1983-84 for new or expanded community health projects. The Federal Government does not expect the introduction of Medicare to lead to increased costs in public hospitals, except in the area of medical staffing, for which it is offering the States compensation. The situation will need to be carefully monitored to ensure that the quality of service provided by public hospitals is maintained. In relation to receipts, the Federal Government has adopted an approach of compensating the States for revenue lost from the provision of services at a reduced rate or at no charge. Therefore, there should be no overall impact on the health budget. Patient fees will be less than currently budgeted, but there will be a commensurate increase in Commonwealth payments to the State.

I am pleased to say from South Australia's point of view that negotiations with the Commonwealth to date, while not yet finalised, have been satisfactory. The Budget proposes an allocation of State funds of $266 million to meet the projected net cost of South Australian Health Commission operations. This sum, together with funds from other sources, will support gross payments of $546 million. In addition, as I said at the outset, the Commission can expect to receive further sums in respect of award increases and inflation from Treasury's provision for round-sum allowances. That is a standstill allocation for the health system and reflects the Government's commitments to ensuring high quality health care and the maintenance of employment levels within the State health system.

Despite the high profile of technology, there is no doubt that health is and will remain a labour intensive industry, and the Government is aware of the association between the quality of patient care and staffing levels. More than 20 000 people are employed in the State's publicly funded hospitals and health care units.

Soon after coming to office last November the Government, as I said earlier, supplemented hospital budgets in order to ensure the maintenance of high quality patient care that South Australians have come to expect from their publicly funded health facilities. The Government has met its commitment to maintain staffing numbers at their levels as at 30 June 1982. As I said in the Legislative Council on Tuesday 13 September 1983, the number of health staff increased by 175 between 30 June 1982 and 30 June 1983.

Actual staff numbers increased from 19 857 to 20 032. Increases have occurred in nursing and in a variety of different support staff categories. The Government has identified a number of areas to which it attaches a high priority and to which any savings from within the health system are to be directed. These are the priority areas to which I referred at the outset and which we have allocated by savings a modest $1.6 million.

First, I refer to non-institutional care for the aged and physically disabled. The percentage of South Australians aged over 65 will increase from 10.1 per cent to 11.5 per cent in the next decade. There is a growing urgency to provide a range of accommodation options in addition to the current number of institutional beds. These options will require expanded support from community services, including domiciliary care, special benefits schemes and rehabilitation services.

I refer, secondly, to services for the intellectually disabled. The main issue in the provision of services for the intellectually disabled is the move away from the provision of institutionally based services in favour of services being provided within community settings. This movement is consistent with trends elsewhere in Australia and overseas.

Thirdly, I refer to health services for Aborigines. The intention is to increase the involvement of Aboriginal people in the improvement of their own health through their participation in the planning, administration and delivery of health services provided for them.

Fourthly, there is health promotion, which I know is dear to the heart of the former Minister. The intention here is to provide a facility whereby short-term, State-wide, cost-effective health promotion activities can be developed and implemented.

The Health Commission intends a modest redirection of resources in 1983-84, again (repeating what I said earlier) to enable a number of initiatives which implement Government policy to be funded. As a consequence, not all health units will have a standstill allocation in 1983-84. To the extent that savings can be made (and that depends both on the rate at which health units costs rise and on the ability of boards of management of health units to achieve target savings), it is proposed to fund the following new initiatives in 1983-84 at an estimated cost, as I said previously, of approximately $1.6 million.

First, an additional $500 000 is to be provided to the Intellectually Disabled Services Council—that is in addition, of course, to the $500 000 additional moneys provided in 1982-83—to open additional group houses in the community, to fund a range of voluntary agencies, and to vacate the remaining unsatisfactory accommodation at Strathmont—the so-called back wards, about which I am sure the member for Coles will remember that I had a considerable amount to say when in Opposition.

Secondly, funds will be provided to establish the Nganampa Health Service, a community controlled health service in the eastern Pitjantjatjara homelands. The estimated full year cost of this service is approximately $300 000.

Thirdly, $150 000 has been allocated towards the establishment of the health development project, the purpose of which is to improve the physical health of schoolchildren, through life style programmes in schools. This programme is to be established in conjunction with the C.S.I.R.O. Division of Human Nutrition and the Education Department.

Fourthly, an additional $240 000, bringing the total in 1983-84 to $400 000, will be provided to allow for the development and implementation of a State-wide programme aimed at assisting people to give up smoking, thus reducing the number of deaths and the cost to the health system caused by that habit.

Fifthly, funds will be provided to establish a sobering-up service in the metropolitan area which will allow the offence of drunkenness to be decriminalised. Sixthly, a State-wide maternal alpha-feto protein screening programme will be established to allow for the identification of possible deformities early in pregnancy; and, seventhly, the position of Women's Adviser will be established by the Health Commission.

In addition, funds have been provided for the expansion of the scheme whereby pensioners can obtain spectacles, to include the long-term unemployed and low-income earners and the provision of contact lenses to non-metropolitan residents where those are clinically necessary. The South Australian Spectacle Scheme is estimated to cost about $2 million in 1983-84. Whilst it is possible to redirect resources in this financial year, I believe (and I cannot stress this too strongly) that the scope for this to continue in the future is limited. In the future, issues related to the quality of care and distribution of services will need to be very carefully addressed before any further resources can be redirected.

With this in mind, very early in my first term as South Australian Minister of Health I commissioned two major reviews of health services in this State, the reports of which I expect to make public in the near future. Dr. Sidney Sax with others has reviewed the quality of care and related issues in South Australian hospitals and similarly, Dr Stanley Smith, with others, has reviewed psychiatric and drug and

alcohol services. Together, I expect these reports to provide a significant input into the crucial resource allocation decisions that have to be made in the next decade.

The Hon. JENNIFER ADAMSON: Notwithstanding the Minister's statements about round-sum allowances which he claims when added to the allocation represent a stand-still Budget, the inflation factor allowed in this Budget is very small indeed. What was the rate of inflation as determined by the health costs index in the last recorded year and what was the last recorded year?

The Hon. J.R. Cornwall: I have already stated my macro position in this matter. I repeat that it is a stand-still Budget. For further information, it is appropriate that Mr Cooper should take up that matter.

Mr Cooper: We have not yet published but have available the price index of hospital purchases for 1982-83. The movement of the index for 1982-83 on 1981-82 was 8.7 per cent.

The Hon. JENNIFER ADAMSON: That seems to confirm my point that, with the best will in the world, it will be difficult if not impossible for the Commission to meet this Budget on the basis that has been allowed for inflation. In regard to the question of cost sharing, will the Minister outline to the Committee the basis for the end of cost sharing and advise us whether South Australia has any relative advantage over the other States in terms of cost sharing and, if so, in what year was that advantage incurred?

The Hon. J. R. Cornwall: It is not appropriate for me to go into that in great detail in regard to the basis of arrangements that we hope to enter in to with the Commonwealth. That may well prejudice the negotiations that are at an advanced stage. I am happy to say that they have proceeded satisfactorily. I am also happy to indicate that I believe firmly that I will be recommending to Cabinet that the cost sharing agreement should be terminated from 1 February. It would seem on what has been negotiated to date that we should be able to negotiate a very good deal for South Australia to 30 June 1985, and that can be negotiated principally not because of the expressed or demonstrated filanthropy of the Commonwealth Department of Health or the Federal Minister but because we were in an advantageous position as a result of retaining the cost sharing agreement.

I repeat: for me at this stage to reveal the South Australian Government's and the Health Commission's position publicly, with regard to the fine details would not be appropriate. Further negotiations at senior officer level will be occurring within the next two weeks, and at that stage I would hope that we can cross the t's and dot the i's. At that time or immediately subsequent to it, I intend to take a submission to Cabinet and once those recommendations are approved it will be the subject of a major public statement.

The Hon. JENNIFER ADAMSON: I recognise that it could prejudice South Australia's case if the Minister were to give extensive details to the Committee. What he has said already confirms the wisdom of the actions of the previous Government in regard to holding out with the cost sharing agreement, but it is reasonable for the Committee to know what guarantees the South Australian Government is seeking for this State in respect of the termination of that cost sharing agreement. I do not believe that information about the kind of guarantees that South Australia is seeking could prejudice our case with the Commonwealth.

The Hon. J.R. Cornwall: I have two responses. First, credit should be given where it is due, and it is perfectly true that the previous Government and the previous Minister did elect to retain or maintain South Australia in cost sharing, despite considerable pressure from the then Fraser Liberal Government; I am pleased that they accepted the advice that I offered at that time. Secondly, I can say unequivocally that negotitations to date indicate to me that we will not in any way be financially disadvantaged. The new agreement will be from 1 February 1984 to 30 June 1985, and that is the basis on which we are negotiating.

Mr GREGORY: My question is about services to Aborigines. Page 10 refers to services mainly for Aborigines, and at page 11 is set out an increase of $261 000. On page 7 reference is made to Nganampa Health Service. How is that intended to operate? Will there be any cost sharing from the Commonwealth?

The Hon. J.R. Cornwall: That is an initiative that I have been working on since we came to Government in November last year (not without considerable difficulty). The idea is to establish a community-based community-controlled health service in the Pitjantjatjara homelands. I might explain in a little detail what that means. There are still many people in the community who have difficulty coming to grips with the idea of an Aboriginal controlled health service. They tend still to reach the conclusion that, because of the levels of education in the Aboriginal population generally, and because they cannot provide accountants, lawyers, doctors and double-certificated nurses in any number from their own ranks, it would be impossible for them to conduct and manage a health service. That is quite wrong, of course, and there are examples to prove that, the more notable one being the service run by the Central Australian Aboriginal Council which employs, among other people, Dr Trevor Cutter, a distinguished physician.

The fact is that Aboriginal people have an enormous amount of experience as consumers of health services and particularly hospital services. They consume, on average, because of the disgracefully poor state of their health (which reflects poorly on Governments of both political persuasions of the past), five times as many health and hospital services as does the white European population. For that reason, by the age of 25 they usually have a vast experience as consumers. It is also for that reason that they have a very good idea of what they want. That does not necessarily equate with the stainless steel and white coats of traditional hospitals as we know them. It is very much in their interests, and I believe very much in our interests as a Government (and certainly a strong policy of this Government), that we support to the maximum extent, in the moral, policy and financial sense, the development of independent health services where appropriate around the State.

The Ernabella Health Service was the first South Australia was able, as a State Government, to actively support. I had discussions on this matter with the Federal Minister for Aboriginal Affairs early in the days of the Hawke Government, and subsequently. The agreed basis for negotiations is that we will contribute $1 for every $4 that the Federal Department of Aboriginal Affairs contributes in this area. That amount is to be over and above normal State health services amounts. In other words, in arriving at that figure, we do not take into account, for example, hospitalisation in any of the State's hospital systems. These negotiations have not been without difficulty. The amount proposed is $1.3 million and we hope that that service can be established as from 1 December 1983. In fact, I am travelling with a party to the Pitjantjatjara homelands next week to continue discussions with the Pitjantjatjara Council and members of the Ernabella Health Service Council. I will be accompanied by Mr Gary Foley, Secretary of the National Aboriginal and Islander Health Organisation, Elliot McAdam from our own Aboriginal Health Organisation, Audrey Kinnear, President of that organisation, and other senior officers.

I hope that we can answer many of the questions still being asked in the area, but it must be appreciated that because of its remoteness communications can be difficult and sometimes become garbled by the time they are about third hand. This is a high priority and I hope that we will

install the initial service, costing $1.3 million in a full financial year. That will be met by a contribution, in round figures of $1 million, from the Federal Government through the Department of Aboriginal Affairs and $300 000 from the South Australian Health Commission in a full financial year. That does not have to be the end of negotiations for further services. Whether it would then be appropriate for us to provide State services through agencies like the Child, Adolescent and Family Health Service and the School Dental Service will be a matter for further negotiation. I am optimistic, and certainly enthusiastic that we get this independent health service going for the Pitjantjatjara people as soon as we can and preferably by 1 December.

Mr GREGORY: On page 45 of this document there are further references to specific services to the Pitjantjatjara community and to the non-metropolitan Aboriginal communities. I note that the increase for the Pitjantjatjara is $274 500 but for non-metropolitan areas there is a decrease of $14 000. Why is there that decrease of $14 000 and what is happening in the non-metropolitan area?

The Hon. J.R. Cornwall: I think that it would be better for Dr Court to answer this question directly because it specifically involves dollars and cents.

Dr Court: It is difficult to compare the 1982-83 outcome with the 1983-84 proposals, given the number of 'one off' expenditures that occur in any one line in any one year. Very simply, the increase for the Pitjantjatjara community is the Nganampa Health Service, which has been talked about and which involves the major part of that increase. The figure shown for metropolitan Aboriginal services is a standstill figure. Because of things such as severance pays and award increases yet to come, it can show a small decrease at the moment, but it is a standstill figure.

Mr GREGORY: On page 47 of the document there is reference to support services for Aboriginal communities. Will the increase of $86 000 over last year's proposed expenditure be sufficient to provide these services?

The Hon. J.R. Cornwall: That is a standstill allocation compared to the 1982-83 outcome. As to whether it will be sufficient, I guess that in the area of Aboriginal health and a lot of health areas I would not be doing my job as Minister if I did not behave like Oliver Twist and always look for a little more. However, it is maintaining things at a standstill level, and that is the best that we are able to manage in that area in this financial year. I remind the honourable member that we have found an additional $300 000 for specific Aboriginal services in a time of very difficult economic constraint.

Mr BECKER: I take it that the Minister has had an opportunity to read the Auditor-General's Report for the financial year ended 30 June 1983. I turn now to some of the comments made by the Auditor-General in that report. At page 385 of the Auditor-General's Report under the heading 'Internal Audit', it is stated:

> I am concerned at the inadequate reporting and accountability to Parliament for revenues and expenditures of approximately $550 million per annum on health services. I conduct audits for only a small number of the total health units and consequently reporting in my annual report to Parliament is generalised and limited.

Yet, under the heading 'Audits of Commission and Health Units' it is stated:

> Approximately 75 per cent of total health sector outlays are covered by audits conducted by the Auditor-General.

It is further stated under 'Internal Audit':

> Internal audit was re-established for the Commission Central Office, and coverage will include the effectiveness of services provided by Central Office units and the efficiency with which they are delivered. The degree to which internal auditing should be pursued through direct scrutiny of health units is under consideration.

At page 386, under the heading 'Cash Management', it is stated:

> A review of investments of funds obtained from a number of sources including—
> - delays in forwarding some revenues to the Commission; . . .
>
> The review disclosed—
> - funds invested at 31 May of $8.1 million, of which a minor portion only was in the nature of private or trust funds;
> - income received for the year from investments was approximately $900 000;
> - a diversity of investment practices;
> - inconsistencies in the treatment of income; and
> - an apparent lack of disclosure of funds held and income earned.

At page 392 under the heading 'Recognised Hospitals—Scope of Audit', there is further criticism of the various hospitals and the systems used. At page 393 under the heading 'Computer System Reviews', it is stated:

> . . . weaknesses were found in—
> - division of duties to detect errors, prevent fraud and restrict access to assets to authorised personnel only; and
> - system integrity and physical security measures which control changes to computer files and programmes and protect assets from unauthorised access.

Under the heading 'Royal Adelaide Hospital' it is stated:

> Patient Accounting—Controls over out-patient billing did not ensure that all patients were charged for services.

The Auditor-General referred to the Modbury Hospital, the Flinders Medical Centre, and in regard to stores procedures stated:

> . . . inadequate controls were exercised over stock holdings. The audit review disclosed that excessive stocks were being held and some items held were obsolete. In addition, management was not aware of stock holdings as regular stocktakes were not undertaken.

In regard to patient accounting, it is stated:

> . . . the raising of charges for pathology and radiology tests was considerably in arrears.

The Auditor-General referred to the Queen Elizabeth Hospital, and in regard to patient accounting it is stated:

> . . . the computer file used to calculate charges to patients was not updated with a pathology fee increase until 11 months after the operative date with the result that approximately $50 000 of revenue accounts were not raised.

I am concerned when I read comments like that from the Auditor-General on the practices of the Health Commission and internal auditing, because I believe that internal auditing is a very important function. It would assist the Minister and the Commission if they quickly ascertained whether there were any problems, and it would assist the various health units if that sort of comment did not come to the attention of the Parliament through the Auditor-General's Report. The comments in regard to the current practices are disturbing, and I want to know what the Minister is doing now to immediately rectify the situation to prevent embarrassing comments about certain activities in the Health Commission.

The Hon. J.R. Cornwall: The member for Hanson has raised, on my quick count, about 12 different matters, although it is fair to say that those matters were related. My memory is not quite photographic, but I took notes as fast as I could as the honourable member talked. Let me first assure the member for Hanson that he need not be overly concerned. The Auditor-General's Reports are, to some extent, historical. This report relates to 1982-83, and I have been running the store only since 10 November last year.

Mr BECKER: You are the Minister now.

The Hon. J.R. Cornwall: I was concerned for some years about the lack of internal audit in the Commission, and I am sure that, if the honourable member cared to consult *Hansard*, he would see that I raised the matter of the lack of internal audit on numerous occasions. I believe that this

is the fourth successive year in which the matter of the lack of internal audit within the South Australian Health Commission has been raised by the Auditor-General. It was for that reason that, very shortly after becoming Minister of Health, I gave very high priority to this matter and asked that an internal function be set up within the Commission. There were one or two abortive attempts at establishing an internal audit system with an internal auditor during the period of the previous Government, and the fact that that did not get up and running is not a reflection on the previous Government or the previous Minister so much as the fact that we can fairly say that there was not a great deal of enthusiasm in some areas of the Commission in regard to an internal audit system.

At my insistence, an internal auditor was appointed on 29 August this year. I have already stated publicly, and I reiterate for the benefit of members, that I envisage that the office of the internal auditor will be expanded as soon as the full extent of the duties of the internal auditor have been thoroughly and completely defined. The member for Hanson also referred (although, as I said, I was at some disadvantage trying to remember everything that he covered from the Auditor-General's Report) to a complaint of the Auditor-General that his office did not do the audit for every health unit in the State. Of course, I do not wish to be critical in any way of the Auditor-General: it would be quite improper for me to do so. However, I remind members that there has to be a balance somewhere. There is little point in talking about the autonomy of hospital boards of management or, as I prefer to style it, the substantial independence of hospital and health unit boards of management on the one hand and then in wanting to go back to the bad old days of the Hospitals Department and forcing everything centrally.

Audits of all hospital accounts are carried out by certified and qualified auditors, and it is my view that they are carried out just as effectively as they would be carried out by the Auditor-General. I will not comment further in that regard, because, as I said, it would be improper for me to reflect adversely or in some sort of combatant way. I have no wish to fight publicly or in private with the Auditor-General, but I repeat that it seems to be entirely appropriate: where hospital boards of management, substantially masters of their own destiny, elect to use certified auditors from the private sector, I have no objection whatsoever. I wonder whether that is a valid criticism. It is certainly not a new criticism, of which I am sure the member would be aware.

One of the other points raised was the question of the $8.1 million that was retained and invested by some of the teaching hospitals. That matter was drawn to our attention by Treasury. If you like, it is a little bit of a flexing of the muscles of the hospital boards of management which perhaps were taking their autonomy a little too seriously or in the literal sense. It is not a practice that is condoned by Treasury, and those hospitals have been instructed that that practice is to cease as a matter of policy and Government direction. Regarding systems reviews, I do not suppose that anything has been reviewed more in this State than the health services area. The member for Hanson, as a distinguished Chairman of the Public Accounts Committee, directed a significant part of that review.

It was also a matter that caused me considerable concern in Opposition. I might say that it is still a matter that exercises my mind and sometimes causes me a little concern as Minister of Health. It is a complex and difficult area. I think that we certainly went through quite a rough period in the mid 1970s and beyond (into the early 1980s) with regard to computing. At one stage I think that successive Governments were tending to get into hospital and health computers because it seemed like a good idea at the time, rather than specifically defining what roles, objectives and advantages there were in specific computing areas. Of course, we have also moved from a position of almost total centralisation as a policy to one in which we now encourage more flexibility and more innovation within the major health units themselves.

Before I ask Mr Cooper to comment on some of the more specific areas covered by the honourable member's comprehensive question, I report that in the 1982-83 financial year several initiatives were completed, and others are quite close to completion. The Admissions, Transfers and Separations System at the Royal Adelaide Hospital came on line on Bastille day, 14 July. I do not think that there was any great significance in that date, or there certainly has not been to date. I took a low-key approach to it. We certainly did not go down there with brass bands or television cameras to announce that it had been born. It was the result of expenditure in excess of $1 million. It appears at this point to be functioning satisfactorily, although there were one or two bugs in the system during the month of August.

In particular, I think the system is a great tribute to Dr Tony Davis, who was primarily responsible for the project. At one stage there were potential serious difficulties with the major computing programme at the Institute of Medical and Veterinary Science. That caused me substantial headaches in the early days of my stewardship. I am now pleased to say that the last two reports indicate that the system appears to be well and truly back on the track, albeit substantially behind schedule. Dr Liz Doyle has been placed in charge of the programme. I know that the member for Hanson (as I said, a former distinguished Chairman of the Parliamentary Public Accounts Committee) had quite a bit to do with Dr Doyle during some of the investigations conducted by the Public Accounts Committee. I would be surprised if the member for Hanson did not share my great faith and admiration in Dr Doyle.

The other two major areas that I can comment on are the Financial Management and Control System which is going in at the Queen Elizabeth Hospital (and it is hoped that once it is up and running it will be a model for extensions to other major teaching hospitals), and the stores and pharmacy Inventory Control System (SAPICS) which is also in the process of being installed at the Queen Elizabeth Hospital. Obviously, other initiatives are going on in the computer field; we are not standing still. I estimate that the health system will spend about $3 million in the 1983-84 financial year. I think the member for Hanson referred to other more specific matters. The Acting Chairman of the Health Commission, Mr Cooper, might have more information.

Mr Cooper: A number of issues have been raised, and I will try to refer to them in order. First, I refer to the question of inadequate reporting and accountability to Parliament. Clearly, the Commission is concerned to continue to improve the extent of its reporting and accountability to Parliament on behalf of the health system. Over the past several years there have been a series of improvements in our documentation. It is worth making the point that we regard this hearing and the papers that we have put before the Committee in the blue and yellow books as our principal vehicle for reporting to Parliament on the management of health services as a whole.

For example, I point out that included in the blue book are comprehensive performance statistics for expenditure against budget for every health unit funded by the Commission. There are also comprehensive statistics of activity, and there are measures of efficiency such as costs per bed-day and staffing per bed-day, and so on. In defence of the Commission, it is not that we are not doing nothing. Of course, we will continue to seek to provide more meaningful information as time goes on. I think the honourable member

addressed the point that, in relation to auditing, the Auditor-General reports on 75 per cent of the Commission's expenditure directly.

In relation to the question of internal auditing, the understanding that the Auditor-General has of internal audit as it has been developed in the Health Commission is perhaps not complete. An internal audit charter was agreed by the executive panel of the Health Commission some months ago, before the Chief Internal Auditor was appointed. The charter states:

> With regard to the functions of the internal audit unit with respect to promotion of compliance with financial and accounting procedures across the health system are:
>
> To develop standards and procedures for internal audit for the guidance of health units.
>
> In conjunction with sectors, to develop systems for monitoring the financial procedures of health units.
>
> When requested and conditional on other priorities, provide advice to health units on audit matters, management information systems, and financial control procedures.

I think that a slightly incorrect impression might have been given, that it is purely a central office activity. That is not the case. In developing internal audit within the Health Commission, it is not conceptionally straight forward. We are actually talking about external agencies, that is, incorporated hospitals. They are external to the Commission, although the Commission has an overall responsibility to Parliament for reporting on their activities. Therefore, one must develop a carefully thought-through *modus operandi* for the Commission internal audit unit, *vis-a-vis* health units. That is what we are seeking to do. At the moment, I have on my desk a proposal from the internal auditor for the staffing of the unit. We were waiting until he took up his position to assess the staffing requirements. I anticipate that a number of suggestions will proceed during the remainder of the calendar year. We are looking at two additional appointments and a computer systems officer to be included as an initial staffing of the internal audit unit. I feel that we are addressing the Auditor-General's comments fairly positively in that respect.

The honourable member also raised the question of investments by hospitals. That is a difficult issue. The Minister referred to it in general terms. I think that two or three points need to be made. First, of course, hospitals hold quite substantial funds, and it is perfectly legitimate for them to make investments. In fact, they would be negligent not to do so. I refer to various trust funds deriving from private practice, donations, and so on, which are all perfectly legitimate. What has occurred over the past 12 to 18 months is that hospitals, consistent with the notion of the managerial independence of hospitals, have developed their own general accounting systems. In the past, most of the larger Government hospitals have used the central processing of accounts system operating on the Reserve Bank. They had a requirement for working capital, but no specific funding was provided for that purpose. Part of the money, they argued, was necessary to provide working liquidity for hospitals, given that large hospitals were now operating on their own bank accounts.

The second point is that while there may have been a practice and an expectation in essential agencies of Government that things such as interest on withheld P.A.Y.E. contributions were the prerogative of the State Government and the Treasury, to my knowledge that has never been promulgated as a policy and we at the Commission were never advised formally by the Treasury at the time that this was taking place that it was not to happen. In the climate of the time, which was encouraging the business management in hospitals, we did not see fit to intervene too strongly. We have now sought direction from the Under-Treasurer as to the appropriate practice with regard to these matters, and the Minister has indicated the Government's policy. As far as the boards are concerned, regardless of the Commission itself, it would be fair to say that, having these funds on hand, they would not have been prudent if they had not invested to the best effect. That is a complicated issue—perhaps not quite as black and white as the Auditor-General would imply.

The question of the following up of outstanding accounts, again, is a difficult issue which has plagued hospitals, particularly since the change in the funding arrangements in September 1981, when we were into billing in a very big way again. There was a long period during which billing had not been a high priority consideration in hospitals because it was not very extensive. The Auditor-General refers to some continuing problems; these have been referred to the hospitals concerned, and we will follow them up with the hospitals.

A general point that I would like to take the opportunity to make is that the record of our larger Government hospitals in relation to outstanding accounts is very comparable with that of other large public hospitals in other parts of Australia. In Victoria one finds that 3.4 months and 3.5 months for large Government hospitals is typical. In New South Wales it is 3.8 months, as compared with 3.5 months that we have in South Australia. For the large Government hospitals, a large proportion of those outstandings are compensable accounts, which necessarily take a long time to collect because there is a whole legal process to go through. Of course, we do not exercise rigorous credit control when a patient presents for treatment as a private organisation might. Having a person make a commitment to the sort of sums of money about which we are talking—thousands of dollars—it is reasonable to suppose that one would have some larger level of outstandings than would be the case for a private enterprise.

The third thing which it reflects is one's practice of writing off debts. One can always reduce one's outstandings by writing off debts. In so far as one keeps debts on the books until the last conceivable possibility of collecting that money has disappeared, one will tend to lengthen the age of one's accounts. Overall, we are continuing to pursue this matter, but there are difficulties and we do not believe that our situation is considerably worse than that of other people facing a comparable situation in other States.

On the question of audit and computing systems, these were taken from references by the Auditor-General to the hospitals concerned. We will follow these up over the next few weeks, basically, with the hospitals to find out what action they are proposing. A whole series of actions have been taken during the course of the year which do not directly relate to that, but an illustration might be useful. The Royal Adelaide Hospital employed additional revenue recovery staff for three to six months during the year. It extended its revenue procedures to produce magnetic tape records, for transmission to the debt collection agency. Modbury Hospital seconded the hospital accountant to the revenue section to take specific responsibility for revenue outstandings. Flinders Medical Centre employed additional staff to streamline its billing functions. In May 1982, additional funds were provided by the sector office to implement the direct billing of in-patient accounts. I will not go through that, but we have a summary of a whole series of actions that have been taken both by hospitals and by the Commission to address this quite difficult problem.

Mr BECKER: I was a little concerned to read the remarks made by the Auditor-General because I thought that things were improving and it created the impression that they might not be. The Minister and Mr Cooper have explained that reasonably well. With the Health Commission the size that it is, one has to expect a little bit of this at times.

Minister, while you have someone from the Flinders Medical Centre with you, what is the current situation in relation to anorexia nervosa, or slimmers disease, patients obtaining accommodation at Flinders Medical Centre? I understand that a young girl who has been assessed by a psychologist at Flinders Medical Centre and told that she should be admitted—I believe that she has lost two stone in a month—cannot be admitted because of the shortage of funds, beds and staff. That allegation has been made to me and tends to be from time to time the type of statement that we have received: that the hospital, because of the shortage of beds, staff and money, cannot admit her. I understand that there are six critical cases on the waiting list and that this girl comes after them. I wonder whether there is a listing of patients at Flinders Medical Centre who are suffering from slimmers disease, and what can be done. I believe, again, that this is a problem that is starting to get out of hand, and it seems tragic if patients who have been assessed by a psychologist that they should be admitted have been told that they must be on the waiting list.

The Hon. J.R. Cornwall: As I am sure all members would be aware, the Flinders Medical Centre, among other things, specialises in the treatment of anorexia nervosa and has a very substantial reputation in that field. However, of course, it is not the only acute psychiatric facility in Adelaide in which treatment of that condition is available. I am unaware of any real shortages in staff that might have been created by the budgetary stringencies of recent years but, as regards the acute psychiatric facility at Flinders, it is well recognised and clearly conceded that the accommodation is inadequate. That is a matter which, as a Government and as a Commission, we must address in the reasonably near future. I think that it is fair to say that of all our hospitals it is no secret that Flinders, not only in the acute psychiatric unit but in the hospital system generally, is starting to come under very considerable pressure regarding bed occupancy. It has become within the past year or two unacceptably high. I am sure that the member for Hanson would be aware that stage 4 of Flinders has not been completed and, as it was envisaged, it is unlikely that it ever will be. We certainly would not contemplate the provision of something in excess of an additional 200 beds.

There is no doubt that we need additional beds. There is no doubt that we need much better accommodation for the acute psychiatric facility at Flinders Medical Centre. As I said, it is a matter which the Government will certainly have to address. Of course, it has been addressed by the excellent report prepared by Mr Cooper, the Metropolitan Adelaide Hospital Planning Framework, which has subsequently been assessed by the Sax Committee. The Sax Committee will be a public document, I anticipate, in less than a month. I hope that as soon as the full Parliament resumes I will be able to table the Sax report.

It makes many recommendations as to the short, medium and long term as to where hospital beds should be directed, apart from its other 214 major recommendations. I concede that there is a difficulty with accommodation at the acute psychiatric section at Flinders. This matter will have to receive high priority in subsequent Government capital works programmes, but it is not within my knowledge in particular health units to know whether or not there are six critical cases on the waiting list and the like. It would be far better if I asked Mr Ray Sayers, Director, Southern Sector (of which Flinders Medical Centre is the major centre), to respond to some of the more specific parts of the question.

Mr Sayers: *Anorexia nervosa* is an increasing problem in this State. We are aware of the problem at Flinders and have been working with Professor Kalucy over the past six months in an effort to overcome that problem. Two things have been done. First, we have introduced Professor Kalucy to Ashford Community Hospital as an interim measure to be able to hospitalise some of the patients in that institution. I have corresponded and set up meetings with Directors of the other sectors because it is not only a problem unique to Flinders Medical Centre because *anorexia nervosa* is becoming a problem State-wide, and the other two major teaching hospitals, Queen Elizabeth and Royal Adelaide Hospital, are also receiving more of these types of patients. The matter has been referred to the Commission. We are having discussions at the Commission level in an effort to overcome that problem. As an interim measure we are negotiating with Ashford in an effort to have patients from Flinders Medical Centre accommodated at Ashford.

Mr BECKER: She could die within a month. What about the six people on the waiting list? This is what upsets me. The girl's workmates are concerned that she has come back to work merely because six others are on the waiting list in front of her. It is unclear when she can go to hospital. These concerned people want to do all they can to help, and something must be done—today. There are six on the waiting list. How can that happen within a health service? I am not satisfied with the answer, and I want something done now.

The Hon. J.R. Cornwall: It is not one of the member for Hanson's better performances.

Mr BECKER: I can get up and really perform if you want me to.

The Hon. J.R. Cornwall: The honourable member has been a frustrated member of repertory. There is no question of allowing this patient or any other patient to die, in terms of doing things about it. It seems to be the height of hypocrisy—although the honourable member is not on the front bench of the Opposition, which I must remember; he used to be—

Mr BECKER: That has nothing to do with it. Do you care about people or not?

The Hon. J.R. Cornwall: The honourable member and the Opposition when in Government and as Her Majesty's Opposition have made great play, as again did the member for Coles today, about the need to continue to trim and cut our expenditures in the hospital area. The system is one that I inherited 10 months ago. Despite the grave difficulties that we face financially, I have been able to convince my Cabinet colleagues to inject almost an additional $5 million in the financial year immediately past, and that has been taken up as carry-over money into the 1983-84 Budget so that the standstill in fact is a standstill on the supplemented Budget for 1982-83. I cannot repair the damage of the previous Administration overnight. If the member for Hanson is genuinely concerned about this patient he should not carry on has he as done quite disgracefully about a resident of the Julia Farr Centre.

Mr BECKER: Come on—that has nothing to do with the question. Come on, Minister, answer the question.

The ACTING CHAIRMAN (Mr Klunder): Order! The member for Hanson should keep quiet. I do not want to have to warn the honourable member. If he has asked his question, he is entitled to an answer, and he will listen to it.

The Hon. J.R. Cornwall: It is well known that the honourable member has carried on in this irresponsible manner and one might almost say disgraceful manner in the past. Obviously, he is doing that again today. If he is genuinely concerned, rather than grandstanding and using this Committee, which is supposed to be here to seek figures and facts in the public interest, I suggest that instead of using the Committee disgracefully for base political purposes, he would be far better employed providing me and my senior officers, who are all here today, with the name and address of that patient, and I will have the matter investigated immediately. There is no need in our system, even with the

pressures that are upon it in specific areas like *anorexia nervosa,* for any patient genuinely needing hospitalisation to be denied that hospitalisation.

Mr MAYES: My question is about the expenditure and receipts summary, page 11. In regard to services mainly for those with physical illness and disabilities, can the Minister explain the make-up of that figure? Does it include all hospital services?

The Hon. J.R. Cornwall: As the honourable member is able to work out for himself, that is a very substantial figure. It includes all acute services other than obstetrics and paediatrics.

Mr MAYES: The final total on page 12 is $546 million, proposed recurrent expenditure for 1983-84, but can the Minister indicate whether that includes an allowance for wages and salaries? How does it compare with the actual expenditure for 1982-83?

The Hon. J.R. Cornwall: As I mentioned at the outset of deliberations, that figure does not take into account the round-sum allowances, which total about $29 million additional. What we are looking at in terms of the total estimated expenditure for 1983-84 is about $575 million. I repeat that we do prepare our Budgets differently from the Federal Budget. For those used to the magic of Budget night federally and being able to do their sums immediately, that is a facility not available to us at the State level because, traditionally, both here and in other States, we have also used the round-sum allowance.

The justification for the round-sum allowance is what I think is a fiction; namely, that if you do not telegraph to the employees in the health service what you are anticipating in terms of inflation it does not become a self-fulfilling prophecy. I am not sure that that has any validity based on practical experience, but, nonetheless, that is the way the system operates. In fact, if one adds that $29 million to the $546 million to get the total figure of $575 million one is looking at slightly in excess of an 8 per cent increase. In real money terms, if one accepts 7.5 per cent to 8 per cent as the inflation rate then one is looking at a standstill Budget.

One has also to take into account that if, for example, a 38-hour week was introduced during the 1983-84 financial year that matter would be beyond the control of the Commission and, therefore, it would become a Treasury responsibility. I am using that purely as an example, and that is not to suggest that a 38-hour week will be introduced in 1983-84. However, it is things of that magnitude which tend to distort the Budget substantially and which are not taken in to account in the round-sum allowance. They are considered quite separately, and I think that that is most appropriate.

Mr MAYES: On page 60, under the heading, 'Debt Services—Whyalla Hospital', there is a figure of $54 000, I presume for 1982-83. The proposed figure for 1983-84 is not available. Can the Minister explain the origin of this debt service charge and what is the likely figure for 1983-84?

The Hon. J.R. Cornwall: That is an historical matter. I will take the member back, I think, to 1969 when the hospital was taken over by the State Government from the Whyalla City Commission and when this debt was taken on board by Treasury on behalf of the State. At some later point in the evolution, once the Health Commission was formed, and the Whyalla Hospital was incorporated as a so-called ex-Government hospital under the Health Commission's Act, that debt servicing was handed over to the Commission. It is a book entry in both the practical and the historical sense. Perhaps Mr Cooper, with his fine sense of history and economics, might have something to add to that.

Mr Cooper: I think Dr Court might be able to answer this question.

Dr Court: The figure for next year will be slightly less than the $54 000 shown. The amount reduces from year to year. I cannot tell the member the exact figure.

The Hon. JENNIFER ADAMSON: It is apparent from the Budget documents, and from what the Minister has said, that this health budget is extremely tight, and that if inflation runs in excess of the anticipated level there is no way in which the Commission can meet its budget. That poses an extreme problem for the health services in maintaining quality of care. The Minister this morning commended the Metropolitan Hospitals Planning Framework Proposals. I draw his attention to page 30 of that document, which states that a reduction of between 10 per cent and 15 per cent in the number of hospital beds is reasonable and achievable without serious disruption or detriment to the service, and that it is, therefore, proposed that planning should be based on the provision of between 2 800 and 2 950 beds in major public hospitals by 1991. Does the Government accept the conclusions of the report and, if so, what is the Government's time table for their implementation?

The Hon. J.R. Cornwall: I have already made it clear to the Committee that the Metropolitan Hospitals Planning Framework was given to the Sax Committee for assessment. That Committee has assessed it and commented on it. I also indicated that I anticipated that the Sax Report would be tabled in both Houses of Parliament in something less than a month. It is not yet a public document and has not yet been considered by Cabinet. I have had the joy of reading this excellent document, but it would be inappropriate for me to comment on what is in it until it has been considered by Cabinet and released.

The Hon. JENNIFER ADAMSON: Acknowledging the inappropriateness of the Minister's commenting on a document before Cabinet has considered it, I nevertheless draw the Minister's attention to page 17 of the blue book and the budget of the Royal Adelaide Hospital. From my understanding of the situation at the hospital it will be extremely difficult for the Royal Adelaide Hospital to continue to make savings of the nature envisaged in this Budget, which represents a reduction from $96.8 million in actual expenditure in 1982-83 to a $95.5 million preliminary budget allocation this year, unless some beds in that hospital are closed. Can the Minister say whether the budget allocation for 1983-84 for the Royal Adelaide Hospital, or any of the teaching hospitals, envisages the closure of any beds during the current financial year?

The Hon. J.R. Cornwall: The short answer to that question is 'No'. However, with regard to the Royal Adelaide Hospital, I will ask Dr McCoy to comment on the budgetary situation. I point out before doing so that the preliminary allocation does not take into account a number of one-offs such as pay-roll tax, awards and, of course, the unallocated amounts and the round-sum allowances. Therefore, it is in fact very close to standstill. I think, specifically with regard to the Royal Adelaide Hospital, that there may be a cut in real terms of something like .5 per cent, but I ask Dr McCoy to comment on that.

Dr McCoy: The Budget allocation for the Royal Adelaide Hospital for 1983-84 is a standstill allocation and does not provide for any change in bed numbers at that hospital. There were a number of major items that caused the variance in the 1983-84 allocation from the 1982-83 actual. The largest of those was $962 000 for the 27th pay in 1982-83. There was also a transfer of $1 million to the Institute of Medical and Veterinary Science for what is called 'non-scheduled services'. I repeat that the allocation to the Royal

Adelaide Hospital is calculated by our staff precisely on a standstill basis.

The Hon. JENNIFER ADAMSON: I note that the provision this year of $95.5 million for the Royal Adelaide Hospital represents approximately 17 per cent of the total health budget. I recall that in 1979-80 the amount allocated to Royal Adelaide Hospital represented approximately 20 per cent of the State's health budget.

There were considerable savings, notably, in the first year of the Tonkin Government, in terms of savings on overtime by re-rostering cleaners, and other savings of a similar nature which did not have any impact on patient care but which represented several million dollars in terms of the hospital's budget. I note that in 1982-83 the hospital appeared (if I am reading the table on page 17 of the blue book correctly) to underspend its budget by $395 000, that being the variance between the budgeted amount and the actual expenditure. Will the Minister explain why that occurred?

The Hon. J.R. Cornwall: I will answer that in general terms and Dr McCoy will comment further. The member for Coles should put the matter in historical perspective. We ought to be clear that, despite the rhetoric, the reality is that the major cuts in the hospital area and particularly in regard to the Royal Adelaide Hospital occurred in the last Dunstan Budget, 1978-79, and that is often not widely acknowledged or recognised. In fact, the 1979-80 Budget, to which the member for Coles referred, was a *de facto* Corcoran Budget, and I am sure that everyone recalls with the same clarity, perhaps not with the same horror, as I recall the events of 15 September 1979. I am sure that the member for Newland recalls that day. That Budget was virtually prepared and inherited.

We recall that there was some rhetoric at the time about the 12½ per cent reduction in the cleaning staff and cleaning costs being in train before the change of Government. However, I am sure that members can remember some of the rhetoric about putting out lights, running up and down stairs instead of using lifts and cutting out the bickies with the morning tea. If one forgets about the rhetoric and comes back to reality, one sees that the fact is that certainly the Royal Adelaide Hospital in particular, but the hospital system generally, did very well during the 1970s until that 1978-79 Budget. By that time, the bubble had burst, and all hospitals since then have faced very substantial cuts from 1978-79 to 1982-83. Almost all health units, by and large, have faced very substantial cuts.

Further, the member for Coles stated that the Royal Adelaide Hospital appeared to have underspent its budget by $370 000 or $375 000, but that was in regard to a total budget approaching $90 million, so that is not a spectacularly bad result. Of course, it is not unusual for hospitals to finish marginally above or below their allocated budget. In fact, at 30 June the Commission does a round, as I am sure the former Minister would recall, and allocates, where it is reasonable to do so, money to those areas that have slightly overrun their budget and redistributes money from the hospitals or health units that have not overrun.

When one considers that there are 178 health units, and that in 1983-84 the total budget allocation will be $575 million, and when one realises the extreme complexity of the system, I believe that it is a remarkable tribute to the efficiency of the Health Commission that in the year just past we came in very close to spot on in regard to the expenditure budget. That point cannot be made too often. In terms of moneys raised and estimates of income, there is no doubt that the figures in the 1982-83 Budget were very rubbery, but, with regard to the proposed expenditure budget, I repeat that it is a tremendous tribute to the Commission and its staff that we came in as near as damn spot on in a budget of $575 million.

Another thing that might have escaped the attention of the honourable member is that previously the budget for the dental hospital was included under the Royal Adelaide Hospital. It was the initiative of the former Minister and her Government to make that area the responsibility of the South Australian Dental Services, which was formed during the period in which the member for Coles was Minister of Health. Presumably, that matter has escaped her attention, but that should not be so, because that action was an initiative of the Tonkin Government and the former Minister, and one which I highly commend. Dr McCoy may be able to add something more precise to those comments.

Dr McCoy: In November last year, a supplementary allocation of $1.7 million was provided to the Royal Adelaide Hospital, because at that time it seemed impossible for the hospital to come in within the allocation. The Government made it a condition of that additional allocation that the hospital would not replace staff without the approval of the Commission, and that condition was instituted at the Royal Adelaide Hospital. Very strict control over replacement of staff was applied for the remainder of the financial year.

I should add, however, that that was not the only cause for the hospital's coming in under budget. For a time, I think in February and March this year, the hospital was unable to recruit a sufficient number of nursing staff, and that also added to the $395 000 underrun that the hospital finished up with.

Mr KLUNDER: I refer to the rights of private practice of medical specialists. I realise that two separate systems operate, and I believe that the system in regard to resident medical specialists now contributes between $1.5 million and $2 million to the health system from the fees received from treating private patients in public hospitals. Before I refer to visiting medical specialists, will the Minister indicate whether he is happy with the system in regard to resident medical specialists?

The Hon. J.R. Cornwall: I consider myself either honoured or unlucky today (I am not sure which): the distinguished former Chairman of the P.A.C. is on my right, and the current distinguished Chairman of the P.A.C. is on my left. I am not sure whether it is bad luck or a tribute to my substantial skill that I am being questioned by people of such a calibre.

The question of the rights of private practice for both salaried medical specialists and visiting medical specialists has been quite vexed, as I am sure members would be aware, for a number of years. The matter was tidied up following a P.A.C. report in 1979, I think. I would not be held to that, but it was certainly within recent memory. I am still not entirely satisfied with the way in which the system operates. I am sure that the member for Newland would be aware of scheme A and scheme B. Those schemes are due for review and renegotiation before the end of this year.

This matter has also been addressed by the Sax Committee of Inquiry, which has made some quite specific recommendations with regard to the rights to private practice, but I am unable to recall the recommendations in fine detail. In any case, as I stated earlier in response to the member for Coles, it would be inappropriate for me to comment before the committee's report has been considered by Cabinet and tabled.

It is an area in which, for a variety of reasons, we will have to retain rights to private practice, particularly for salaried medical staff. Conventional wisdom suggests that we could not compete in the market place with salaried medical officers without offering the additional 25 per cent bonusing. The other reason is that it is a question of status within the profession for them to be able to take referrals from throughout the system. In general, we intend to persist

with the principle and the practice of rights to private practice for both salaried and visiting medical specialists. With regard to the current state of play in negotiations and other details, I think it is appropriate for Mr Alan Bansemer, who is in charge of the Policy and Projects Division, to respond more specifically.

Mr Bansemer: The Commission has been pursuing for a number of years consistent rights of private practice arrangeents for all categories of medical staff utilising the hospitals, be it on a salaried sessional or a fee-for-service basis. As the Minister has said, the issue of rights of private practice has been commented on by the Sax Committee of Inquiry. It is a specific aspect of the new Medicare arrangements, particularly in respect of diagnostic services (in particular for pathology and radiology).

The Medicare legislation has now been passed by Federal Parliament and there will be discussions between the South Australian Health Commission and the Commonwealth Department of Health in that respect in the near future. Those discussions, together with the Sax Report, will enable new private practice arrangements to be entered into in negotiations with SASMOA, early in the 1984 calendar year, probably from 1 February to coincide with Medicare (but not necessarily so).

Mr KLUNDER: I believe that those comments reasonably describe the situation for resident medical specialists. However, the situation in relation to visiting medical specialists is considerably different. The same scheme of 25 per cent on top of salary does not apply in that case or at least is not as strictly enforced. Could I have some further information?

The Hon. J.R. Cornwall: I believe that the member for Newland is referring to salaried medical specialists, not resident medical officers. The member would be aware that a resident medical officer is an intern and that a registrar is next up the ladder. Incidentally, with the overtime that some of our senior registrars are paid it is sad that they cannot afford to qualify as specialists. As an aside, it is now possible for them to drive a leased Porsche before obtaining a fellowship.

Mr INGERSON: Is it quotable?

The Hon. J.R. Cornwall: It is on the record. It is quotable. Not only that: it is guaranteed because it is salary plus overtime. We are no worse off; indeed, I think we are better off than some of our Eastern States counterparts. There is no doubt that they do rather well in 1983. I am not quite sure what matters the member for Newland wants us to address. I take it in the round that he is looking for more details in relation to schemes A and B as they apply to both salaried medical specialists and visiting medical specialists. I will ask Mr Bansemer to further expand on that area. The mysteries of schemes A and B are things with which my great mind has not yet coped. The complexities of the schemes are a bit much, even for me. Mr Bansemer seems to understand them well, and I think it would be appropriate if I asked him to comment on them in some detail.

Mr Bansemer: Strictly speaking, rights of private practice only apply to full-time salaried staff. They do not apply to visiting staff, be they sessionally employed or employed on a fee-for-service basis. As such, schemes A and B apply to full-time staff only. The differentiation between schemes A and B is that scheme B is a different scheme that relates specifically to pathologists, because of the way that pathology referrals are undertaken and the difficulty associated with delineating private practice in that area.

The intention of the Medicare arrangements, and now the Medicare legislation, is that the institutional billing arrangements, the arrangement by which hospitals raise accounts for a doctor in respect of private practice, provide that it will happen with respect to not only salaried staff as at the present time but also sessional visiting staff and fee-for-service staff. That is a significant extension in the diagnostic services area and it represents a change throughout Australia in that regard.

The application of facilities charges as distinct from the right to private practice to all services on which a doctor earns income using hospital facilities is a matter that has been addressed by the Commonwealth in its Medicare considerations and also in the Sax Report. The Sax Report specifically recommends how South Australia might approach that issue. I could read into the record the specific details of schemes A and B, but they do not actually impinge on the visiting staff mentioned by the honourable member.

The Hon. J.R. Cornwall: I make two points: first, the visiting medical specialists in particular cases and in certain health units have given and taken a degree of flexibility. For example, it was recently brought to my attention by a disgruntled colleague of a medical specialist (not a disgruntled colleague of mine, because I try not to have any) that one of the visiting medical specialists at a teaching hospital was allegedly 'going home early and seeing private patients in sessional time' for which he was paid by the hospital.

An investigation of the allegation revealed that the specialist in question often worked substantially more than the 3½ hours of his session and, from time to time, came back quite outside those hours to respond to specialist calls to public patients. As a *quid pro quo* for that, on occasions the specialist certainly saw patients in his sessional time. By and large, the credit accruing to the hospital for the payment of those sessional fees was certainly well and truly in advance of 3½ hours. I do not know to what extent I would want to interfere with that (it is virtually an honour system), unless there was any evidence of widespread abuse, and that certainly appears not to be the case at the moment.

The other thing that Mr Bansemer touched on, and which I also might touch on at this stage, at least in a preliminary way, is the whole question not only of facilities charges but privileges charges. It is my notion at the moment that we certainly ought to further investigate facilities charges for all specialists using hospital facilities to generate private income. I do not know of any other profession in which the taxpayers are called on to provide all the facilities without some charge being made; it certainly does not happen to dentists, surveyors, architects or almost any other profession that one would like to nominate. I would recommend to my Cabinet colleagues that we pursue this matter of facilities charges vigorously once the Sax Report is at hand.

Further to that, I intend to investigate vigorously the question of whether or not it is appropriate for specialists, using our teaching hospitals to see private patients, to pay privileges charges. In other words, it is a substantial honour, and almost a necessity, if one is to be pre-eminent in one's specialty or sub-specialty that one has a teaching hospital appointment. That is a privilege, and I do not think that it is unreasonable for us to ask those specialists to make some modest contribution for those privileges. I would certainly give the Parliament notice that I intend to pursue that area once the Sax Committee Report is available.

Mr KLUNDER: In the area of the chief internal auditor who, I understand, has been appointed, is it possible to give me some idea of the role that this person is expected to play, what his powers are and, in particular, whether it is intended that he will work only within the Health Commission or whether he will have the power to investigate the accounts of various hospitals and, if so, which hospitals?

The Hon. J.R. Cornwall: I am not sure whether the member for Newland was present previously when Mr Cooper responded at some length on a similar line of questioning from the member for Hanson.

Mr KLUNDER: I understand that he did reply, but did not answer particularly the detailed question of whether the internal auditor has power to investigate accounts of hospitals or whether he should stay just within the Health Commission.

The Hon. J.R. Cornwall: Perhaps I should answer that first and ensure that Mr Cooper has not too much room for manoeuvre there because, as Minister of Health, I have very firm views on the subject, and so does the Government. I know that the health units to which the honourable member is referring are not terribly enthusiastic about the internal auditor's expanding his activities into those areas. It is certainly our intention as a Government, and my intention as Minister of Health, that the internal auditor should extend well beyond the immediate confines of the Commission at 52 Pirie Street, Adelaide. As we are restricted by the time being almost 1 o'clock and having circumscribed Mr Cooper to that extent, it would be appropriate for him to give the Committee substantially more details about those proposed activities, but it may be appropriate—I am in your hands, Mr Chairman—if we were to continue on that question after the luncheon adjournment.

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

Mr Cooper: The question asked by the member for Newland dealt with the power of the internal auditor to inspect and check costs and accounts. The internal auditor has the powers of the Commission which, in regard to incorporated hospitals and health units, are extensive and require records to be produced for inspection. The Commission as a whole is responsible for ensuring proper financial procedures in health units and for reviewing hospital expenditure. The internal auditor's role will be to strengthen and support the work already being carried out by the Commission's sector officers in that regard.

Mr Oswald: Regarding the staffing of certain units at the Royal Adelaide Hospital, I refer to a report in the *Advertiser* of Friday 23 September 1983 headed 'Staff shortages cuts to respiratory service', which states:

A shortage of medical staff at the Royal Adelaide Hospital is restricting the services of a specialist department which treats respiratory diseases. The director of the hospital's department of thoracic medicine, Dr R. Antic, has sent a memo to all heads of units in the hospital warning them that his department may not be able to provide a full service because of a 'shortage of medical staff beyond the control of the department'. The Royal Adelaide Hospital administrator, Dr N. A. Elvin, said the department was 'about two physicians short'. 'One physician died about four or five weeks ago and there is one resident medical officer down because of rostering reasons,' he said.

I have been told that the deceased physician has not yet been replaced. Regarding the Burns Unit, today's *News*, referring to a statement made by Dr Ritson in the Legislative Council, states:

Dr Ritson told the Legislative Council specialist staffing of the unit had been cut 50 per cent.

'According to doctors who have spoken to me, it couldn't cope if we had another Black Wednesday or an aircraft accident,' he said.

'I have been informed some operations are being done by juniors without supervision.'

A report in the *News* of 11 April 1983, referring to the Burns Unit and its use in the case of the victims of the Ash Wednesday bushfire, stated:

Royal Adelaide Hospital Burns Unit urgently needed support, according to the widow of a firefighter who died last week as a result of the Black Wednesday blaze. Ronald Childs, 57, a retired engineer, suffered burns to 80 per cent of his body. He became the fires' twenty-seventh victim. His widow, Mrs Betty Childs, of Mount Barker, said the unit had been so short-staffed she had been tempted to complain to the Health Minister, Dr Cornwall. 'On one visit I was asked to watch the intravenous drip while the sister went to tea,' Mrs Childs said.

The Burns Unit is one of South Australia's specialist services and I understand that it is at present short-staffed. I am informed that, as stated in the newspaper report, mid-week operating lists are now being performed by registrars without consultant supervision. The registrars and anaesthetists are unhappy about this situation.

The ophthalmic clinics have a six-month waiting list for elective surgery, including plastic surgery. In a report headed 'Waiting list for surgery at South Australian public hospitals', the *Advertiser* of 24 September states:

Most South Australian public hospitals have waiting lists for non-urgent surgery. It ranges from a few weeks for conditions like gallstones and orthopaedic surgery to one to two months for plastic surgery, ear, nose, throat and eye operations, and six months for vascular surgery. The acting administrator at Flinders Medical Centre, Mr J. Hehir, said yesterday that a high intake of emergency cases often resulted in operations being cancelled at short notice. The medical superintendent at the Royal Adelaide Hospital, Dr Susan Britton, said elective surgery was often disrupted by the hospital's high volume of emergency cases. The medical superintendent at the Queen Elizabeth Hospital, Dr J. H. Knebone, said that some clinics at the hospital had long waiting lists, particularly plastic surgery which could be more than six months. The list for ear, nose and throat surgery and some plastic surgery was in excess of six months.

I also understand that the curfew applying at the Royal Adelaide Hospital prevents operating lists from going over time, and the gross inefficiency of the administrative process in calling in patients has resulted in gaps in the operating lists so that although, when judged by statistics, clinics do not look to be very busy, they are in fact being thwarted in their efforts to get on with the job.

I understand that the former Director of Anaesthetics has retired and will not be replaced and that the staff, by resolution, offered to extend sessions, without payment, so as to clear the backlog, but this offer was refused. As a result of the foregoing, morale at the Royal Adelaide Hospital is very low. Members of the staff believe that theatre utilisation figures misrepresent the real problem and that the hospital board is not aware of the situation. To the extent that the estimates of salaries must contain a component for sessional payments, are these estimates based on staffing levels before or after the cuts and do they provide for an anticipated increase in demand after the commencement of Medicare, which the Australian Labor Party believes will enable many people to afford non-means tested public hospital care for the first time?

The Hon. J.R. Cornwall: Recently, on several occasions the hospitals have received budgets that are negotiated with each of the hospitals and other health units by the sector directors and sector representatives.

Provided those budgets are then allocated in a way that is generally in keeping with the policies of the Government and the Health Commission, there is a substantial degree of independence granted to the hospital boards of management and hospital administrations as to how the money is allocated and spent within each individual unit.

One thing which has concerned me personally and which has been a high priority for the Government is to restore and ensure the quality of care for which South Australia's major teaching hospitals have been and remain the envy of many of our colleagues in other States. It was for this reason specifically that I was able to round up some of the best, if not the best, medical administrators in Australia under the chairmanship of Dr Sax to conduct the Sax Committee of Inquiry. That is the first time in Australia that a major inquiry has been held in which the major thrust of the inquiry has been precisely on that point; that is, the restoration and maintenance of high levels of quality of care in those hospitals. The Sax Report, to which I referred earlier and which will be available soon, will be, I hope, a blueprint for successive Governments of whatever political persuasion to follow in regard to quality assurance mechanisms in South Australia to the end of this century.

Regarding Royal Adelaide Hospital, in particular, I will be asking Dr McCoy, Executive Director, Central Sector, to respond to the specific matters raised, but in regard to R.A.H. there seems to be quite an amount of medical politics being played at that hospital now. Some of that may be in anticipation of recommendations that are likely from the forthcoming Sax Committee. It is not surprising that particular units within those hospitals would not want to see themselves disadvantaged and are taking out some insurance in advance in case they do not fare as well as other units in particular hospitals in the Sax Committee's recommendations.

One of the terms of reference of the Sax Committee was specifically to look at the allocation of funds, not just between health units and between hospitals, but within units and departments within particular major hospitals. No doubt, we have been seeing some medical politics being played in recent weeks. In regard to the two questions about waiting lists and the so-called overtime for the lists of sessions, yes, for elective surgery there are waiting lists. I do not believe that there are any waiting lists of which I am aware now which would be cause for alarm or dismay but, with the stringencies that have been forced upon the system in the financial years since 1978-79, in particular, inevitably now there are some waiting lists for elective surgery. Somewhere there is a happy medium. For example, the United Kingdom used the waiting lists as a deliberate tool to discourage discretionary surgery. I am not talking about unnecessary surgery in the sense of performing, for profit, something that is not needed: I am talking about what is called 'discretionary' surgery.

It has been found in the United Kingdom and other countries that, by extending the waiting lists, one sometimes finds, particularly where medicine is being practised on a salaried basis, that so-called discretionary surgery rates drop substantially. Indeed, the alternative P.S.R.O. approach, used in the United States in which many other parameters are used, has proved to be on objective analysis probably a costly failure. Certainly, it is not a model that we would want to adopt here any more than we would want to use the tool of unacceptably long waiting lists as a method for reducing discretionary surgery.

I refer to the complaint that these days the surgeon and the operating theatre team do not simply carry on past the appointed time for any session to conclude to tidy up anyone who has not been attended to in the surgical list, because of unforseeen circumstances, which extend the period of time spent on individual patients. There are some difficulties because in this day and age the nursing profession rightly demands reasonable conditions of employment. The profession no longer wishes to work under Florence Nightingale conditions and I support it in that view.

I do not believe that being a nursing sister should any longer involve working 70 or 80 hours a week without overtime and cop it or else. That is unacceptable to us as a Government, although inevitably it is sometimes more economic if elective surgery is deferred for another time. In the realities of the economic situation in 1983, this situation is likely to persist for some time.

In regard to the shift to public hospitals under Medicare, I have said often that the best guesstimates available to the Government, based on the experience of many different systems between 1975, when the original Medibank came into being, through to September 1981, when all vestiges of the original Medibank scheme were dismantled (about six schemes later), of the shifts to and from public to private hospitals and back again in South Australia have not been terribly marked. I estimate that they would not be greater than 3 per cent or 4 per cent with the introduction of Medicare on 1 February. Turning specifically to the issues of the Thoracic and Burns Units at Royal Adelaide Hospital and the reported waiting lists for plastic surgery in public hospitals generally, it would be much more satisfactory if I asked Dr McCoy to respond to those matters.

Dr McCoy: The allocation to R.A.H. in 1983-84 is based on a standstill allocation. I said previously that that does not provide additional resources for any change in the work load that may or may not accrue as a result of Medicare. It is of interest to look at the work load of R.A.H. in the past two years. In fact, there was a slight reduction in the number of admissions to the hospital. In 1981-82 the number of admissions was 42 657 and in 1982-83 it was 42 173—a slight reduction. There has not been an increase in work load at R.A.H. in recent times. The specific question relates to thoracic medicine. Dr Hunter, Director of Tuberculosis, died a few weeks ago.

A registrar attached to that department was sick and unable to be on duty. He has now returned to duty and the hospital is considering the question of a replacement for Dr Hunter's position. I know that that matter is being considered at this time by the Administrator and the Board. The question of operating theatres has been mentioned by the Minister. The hospital has instituted a policy requiring elective operating lists to conform to the four-hour list limit. This stysem has been instituted for approximately 12 months and is working satisfactorily. It is occasionally necessary to delay an elective operation on a patient who has been admitted because an emergency or some mishap has occurred in an earlier operation requiring that the later operation be delayed until a subsequent day. The patient's operation is usually performed the next day. We recently checked on this matter and found that only once in a few months is it necessary to send a patient home to be recalled for an operation at a subsequent time.

I turn now to the Burns Unit. Registrars do perform operations in the Burns Unit and this is standard practice. All registrar work in hospitals is under the supervision of consultant staff. There are occasions when consultant staff may not be physically present in the operating theatre during a minor procedure when the full details of the procedure have been worked out with the consultant prior to the operation. No registrar in the burns unit at the Royal Adelaide Hospital would ever perform in an unsupervised way. The question of waiting time has been raised. There is factual information available on waiting times. At the Royal Adelaide Hospital the waiting time for general surgery is about two or three weeks, for orthopaedic surgery up to three months, ear, nose and throat, for a minor procedure from four to six months and a major procedure three to four months. The problem at the Royal Adelaide Hospital, if there is a problem, is in plastic surgery where there is a waiting list for some procedures in excess of 12 months. However, those procedures could be regarded as being in the field of cosmetic surgery. Certainly, no urgent operation is ever delayed at the Royal Adelaide Hospital if occasioned by trauma or cancer. Most patients are dealt with expeditiously. There are, of course, a number of plastic surgical procedures that come into the category of discretionary surgery as mentioned by the Minister and there is a waiting list for those at the Royal Adelaide Hospital.

Mr Oswald: I gather from that reply that the Minister is satisfied about the nature of waiting lists and is satisfied that the present cuts in staffing levels will not interfere with staff ability to cope with Medicare. I think that that is assumed in the reply given thus far. Does the Minister really believe that the medical staff of the Royal Adelaide Hospital would have offered honorary service if there were adequate staffing levels, and does he agree that the decision to refuse this offer of free service highlights an anti-doctor attitude on the department's part?

The Hon. J.R. Cornwall: I have also stopped beating my wife. With no disrespect, that is a loaded and rather foolish question. We have examined the matter of staffing previously. The Budgets of teaching hospitals, in particular the Royal Adelaide Hospital, were supplemented by the Bannon Government as one of its first major acts. As Dr McCoy has already told the Committee, the major beneficiary of that major supplementation was the Royal Adelaide Hospital, which received $1.7 million. That has been carried over in a so-called standstill Budget to 1983-84, so any suggestion that staffing cuts have been a policy that I have pursued is a complete nonsense. To suggest that I am satisfied with a situation as alleged where there may be inadequacies of staff in particular units is also quite nonsensical. I have not at this point been given other than anecdotal evidence that there is, in fact, any permanent staffing shortages in any of those units.

As Minister, I cannot be held responsible for the unfortunate or untimely death of any medical staff in any of the units—that is reducing the whole discussion to a basis of absurdity. However, I do not concede in any way that I have been personally responsible for staffing cuts in particular units. I have made it clear previously that there have been no staffing cuts in general in our hospitals and that we specifically moved to stop that happening. As to what happens in individual units, I think I ought to make a couple of things very clear to the Committee. First, I am the Minister of Health and not the Chairman of the Health Commission. There has been a very regrettable tendency in recent years for the Minister, particularly my immediate predecessor, in the health area to act as Chairman as well as Minister. That is not, as I see it, the role of the Minister of Health. I do not think that the Minister is an administrator and to suggest that he should be involved in the day-to-day conduct of one or all of the 178 health units in the State of South Australia again is an absurd notion and I most certainly reject it. I obviously accept responsibility for policy, and that is a perfectly legitimate and proper role. That policy is that there will be no further staff cuts in our teaching hospitals. We have managed, by and large, to restore what was a very poor morale in the teaching hospitals generally. That position has been reinforced by a survey performed in recent times.

The general level of satisfaction with our hospitals in South Australia is again high and I intend to see that it stays that way. I believe that Dr McCoy might have more to add with specific reference to those individual units that were mentioned and I will ask him to do that in a moment. It is not my intention to play petty politics either at the level of small 'p' politics that appear to be going on, particularly at the Royal Adelaide Hospital or, more importantly, in the matter of quality assurance and administration as it affects those hospitals. I ask Dr McCoy to respond further with regard to the units, if he thinks it appropriate.

Dr McCoy: The Health Commission regularly monitors staffing levels of all hospitals. I do not have the figures before me for the past 12 months, but I can recall accurately that full-time equivalent staff numbers at the Royal Adelaide Hospital from July 1982 to June 1983 increased by a small number, I think 20—it was certainly of that order.

Therefore, there has been no overall reduction in the number of staff at the Royal Adelaide Hospital. Of course, there are changes in emphasis in the hospital in regard to increasing specialisation, and there is a need to review staff in individual departments constantly so that imbalances are not perpetuated. The Administrator and the hospital board constantly review staff, and there are times when minor reductions in some areas are suggested to provide resources for expanding areas. To my knowledge they are the only changes that have been contemplated at the Royal Adelaide Hospital. In fact, very few of those changes have taken place.

Mr Oswald: I asked whether the Minister really believes that the medical staff at the Royal Adelaide Hospital would have offered honorary services if there were adequate staffing levels. The staff offered their services, and the Minister, through the Health Commission, turned down the offer. It seems strange that the Minister can sit there and reply at length knowing full well that what I say is factual. The Minister may wish to comment or he may pass by that point.

The Hon. J.R. Cornwall: I am perfectly happy to comment. The honourable member has returned to his nonsensical argument, which I thought I refuted adequately and at some length. I understand that some members of the medical staff made an offer to the Administrator and the Medical Superintendent of the Royal Adelaide Hospital. I made the point very clearly that I am not involved in the day-to-day administration of the Royal Adelaide Hospital, the Queen Elizabeth Hospital, the Modbury Hospital, the Flinders Medical Centre or the hospital at Booleroo Centre, for that matter. I am the Minister, not the Chairman, and I am certainly not the C.E.O. of any of the hospitals. Nor have I any qualifications that would remotely qualify me to act in that position. I happen to be a very good Minister, but I am not Chief Executive Officer material and I do not have any pretentions to being Chief Executive Officer, either at Booleroo Centre or at the Royal Adelaide Hospital.

The offer was made to the Chief Executive Officer, Dr Elvin, and to the Medical Superintendent. They did not consider that that action was necessary and, as I understand (and I will ask Dr McCoy to comment further), that message was relayed to the people who made the offer. I would make a further point, which I believe is very important—ever since I became the Minister I have been trying to introduce a note of realism into this concept of hospitals' so-called autonomy. No-one who has any brains or even any pretentions to having any intelligence pretends for one moment that that autonomy should be taken literally. However, under the charter (the South Australian Health Commission Act) a very substantial degree of managerial independence is given to individual health units, provided they operate within the general policy guidelines of the Government of the day and the South Australian Health Commission. From time to time the Opposition has made all sorts of statements that autonomy is a sacred thing and that I should not be seen to be attacking it, that I am upsetting hospital boards of management, and so on.

At the same time, with the remarkable inconsistency for which they are becoming noted, Opposition members say that I should be involved directly (and that is the inference of the member's question) in the day-to-day management and decision making of the board of management and the administration of the Royal Adelaide Hospital. That is totally inconsistent. Regarding quality assurance, of course I have a duty and I am discharging that duty via the senior officers of the Commission. I hope that I do not have to go over, for the eleventh time, the fact that quality assurance is paramount in the Government's policy and that we are about ensuring that quality assurance is put in place and maintained and will be extended by many of the major recommendations of the Sax Committee.

However, I repeat yet again that it is not my business as Minister of Health to be involved in the day-to-day conduct of individual health units. I believe that Dr McCoy may be able to add more specifically to that answer, as it impacts upon the offer of some of the small 'p' politicians at the Royal Adelaide Hospital who involve themselves in these matters.

Mr Oswald interjecting:

The CHAIRMAN: Order! Interjections are out of order, particularly interjections from someone who is not a member of the Committee.

Dr McCoy: An offer was made by some members of the staff to provide honorary services. It was the view of the administration of the Royal Adelaide Hospital that that additional service was not required. The medical staff complement of the Royal Adelaide Hospital is, of course, huge, and by any criterion it is sufficient for the work load of that hospital. Comparisons that were undertaken two years ago between the major teaching hospitals in this State and similar teaching hospitals interstate showed that the medical staffing level of the Royal Adelaide Hospital and indeed that of most of the major teaching hospitals in South Australia was at a good level and in some comparisons it was quite high. I do not believe that there is any objective evidence by which one could say that staffing levels at the Royal Adelaide Hospital in medicine or in any other category are deficient.

Mr PLUNKETT: The document at page 16 refers to special benefits. The Minister in his opening address said that the pensioner denture scheme would involve some unemployed. Will all unemployed people come under that scheme? How many schoolchildren will come under the dental scheme? I note that $942 800 has been allocated in this regard: what further finance will be allocated to this scheme? If more people come under this scheme, most certainly that sum will not be adequate. As the Minister has just received a fair bit of criticism, I would like to say that since he became the Minister of Health I have had a lot of dealings with the denture and spectacle schemes and I have found that my constituents have been better treated than they were treated under the previous Minister of Health. At that time it was practically impossible for those people to receive attention without having to wait for 12 months.

The Hon. J.R. Cornwall: I suspect that several matters are rolled into the honourable member's question. The honourable member has touched on the South Australian spectacles scheme, to which I will return in a moment. I believe that he also touched on the school dental scheme, to which I will also return in a moment. He also touched on the pensioner denture scheme, both as to the scope of its services and its funding. The spectacles scheme is a refinement and extension of the pensioner spectacle scheme which was introduced by the previous Government on 1 November 1982, just five days before the State election. It was a commendable scheme, but it suffered from several major disabilities, the greatest of which was that it was open ended.

It became very clear to us within a matter of months of getting into office, if not weeks, that the pensioner spectacles scheme could not be allowed to proceed on an open ended course. Accordingly, I set up an inquiry in to the pensioner spectacles scheme in, from memory, April this year after it had been operating for less than five months. As a result of the inquiry, the scheme was extended to include certain categories of low-income earners and long-term unemployed as defined by health cards. This year the scheme will cost $2 million in total. The estimate shown is $1.2 million, and I will ask my advisers to elucidate that position in a moment.

The other area mentioned by the honourable member was the school dental scheme. I brought Dr David Barmes, the Chief of oral health of the World Health Organisation in Geneva, to South Australia and he informed us that it is one of the finest schemes of its kind in the world. Certainly, it is by far the best in Australia and it is a scheme of which we should all be very proud. I think the great majority of South Australians, particularly South Australian parents, are quite rightly proud of the scheme. We have promised to extend a school dental scheme to all secondary students over two parliamentary terms, or six years. The first move to implement that decision occurred this school year when we made the services of the school dental scheme available to all secondary school students who qualify for the so-called free book list. The 13 000 secondary school children from financially disadvantaged families now have immediately available to them the services of the primary school dental scheme.

The pensioner denture scheme to which the honourable member also referred was an initiative of the Tonkin Government and, in particular, the previous Minister, Mrs Adamson, the member for Coles. It is a very good scheme. I would have thought that it was one of the significant initiatives of the previous Administration to which I can pay almost unrestrained praise. We have no intention of allowing the scheme to diminish in any way. At the moment, we cannot find our way clear financially to extend it beyond people who hold a pensioner health benefit card. In summary, the South Australian spectacles scheme has been expanded, and an amount of $2 million has been made available to it in this financial year. The school dental scheme has been expanded and has been financed principally by a small modification in the rate of re-examination of primary school children who, following fluoridation and the operation of the school dental service over a fairly long time, have fairly good oral health. The pensioner denture scheme is being maintained. To the casual observer, the money figures would be a trifle misleading, to put it mildly. I will ask Mr Cooper to further explain the figures to the Committee.

Mr Cooper: I will attempt to clarify the estimates. Essentially, in relation to the spectacles scheme, an amount of $1.224 million is shown. There is also an amount of just under $900 000 shown as funds yet to be allocated. That money is held as a reserve to be allocated in the course of the year, but allows for a cost of $2 million. We expect that money to be applied to the spectacles scheme if the estimated costs eventuate. The increase in cost is due to having to meet the cost of the scheme for a full year (the scheme was not introduced until the middle of the previous year) and the extension of the scheme to the long-term unemployed, as mentioned by the Minister.

The other point worth clarifying in relation to the pensioner denture scheme is that the initial estimate reflected in the figures was $942 000. However, the books were prepared some weeks ago. Subsequently, the management of the South Australian Dental Service has been able to increase the allocation of funds to the scheme to $1.125 million. That sum allows for the costs incurred last year with an inflation factor of 6½ per cent.

Mr PLUNKETT: I refer to Hindmarsh Community Hospital on page 15 of the blue book. That hospital is located in my district. I note that there was an allocation of $22 500 for the previous year and no allocation for this year. Is it intended to continue to provide finance to the Hindmarsh Community Hospital?

The Hon. J.R. Cornwall: The short answer is 'No'. It is worth providing a brief history of the Hindmarsh Community Hospital. Members would be aware that metropolitan community hospitals are not the financial responsibility of the State and particularly of the Health Commission. They are available to insured patients, not to public patients, particularly since the abolition of section 34 beds. Therefore, there are no public patients in private hospitals at this time. In other words, they are self supporting. They collect their daily bed charge and other charges from insured patients and receive a subsidy, currently $16 a day for medical patients and $28 a day for surgical patients.

We were approached by people representing the Hindmarsh Community Hospital prior to Christmas last year, I think from memory. It seemed that there was a threat that the hospital would be closed and, therefore, staff would

automatically lose their jobs in a pre-Christmas situation. Obviously, I did not want that to happen in a crisis situation, so I asked Cabinet to make a specific allocation to keep the hospital going for an interim period. In the meantime, I directed a specific inquiry to the Sax Committee to assess the Hindmarsh Community Hospital as to its future role, viability, and so on. It is a small hospital in rather poor repair. The management of the hospital had something of an idea that, if the hospital considerably extended its operating theatres and proselytise in the surgical and medical community generally, the hospital might be able to get itself back to a bed occupancy rate that would restore viability. When the hospital approached us it had potential for 30-bed occupancy but had an actual average occupancy rate of something like five or six beds at any given time.

Quite obviously, that was a hopeless situation economically. It is surrounded by high quality hospitals—both community and public—and it is an ageing area, as the honourable member would be aware since he represents constituents in that region; it has an ageing population and a high number of aged pensioners who are pensioner health benefit card holders, to whom, of course, the facilities of the hospital are not available because they are public patients. All things being considered, it did not seem to be wise as a State to continue to support the Hindmarsh Community Hospital. That decision was certainly reinforced by a specific report which we received via the Sax Committee from one of its very skilled members.

So we have not supported the Hindmarsh Community Hospital financially for some months, and it is not our intention to support it financially in 1983-84. This has been conveyed to the board of management and to the local council which is involved. I am unaware at this time as to what arrangements they have made, but it would seem almost inevitable that at some point the Hindmarsh Community Hospital will close on the basis that it is no longer viable and that, by and large, it is unable to meet the needs of the great majority of the population of the area in the sense of its being a true community hospital.

Mr ASHENDEN: I would like to ask the Minister two questions on the Mount Gambier Hospital, and then a third question in a different area. When the member for Coles was Minister of Health she approved the establishment of a psychiatric unit at Mount Gambier Hospital. I believe that subsequently you, Mr Minister, also gave the approval for that unit to go ahead. The unit itself was also approved by the Health Commission in 1982, but since then no progress appears to have been made on that unit. Does this mean that the Minister has withdrawn approval and funds for that unit; if so, why? If not, why has there been no move to establish that unit?

The Hon. J.R. Cornwall: First, I make it very clear that I have not withdrawn approval or funds for an acute psychiatric unit at the Mount Gambier Hospital. Secondly, it is pretty difficult to run an acute psychiatric unit without a psychiatrist; this is a matter which will have to be addressed. Further, in the specifics of the area, I will ask Ray Sayers, the Director of the Southern Sector, to comment in a moment.

Before leaving the subject, I will comment on the Mount Gambier Hospital in general terms. I am sure that members would recall—and I know that the member for Coles would recall—that there was quite a kerfuffle at the Mount Gambier Hospital in the latter half of 1982. All sorts of allegations were made because the administration was rather over-enthusiastic in its pursuit of new management initiatives, if one might call them that, and in its cost containment programmes.

It was very obvious that when the residents of Mount Gambier were patients of the hospital they did not like mixed bathing. When one of the surgical wards was closed and male and female patients were pushed into one end in a mixed sex situation and were forced to use common bathroom and toilet facilities they did not appreciate the situation—to put it mildly.

As a result of that becoming a matter of public controversy, the then Minister appointed Dr Barry Catchlove from the Royal Children's Hospital in Melbourne to conduct an investigation into the administration and affairs of the Mount Gambier Hospital. I thought that that was a good appointment, and as a Government we continued it after we came to office in November. The Catchlove Report subsequently came in; the matter was discussed by all interested parties; a seminar was held in which I participated, as did senior officers of the Commission; and several things have been done since which have put the administration back on the track to the extent that it was ever significantly off it and which have also assuaged the fears of medical officers, the administration, and nursing staff in particular.

Only last week, I announced a $41 000 consultancy, which has been let to Ernst and Whinney, to further delineate the needs, roles, functions, and so forth, of the hospital. I gave a commitment in a pre-election situation that we would seek to upgrade the Mount Gambier Hospital to regional base hospital status. I think that I am able to tell the Committee without going into any great depth that one of the many recommendations of the Sax Committee of Inquiry confirms that and recommends quite clearly that we should work towards regional base hospital status in all these sorts of things, including accreditation of the Australian Council on Hospital Standards which that involves.

The question of an acute psychiatric facility is also addressed, of course, in the Smith inquiry into mental health services in South Australia. All of that is background. I repeat that of course the Commission is committed to the establishment of an acute psychiatric facility within or about the hospital, and that commitment is hardly likely to be affected by free enterprise, democratic socialist ideology or anything else. It is based very soundly on the need of the area and is an ongoing commitment. Having said that, I ask Mr Sayers to fill the Committee in on the specific details of where that is at or what is likely to happen in the next year or so.

Mr Sayers: The psychiatric in-patient facility at the Mount Gambier Hospital is only an interim arrangement. It was approved some 14 or 15 months ago and the matter is now with the Public Buildings Department, where plans are being drawn to enable the interim facility to be made available to Mount Gambier. It is not to be taken as the long-term solution to the needs of the community, but the more urgent nature of the current psychiatric efficiency is such that we are attempting to put in a six-bed interim psychiatric ward which can be easily converted back to normal acute facilities if the need arises.

One other situation in relation to the psychiatric service at Mount Gambier is the further extension of the psychiatric extended care service with the employment of an additional psychiatric nurse and some further social work and occupational therapy support for that service. So, there is an expansion of the psychiatric extended care service, and the Public Buildings Department is currently drawing the plans for the conversion of an existing ward in the hospital to a six-bed interim psychiatric in-patient facility.

The Hon. J.R. Cornwall: I might add to the question of the psychiatric nurse that was raised by Mr Sayers that I consider it undesirable in the longer term that a psychiatric nurse should be in Mount Gambier in splendid isolation. Two things must happen, and I will urge the Commission to investigate them further: one is that the opportunity be made available for any psychiatric nurse who is stationed

in Mount Gambier or in any other country area to have access on a regular basis to his or her peers at the major psychiatric hospitals.

Also, as soon as it is reasonably feasible, we should double the number from one to two. Personally I do not think that in the long term a psychiatric nurse should be asked to work alone. That is one of the many recommendations of the Smith Committee of Inquiry.

Mr ASHENDEN: I understand that the main lift at the Mount Gambier Hospital is suffering from recurrent breakdowns and stoppages. Last week, two visitors were trapped in the lift for 15 minutes, and it could have been serious if a patient on the way to an emergency operation had been trapped. The previous Minister of Health provided a new secondary lift last year, and the situation then was dealt with swiftly. Will the Minister have this serious problem investigated and solved urgently?

The Hon. J.R. Cornwall: The previous Minister of Health presided over a situation where the capital funding for the entire health system in South Australia deteriorated to under $12 million a year, which is about half of what we really need to replace facilities on a 75-year rolling cycle basis. In the first year of this Government the amount available has been restored to over $19 million. I am aware of the marked deficiency in the lift system at Mount Gambier. It was forcibly drawn to my attention recently when a preliminary study on the replacement or upgrading of the lift system at an estimated cost of $440 000 was referred to me.

The fact that the Mount Gambier Hospital has five storeys and that the estimated cost of this work is almost $500 000 indicates the real problem in this area of capital funding and points up the wider problems created by the previous Government with its precedent of using Loan money to balance the recurrent expenditure Budget. If the honourable member wishes to ask a question about what the Government has done to rectify that disastrous situation, I will reply to it specifically.

Mr ASHENDEN: I refer to the Minister's activity in his capacity as Minister of Health. The Minister would have us believe that he is an excellent Minister. Does he believe, however, that it is normal courtesy for a Minister to tell a member when a Ministerial visit is to be made to that member's district? On three occasions the Minister has visited the District of Todd to undertake specific duties in his role of Minister of Health. Why has he on no occasion advised me of his visit, as is the practice generally amongst Ministers and was indeed the practice of the previous Minister of Health?

The ACTING CHAIRMAN (Mr Klunder): There is only a loose connection between the question and the Estimates, but I will permit the question.

The Hon. J.R. Cornwall: The question seems to be an indication of how the mind of the member for Todd works and of his priorities. It provides a rare insight into the honourable member's mind. It is my custom always, and members of my staff are instructed always, to notify any member whose district I am to visit. If there has been a slight on the honourable member for Todd, it is entirely unintentional. I have better things to occupy my mind than trying to slight him in any way. I very rarely think about him.

Mr ASHENDEN: The arrogance of the Minister must be seen to be believed. I would like to have my question answered.

The Hon. J.R. Cornwall: The honourable member is not high on my list of priorities and, although I tend to be something of an insomniac when I think about the $575 million Budget that I administer, the member for Todd is not a reason for my insomnia. On one of the occasions to which he refers, both he and I attended the 10th anniversary of the establishment of Modbury Hospital. I always try to see that members are advised before I visit their districts. However, I have been an extraordinarily active Minister in getting around to the health units. I have visited more than 100 health units in the city and country in the first 10 months of my term as Minister. When visiting as many as five health units in a day on a three-day trip, the odd mistake may be made in not notifying the member for the district of my visit. If such an error has been made, I apologise profusely and am humbled by the fact that it has been drawn to my attention by the member for Todd.

Mr INGERSON: As one who has for many years sat on various health committees, I believe that this morning's proceedings have probably been the best example of filibustering and egomania through which I have sat. The statement was made this morning that outstandings in the hospitals sense are higher and would be expected to be higher than they are in the private sense. However, I find that hard to accept: public funds need to be protected and monitored in accordance with sound accounting practices just as much as do private funds.

I am concerned about the fact that accounting practices involving both crediting and debiting of accounts in the private area are not adopted in the public health field. Many companies have a turnover of $19 million and find it simple to run a debit and credit system. Why do not the hospitals adopt such a system?

The Hon. J.R. Cornwall: It seems most unfortunate that the millionaire pharmacist from Bragg seeks to denigrate the public sector and, by inference, the very senior and competent officers of the Health Commission who are charged with co-ordinating, integrating and running the system generally. I do not believe that they need me to defend them. I will be pleased to have Mr Cooper respond to that question in the first instance as I believe that they were his comments to which the member for Bragg was referring.

Mr Cooper: In regard to the first part of the question, the argument I presented was that the level of outstandings in a hospital are likely to be higher in a hospital than in an equivalent commercial enterprise. I repeat the reasons which I gave this morning. Probably the most important is that many of the outstanding debts relate to patients claiming under workers compensation legislation. Those claims take a considerable time to process and the hospitals—

Mr Ingerson interjecting:

Mr Cooper: I am not sure whether I can respond to interjections.

The ACTING CHAIRMAN (Mr Klunder): You should not.

The Hon. J.R. Cornwall: On a point of order, Mr Acting Chairman, I do not mind the heat of the kitchen myself, because I am a politician, but it is grossly out of order for members to interject on my officers. I have a duty to protect them.

The ACTING CHAIRMAN: If the Minister had not interrupted, he would have heard that I was making that point at the time the Minister began speaking. Certainly, the Minister should not be interjected on, and most certainly other witnesses should not be subject to interjections.

Mr Cooper: The question of workers compensation applies presumably only to hospital services. It also applies mostly to public hospital services in that they are a result of accidents and injuries, which go to the large accident departments of our main hospitals.

The second point is that we do not run a credit check of patients when they present for treatment, particularly if they present through the accident department. In a commercial transaction, not necessarily the hospital, but at John Martins, Coles or Myers, if a company was to extend credit of thousands of dollars, the person involved would be subject

to credit checks. There are some poor risks in the hospital business.

The third point I made was that the outstandings to an extent reflect the practice of writing off bad debts. Traditionally in hospitals we have not written off debts until such time as every possible opportunity has been exhausted for the debt to be recovered. That tends to be part of outstandings. Really, I am just repeating what I said. With respect to the second part, I seek some clarification, because I am not quite sure what systems the member was referring to.

The Hon. J.R. Cornwall: Before calling on Dr Court to give us more figures on compensable patients, to make it clear why we have particular difficulties in the public system versus the private system, I point out that one of the further problems encountered in the public hospital system is the infamy of the fifth Fraser health scheme of which the previous State Administration was an enthusiastic supporter.

There was a large and dramatic increase in the number of people in South Australia who did not qualify for health cards but who, on the other hand, because they were the working poor, could not afford to be insured with flat rate insurance. That was one problem.

Of course, the other problem was that we were increasingly forced to cope with and deliver quality services to rapidly increasing numbers of people who did qualify for health cards because they were losing their jobs or because, for one reason or another, in the difficult economic times, they became eligible for health cards. That put an enormous strain on the Budget. It is a risk that would not be taken; it is not taken by private hospitals or private pharmacists; and it is one with which we had to cope, because we were in the business of delivering first-class hospital care to all the people of South Australia who chose to use our system. Just to illustrate further the difficulties with regard to compensable patients, Dr Court has figures that he should give to the Committee.

Dr Court: The figures that the Minister refers to quite specifically cover the percentage of compensable accounts in the total outstandings. It is 41 per cent of the total for the four hospitals mentioned in the Auditor-General's report, and that figure rises to 50 per cent at R.A.H. Of the outstandings of $6.6 million, as referred to in the Auditor-General's Report, $3.338 million are compensable accounts. There are two other additional points that I should add in relation to the figures in the Auditor-General's Report. One is that the figure of 3.5 months outstanding, which has been quoted, is calculated using average monthly raisings for the 1982-83 year.

There were two fee increases during the year so that the methodology used normally when making these comparisons with other States would be on the total raisings averaged in the last three or four months after the 1 February increase. That would significantly reduce the figure of 3.5 months.

The other calculation mentioned in the Auditor-General's Report is to estimate total outstandings at $27 million. That calculation is based on an assertion that, because the four hospitals mentioned comprise 50 per cent of total revenue raisings, one can multiply total outstandings of $13.5 million by two and get $27 million for the whole system. In fact, those four hospitals represent 60 per cent of the total outstandings merely because of those compensable accounts. The actual total outstandings are much nearer $23 million.

Mr INGERSON: First, as a personal explanation, I wish I was so lucky to be a millionaire pharmacist. Perhaps if I had chosen to be a vet I might have been able to achieve it.

My next question relates to page 6 and deals with strategy. The comment made concerns restructuring the South Australian Health Commission to allow it to operate more efficiently. Will the Minister give greater details?

The Hon. J.R. Cornwall: I will be pleased to do so. Currently, we have a Bill before the Upper House which seeks to amend the structure of the Commission, as comprised of Commissioners, which will change it from a Chairman, who is the Chief Executive Officer of the Commission and seven part-time Commissioners, to a full-time Chairman, a full-time Deputy Chairman and three part-time Commissioners. I believe that this will meet the requirements as both the Government and I see it of the Commission's needing to be concerned with the most efficient administration possible.

One of the difficulties was the old set-up of the Chairman and the seven part-time Commissioners, as well as the Health Services Advisory Committee. The Bill further seeks to disband the Health Services Advisory Committee, because the Commissioners found it very hard to find a role for themselves.

Some of them wanted to be involved in the day-to-day conduct of the Commission, which was hopeless. Some of them were very enthusiastic about devising and arranging policy, which again I did not think it appropriate for the Commissioners to do. We have a Policy and Projects Division that is very well equipped with senior professional officers who are well able to develop policy. I think that, if one looks at the matter in the private corporate sense, one sees that the Commissioners have a real opportunity to act as a watchdog on the operations of the health service. For that reason, I made these submissions to the Alexander Inquiry.

You would be well aware, I am sure, Mr Chairman, that one of the things that the Government did as part of its inquiries into the general administration and efficiency of Government was set up the so-called Alexander Inquiry under the chairmanship of Mr Don Alexander, Deputy Director-General of the E. & W.S. Department, to look into the whole structure and operation of the Commission, meaning the Commissioners and the Commission as generally understood by the 300 employees in Pirie Street. The recommendation was that we should tighten the Commission, with which I fully agreed and which, in fact, I commended to the Alexander Inquiry. The three part-timers, subject to the legislation passing both Houses, should comprise, according to the Alexander recommendation, a person who is or was prior to retirement a senior public servant; a person with experience and senior in medical and hospital administration; and a senior and qualified person from the private sector experienced in administration.

In anticipation that we will be able to restructure the Commissioners and the Commission according to what is proposed in the legislation, I have recently replaced some of the former Commissioners with Commissioner Mary Beasley, who fits the classification of a senior public servant well versed in the workings of the system; Mr Rick Allert, who I suppose one could describe as a company doctor extraordinaire (and it is nice to have a company doctor in the Commission); and Dr Brendon Kearney, former Deputy Chief Executive Officer and Acting-Chairman of the Commission for some time and recently appointed Director of the I.M.V.S.

Mr INGERSON: I turn now to stores and pharmacy inventory systems, which are mentioned on page 20. Will the Minister explain what has been achieved and is hoped to be achieved with the next stages of these systems?

The Hon. J.R. Cornwall: I believe that I could, but I think that Mr Cooper can do it much better than I, so I ask him to respond to the question.

Mr Cooper: This is a very advanced system for the control of inventory in hospitals. It has been piloted at the Queen

Elizabeth Hospital. The current position is that the stores receiving element is operational. We expect to have a full stores system, including the distribution end, implemented when the software, which should be available in October and which will take two months to implement, becomes available. This involves a complex exercise in a whole series of substores throughout the Queen Elizabeth hospital. The final component is a stores and inventory control system specifically for the pharmacy which we expect to be implemented in the early months of 1984. The current position is that that system in underway. However, there have been some delays.

When we went to tender for this system we were unable to identify any commercial software package that was tendered that met more than, I think, 65 per cent of the functions required, so there has been quite a lot of new software development involved for this system. There has also been a great deal of work which began at the beginning of the software development in parallel with development of a computer system in the reorganisation of the manual stores procedure within the Queen Elizabeth Hospital and in the physical reorganisation of the store. In summary, we have had a substantial upgrading of the general stores system at the Queen Elizabeth Hospital and expect to have a fully operational stores system at the end of this year or in January of next year and an extension to encompass the pharmacy system and maintenance store in the first part of next year.

Mr GREGORY: Under the heading 'Services for the protection, promotion and improvement of public health', the yellow book (page 52) refers to occupational health, the lead project industrial hygiene, and dust monitoring in occupational health services. Will the Minister advise how much has been spent on occupational health this year, and what the Government intends to accomplish by spending that money?

The Hon. J.R. Cornwall: It would be most productive if I answered the second question first, and that referred to where we are going in regard to occupational health. The more specific question related to the funding, and I will ask either Mr Cooper or Dr Court to respond in that regard. We have taken several initiatives in occupational health already in our first 10 months. It is an area to which the Government in general and the Minister of Health accord a high priority. It seems to me (in fact, it is to state the obvious) that in Australia generally and in South Australia in particular we have not done anything like enough in the occupational health area in the past two decades. There is a terrible shortage of adequate statistics, for example.

I have said on many occasions (this is not an original quote, as I am sure the member for Florey will recognise) that it is perhaps ironic that there are better figures on diseases of animals in abattoirs than on industrial diseases of workers. That is something that we intend to do a great deal about. Already, we have recruited Dr Chris Baker from the Wellcome Foundation, who was head of industrial health in that Foundation in the United Kingdom. We have been fortunate enough to recruit Dr Baker to the official position of Deputy Executive Director of Public Health. It is anticipated that in the fullness of time Dr Baker will be the Director of Occupational Health Services. Dr Milton Lewis is currently the Acting Director of Occupational Health Services, and there are some very substantial technical and scientific skills in the senior personnel in that division.

We have already met an election commitment to pay particular attention to repetition injury or tenosynovitis, as the group of diseases that occur from repetition is characterised. At this moment we are putting our own house in order. The major initiative to date has been to devise and implement a three-stage programme across the board in the Public Service area, and that includes all State Government departments and statutory authorities. Under stage 1 of that programme, a team, including a medical officer employed on a contract basis, has surveyed a representative sample of 500 employees, taking oral and medical histories, so that we can obtain some idea of the percentage incidence of repetition injury in the State Public Service.

The next stage will be to devise and supervise control methods that will be put in place in the public work force. The third stage, which we hope will be completed before the end of this financial year, will involve going back and checking how effective those control measures have been. The first priority is to put our own house in order, and to do that we have employed an additional two full-time ergonomists in the occupational health area in addition to Mr Trevor Shinnick, who has been employed for quite some time as a senior ergonomist.

We have given a special grant to the Adelaide Womens Health Centre to provide a half-time medical officer and support staff to conduct a clinical survey amongst the female work force, particularly amongst women who attend the Adelaide Womens Health Centre. That is in addition to the programme that is being conducted in the public sector. The ergonomists are available to advise both employers and trade unions in the private sector on any problems that arise in the work place, whether it be in an assembly line situation or in regard to white collar workers who are involved with data processing machines and word processors. That consultancy service has been considerably expanded by the employment of two ergonomists.

I believe that that is a reasonable thumb-nail sketch of what we have done to date in regard to repetition injury. As another important initiative, the Minister of Labour and I conjointly have set up a steering committee that is chaired by Dr John Matthews of the V.T.H.C./A.C.T.U. Occupational Health Clinic in Melbourne, who is well known and distinguished for his work in the occupational health areas. Dr Matthews is the Chairman of the steering committee, to which three working parties report individually; one has been charged specifically with considering how we can best implement the election undertaking that was given by the Minister of Labour, Jack Wright, to establish a tripartite authority comprising employers, employees and Government to consider the whole range of legislative areas, law enforcement and so on, in an area that is most properly the domain of the Minister of Labour. The working party will make recommendations specifically to the steering committee.

The second working party has been asked to consider the feasibility and practicality of establishing a South Australian Institute for Environmental and Occupational Health. It is envisaged that the present Occupational Health Branch would be used as the nucleus for that institute. While not wanting to pre-empt the findings of the working party through the Committee, I indicate that in broad terms it is envisaged that it should be an independent unit incorporated under the South Australian Health Commission Act which would have contact with one or more of the learned institutions, such as the Institute of Technology or the Royal Adelaide Hospital, through the University of Adelaide medical school, for example.

Again I am spelling out these things in very broad terms without pre-empting the committee's findings, but it would also be available in a consultative capacity to employers, employees, and Government, with the tripartite authority being responsible for the collection of very important statitics, to which I referred previously.

It is very much an area in which I think information is power, because we must have a much improved and broadened information base from which to work. The third working party is examining and will report on a trade union

managed and conducted occupational health centre or centres. In broad terms, it is envisaged that the centre or centres will have two principal roles. One role relates to the conduct of clinical services, and I will not take up the Committee's time explaining that role in any detail, because I think it is self-explanatory. The other role would be to advise workers in the work place on safety measures and to assist workers on the job to negotiate safety agreements with employers. We see the latter role as being most important.

It is envisaged that Government funding will be used in the first instance to set up the centre or centres. After a period of two to three years, because of the nature of the present workers compensation insurance arrangements and the Medicare arrangements where appropriate, the centre or centres will become financially self-sufficient. Indeed, expansion may occur to an extent that allows for the employment of a legal officer or a social worker and further expansion in appropriate fields. The centre or centres will not be conducted under the aegis of the Health Commission and will not be under the control and direction of the Minister of Health.

It is also envisaged that the initial centre will have its own constitution and will be conducted by the Trades and Labor Council or one of its appropriate affiliates. The original centre could be based at Trades Hall, for example, because that is an appropriate location. I hope that, once the centre becomes a financially viable organisation, it may well be able to set up satellite occupational health centres in areas such as Elizabeth, Port Adelaide, Noarlunga, the Iron Triangle, and so on. I stress that after the initial setting up period the centres will not be a financial liability for Government. They should be self-supporting and independent of Government so that, even if a change of Government occurred in the democratic process at some future time, their future should be assured. I refer to the question of funding for occupational health this year. I think I indicated briefly at the outset that we already have a substantial range of services provided under our existing occupational health branch.

Dr Court: I am afraid that the figures required by the honourable member are not available. I undertake to convey them to the Committee at a later time.

Mr GREGORY: I refer to page 56 of the yellow book and the programme titled 'Enabling Services'. The subprogramme 'Health systems support services' refers to a transport component and the St John Council and the Royal Flying Doctor Service. Can the Minister say what finance has been given to those two organisations and what services are they providing to the community for the money they are receiving from the Government?

The Hon. J.R. Cornwall: The short answer is 'No'. A direct grant is made to the St John Council in return for its running a State ambulance service. That amount is shown on page 15 of the blue book. The estimate for the 1983-84 financial year is $3 402 800. Of course, that only tells part of the story. The St John Ambulance Service is subsidised, indirectly, to a very large degree by the payment that it receives for its clinic car service and the ambulance service that it conducts from our public hospitals. The money raised from those services amounts to a figure substantially in excess of the $3.4 million shown in the Estimates on page 15 of the blue book. Dr Court will provide more details in relation to the specific dollar amounts in a moment.

The Royal Flying Doctor Service is principally funded by the Federal Government. It has always been regarded as a Federal responsibility, because it is a national organisation that runs State branches. It is also significantly funded by public donation. It is an extraordinarily highly regarded service unique to Australia. The actual amount provided to the Royal Flying Doctor Service is indicated on page 15 of the blue book as $382 000 for the 1983-84 financial year. Of course, that amount does not represent anything like the actual cost of running the Royal Flying Doctor Service. Dr Court will explain the more specific amounts for St John.

Dr Court: The main figure that the Committee may be interested in is the total gross payment budgeted for the St John Council in 1983-84, which is $11.993 million. That figure will be offset by the sorts of revenue that the Minister mentioned in terms of ambulances, clinic cars and other charges in relation to the hospital system. The offsetting receipts, as shown on page 17 of the blue book, amount to $8.591 million. That makes up the net funding that the State Government will provide of $3.402 million. If the Committee desires more information, Mr Sayers, from the Southern Sector, who has overall responsibility for that Budget line, may be able to provide it.

Mr GREGORY: Also on page 56 of the yellow book there is reference to the Red Cross. I note that a similar amount is mentioned on page 15 of the blue book. Page 60 of the yellow book refers to 'Grants to Red Cross Blood Transfusion Service'. The outcome for 1982-83 is shown as nil. The proposed expenditure for 1983-84 is not available. Could the Minister explain that?

The Hon. J.R. Cornwall: That situation certainly requires some explanation. The Red Cross Blood Transfusion Service is funded by the State Government through the Health Commission. Originally, a significant part of the funding came from the Minister of Health—Special Grants line. Originally, the Minister of Health—Special Grants line was for innovative grants and special 'one off' grants that arose in particular 'one off' situations. A lot of that money became institutionally committed over a number of years. It was considered desirable in the accounting for 1983-84 that it be taken out of the Minister's personal money-bag and accounted for directly through the Commission.

You will see that there is no longer a grant to the Red Cross Blood Transfusion Service from the Minister's own area and that it now comes directly from the South Australian Health Commission. The amount estimated to run the Blood Transfusion Service, which it is estimated that the Health Commission will put in for 1983-84, is $3.152 million. I am sorry; I have been corrected; I am not as philanthropic as I thought. That actually includes, I am told, $1.3 million from the Commonwealth. The service is Government funded.

The Hon. JENNIFER ADAMSON: Before proceeding with my questioning, I will make two observations: the first is that self-praise is no recommendation and, on that basis, the Minister has certainly not recommended himself to the Committee, to the Parliament or to the community of South Australia today. In fact, his ego tripping has been a revelation to those members of the House of Assembly who are not normally subjected to such tactics, but I can understand the concern of the Minister's Upper House colleagues for what they describe as his ego tripping.

The second is that it has been traditional in this Parliament for questioning on the Budget, whether under the old line system of Budget examination or under the new programme performance budgeting system, for the Opposition to be given the opportunity to question the Minister at length. Certainly, under the previous Government questioning of Government Ministers by their own members was limited to the absolute minimum. I note that that tradition has been reversed and that the Minister has been given the opportunity to answer a series of Dorothy Dix questions from his own members, which has resulted in a filibuster, which does not really serve the purpose of the Estimates Committee—particularly such a ponderous filibuster as the Minister has engaged in.

I refer to page 14 of the yellow book (to the resource allocation for the Chairman's office) and ask the Minister whether he can inform the Committee of the precise terms of appointment of the new Chairman of the Health Commission: not only his salary but also his specified leave and any other emoluments or conditions which are written into his contract. We have noted with some surprise that the new Chairman has accepted an appointment as a clinical professor at the Flinders Medical Centre and that he is continuing with commitments that he had with the World Health Organisation prior to his appointment.

Whilst it is easy to understand that commitments formerly entered into by the new Chairman would have to be honoured, I would have thought that the job as Chairman of the South Australian Health Commission—which I would regard as one of the most, if not the most, onerous in the Public Service in South Australia—would require a full-time commitment and not leave open any opportunity for other commitments within the State. So, I ask for the precise terms, conditions, salaries, emoluments and leave entitlements of the new Chairman, and also whether any fees which he receives (if any) in his capacity at Flinders Medical Centre or in any other capacity are deducted from his salary as Chairman.

The Hon. J.R. Cornwall: I point out at the outset that it was not me who politicised the Estimates Committee today; it was in the first instance the member for Hanson, and it is typified by the snide sorts of remarks being made by members on my right at this very moment. If there has been any abuse of the committee system, which is still relatively fragile because this is only the fourth year in which we have had this system operate, it has certainly not been by members of the Government but by members of the Opposition.

The quality of questions has not been very high, and I do not believe that some of them have been relevant, even in the most tenuous way, to the documents that are before us. I cannot, for example, imagine what my alleged failure or otherwise to notify the member for Todd that I was visiting the Modbury Hospital has really got to do with the yellow book, blue book or any other book.

As to the allegations of Dorothy Dix questions, if members like to read *Hansard* when it is available they will see that that allegation, of course, is ridiculous. I would have thought that some of the hostile and vicious questions that I have received from members like the member for Florey and the member for Unley, for example, make it very clear that there was certainly no collusion in any normally accepted sense of the term.

I turn now to more important and statesmanlike matters; that is, specifically the appointment of the distinguished Chairman of the South Australian Health Commission, Professor Gary Andrews.

Members interjecting:

The CHAIRMAN: Order from both sides!

The Hon. J.R. Cornwall: At the time of Professor Andrews' appointment I described it as a coup for South Australia, and I continue to describe it as that.

Members interjecting:

The CHAIRMAN: Order! The member for Todd and the member for Florey: I want to hear the reply even if they do not.

The Hon. J.R. Cornwall: I must say that I am almost distressed by the puerile antics of the member for Todd. I thought that he was here to consider seriously the Budget that is before us, which will expend $575 million of taxpayers' money. It ought to be noted by those taxpayers that the member for Todd has carried on in an infantile way for most of the day.

Mr ASHENDEN: On a point of order, I ask the Minister to withdraw those comments. I take exception to them; I regard them as most unparliamentary. They are certainly no description whatever of my attitude to this matter. Unlike the Minister, I do treat this matter seriously and if his ego was not so large he would be able to see that.

The CHAIRMAN: I understand that the words used by the Minister were not unparliamentary, but if they are objectionable to the member for Todd I ask the Minister whether he would consider withdrawing them.

The Hon. J.R. Cornwall: I have to put some rider on that. If the member for Todd could begin to behave himself, I would certainly be—

The CHAIRMAN: The Chairman will decide and keep order, and from now on I intend to keep strict order.

The Hon. J.R. Cornwall: Thank you very much. Since the member for Todd seems to think that there is one rule for him and one for the rest of us, I withdraw the words that he finds offensive, but I do not believe that they are unparliamentary.

Reverting to the Chairman's appointment, I was saying when I was rudely and inappropriately interrupted by the member that I believe that Professor Andrews' appointment was an absolute coup for South Australia. He is a very distinguished medical academic. He was the foundation Professor of Community and Geriatric Medicine at the University of Sydney, based at Westmead Hospital. Prior to that he was a Commissioner with the New South Wales Health Commission. He has had a long and distinguished career in both the medical academic area and the administration area.

When I was able to persuade him that he should come to South Australia, I was delighted, as was the Government and as all South Australians ought to be. He, of course, in addition to his work as the Professor of Community and Geriatric Medicine at Westmead has also had numerous contracts with the World Health Organisation over quite a lengthy period, which, of course, gives some indication of the high regard in which he is held not only in this country but in the world scene. It was not easy in the circumstances to entice him from a very senior life tenured position which he held at the University of Sydney to come to South Australia at the age of 44 to a contract position.

He had been employed in the New South Wales system ever since he graduated over 20 years ago. I believe that all reasonable Parliamentarians and all members of the South Australian public would realise that in those circumstances there had to be negotiations with a little give and take. Notwithstanding that, Professor Andrews was employed at the advertised salary of $63 000 a year, the same as his predecessor, who was appointed by the former Minister.

There had to be negotiations on superannuation because Professor Andrews could not transfer from the New South Wales superannuation scheme to the South Australian scheme, so special conditions in that respect are still being negotiated. Originally, there was to be a lump sum payment on expiry of the contract that we were negotiating, but those negotiations were upset to some extent by the Commonwealth Government. To the best of my knowledge, the current negotiations have not been completed, but the resultant arrangement will not be extraordinary.

As to Professor Andrews's appointment as Professor of Clinical Medicine at the Flinders Medical Centre and at the Adelaide University Medical School, he sought, understandably, to keep some links with his previous academic achievements. It has been agreed that he devote one half-day a week to the unpaid honorary positions of visiting Professor of Clinical Medicine at both Flinders and Adelaide. Those appointments had to be granted by the universities: there was no way the Government or I as Minister could

direct the universities in that regard. The appointment to both positions has been made on the Professor's considerable merit in the academic field.

Regarding Professor Andrews's contracts with the World Health Organisation, I knew when he came to us that he would wish to continue that association, but it was obvious that he could not continue it on the same level as he had enjoyed while he was at the University of Sydney. At various times he had W.H.O. contracts in Qatar, Korea and the Philippines, to name but three countries. After discussion, it was decided that he should and would restrict his W.H.O. association to a maximum of six weeks a year outside South Australia and that part of that period, up to two weeks, should comprise annual recreational leave. The emoluments that Professor Andrews will receive on these contracts are very much a matter between him and the Commissioner of Taxation: they have nothing to do with me as Minister or with the Government. That agreed arrangement in respect of W.H.O. contracts is part of his contract of appointment to the position in this State. I should have thought that it would be stupid and disastrously myopic of us not to urge Professor Andrews to maintain his contracts with the W.H.O., which holds him in high regard.

Professor Andrews is an outstanding world expert in his field and neither I nor the Government would have it otherwise. It should be noted that at a time when the population of South Australia is ageing rapidly it is highly desirable that the Chairman of the Commission is a world expert in the area of gerentology and that he keep up as well as lead the world in his field of expertise. The conditions of leave applying to Professor Andrews, other than leave of absence for six weeks each year to which I have referred, are the same as those applying to any other senior appointee to the Health Commission.

The Hon. JENNIFER ADAMSON: As I understand the position regarding the six weeks each year that Professor Andrews will spend with the W.H.O., up to two weeks will be taken as annual recreational leave, with the result that he will be away from the Commission for two months each year. In telling members that the Professor will spend half a day as honorary Professor of Clinical Medicine at Flinders and at Adelaide University, does the Minister mean that the Professor will spend half the day at each university or that the half day will cover his work at both universities? In other words, will the Professor work a four-day or a 4½-day week for the Commission?

The Hon. J.R. Cornwall: It is half a day a week in total. That does not mean that the Chairman will work only a 4½ day week however, as he is extremely industrious and diligent and works on many weekends as do the rest of us.

The Hon. JENNIFER ADAMSON: Since coming to office the Government has conducted various inquiries. Can the Minister say how many inquiries have been conducted and give details of their individual and aggregate cost?

The Hon. J.R. Cornwall: The estimated cost of the Sax inquiry into hospital services is $90 000. The Smith inquiry into mental health services, for which two members were brought from the United Kingdom, one from New York and one from Western Australia, has been estimated to cost $45 000. The review of the management of the Health Commission, referred to as the Alexander inquiry, has been estimated to cost $3 000. The estimated cost of the Opit inquiry into the St John Ambulance Service is $5 500. The Barmes inquiry, for which Dr Barmes was brought from the W.H.O. headquarters at Geneva and in respect of which he was assisted by a leading Sydney dentist, has been estimated to cost $10 000.

It is interesting if one compares that with the consultancies that were paid by the Commission's central office, excluding computing, because in 1981-82 it was $104 929 and in 1982-83 it was $78 737. The point is that when one considers the calibre of the people we brought in to establish directions and quality assurance in the South Australian Health Services into the 1990s and beyond, we have had extraordinary value for money.

The Hon. JENNIFER ADAMSON: I am interested in the cost, albeit estimated, because I thought that the Alexander Committee had reported, although the cost was $3 000. I do not know what was the hourly rate for that Committee, but at normal consultancy rates it looks like about 60 hours for an inquiry which was allegedly to examine the whole operation of the Commission and make recommendations for its restructuring. That seems a minimal amount of time to spend on what most people would consider to be a major operation.

The Hon. J.R. Cornwall: The answer is pretty simple: all the people involved in the Alexander inquiry were public servants.

The Hon. JENNIFER ADAMSON: Surely the inquiry was conducted on a programme performance basis and presumably the Commission would have been charged by the departments for the respective personnel engaged if the Government is pursuing p.p.b.

The Hon. J.R. Cornwall: I will obtain further details rather than pursuing the matter in a *quasi*-political manner. We will get the facts from Mr Bansemer, Director, Projects and Policy.

Mr Bansemer: The cost of the Alexander inquiry represents the consultancy fee for Mr R. Allert, who assisted the inquiry. The inquiry was conducted as part of the Guerin review of the Public Service. As such, costs were not charged to the Commission. I cannot answer whether they were charged to the Premier's Department or whether they were met by the Public Service Board or the individual departments concerned.

The CHAIRMAN: The honourable member has already asked three questions, and I hope that this final question will tidy up the matter.

The Hon. JENNIFER ADAMSON: I merely seek information about the qualifications of Mr Allert in the field of health administration.

The Hon. J.R. Cornwall: We are getting heavily into character assassination and denigration today. Mr Allert's qualification as a high-profile operator in the private sector in accountancy and business management are well known, as I told the Committee some time ago when I talked about Mr Allert's appointment as a Commissioner. I thought it appropriate that we have a company doctor in the Commission. Mr Allert's expertise back through his many years as principal and senior operator with Peate Marwick and Mitchell before going into practice on his own account is well known.

The Hon. JENNIFER ADAMSON: I rise on a point of order. The Minister's statement that a straight question about the qualifications of a person is tantamount to character assassination should be struck from the record because I had no intention and made no attempt in any way to denigrate Mr Allert. I was simply seeking information.

The CHAIRMAN: The member for Coles has made a point, but the matter cannot be struck from the record.

Mr MAYES: I am somewhat tempted to seek from the Minister information about the cost of this hearing today. Having raised the matter earlier today, Mr Chairman, I accept your ruling. After seeing the officers involved in the exercise today, I believe that the exercise could be completed in a simpler and more economic way, but I understand that such comment cannot be accepted as a question, and so I hesitantly withdraw any thought of asking the Minister that question. I refer to grants given to non-recognised hospitals

(page 60 of the Estimates schedule) and ask what form those grants take. In what direction are they placed?

The Hon. J.R. Cornwall: That figure refers to equipment subsidy.

Mr MAYES: Reference is made in a preamble to the establishment of a sobering up service in the metropolitan area so that the offence of public drunkenness can be decriminalised. Do the funds allocated come directly from the allocation on page 36 in regard to adults and problems arising from drug and alcohol abuse?

The Hon. J.R. Cornwall: The simple answer is 'Yes'. The funds will be provided and administered by the Alcohol and Drug Addicts Treatment Board or whatever the appropriate body may be by the time the provision is in place. Suitable legislation to decriminalise public drunkenness was passed in Parliament six or seven years ago but has never been implemented. It is our express intention to have the offence of public drunkenness removed before the end of this financial year and that appropriate sobering up centres be provided both in metropolitan and in country areas.

Negotiations with the Police Department, the Attorney-General's Department and all other interested Government and community bodies are proceeding and are close to finality. I expect that in autumn 1984 we will be able at long last to not only proclaim the legislation which will remove the offence from the Statute Book but make adequate provision for handling people who are drunk in public places.

Mr MAYES: Will the administration of this programme come under the direction of the Alcohol and Drug Addicts Treatment Board or will there be a separate administrative arrangement for this programme?

The Hon. J.R. Cornwall: It will come under the administration of whatever the alcohol and drug services body is at the time of proclamation and implementation of the scheme.

Mr BECKER: I refer the Minister to page 24 of the blue book where it refers to the Health Commission in statement No. 10 under the heading 'Recognised hospitals'. The staff to patient ratio at the Queen Elizabeth Hospital is 1:4.84. I wonder whether that is considered to be a satisfactory ratio. I am concerned about an article which appeared in the *Advertiser* on Wednesday 21 September under the heading 'Q.E.H. contributed to my husband's death—widow'. I am interested in this article because it relates to an allegation that the person passed away because of an epileptic fit. I did not know that there was such a thing as an epileptic fit in an actual sense. Having checked with a neurologist as to whether a person could die from a seizure, I was told that it was highly probable that that could happen.

I am concerned that this is the second time that something of this nature has happened concerning one of our hospitals. My experience is that it is extremely unfortunate for a hospital to come under such criticism. Hospitals treat thousands of out-patients, and I wonder whether other hospitals are experiencing the same sort of criticism or whether the Queen Elizabeth Hospital is being singled out for attack. I wonder, also, what this is doing to the credibility of the Q.E.H., which is of a very high standard.

The Hon. J.R. Cornwall: First, as the member for Hanson should know, the matter to which he has referred is now the subject of a coroner's inquiry and it is therefore quite improper for it to be canvassed here. I do not intend to transgress in the same manner as has the member for Hanson.

The general thrust of the question regarding accident, emergency and casualty services at our major public hospitals is a good one. This is a matter that has concerned me deeply ever since I entered this Parliament eight years ago. I am sure that you, Mr Chairman, would remember that I raised this matter several times when I was on the back-bench in Government at least six, and possibly seven, years ago.

The matter of the Queen Elizabeth Hospital, in particular, and quality of care in the accident and emergency areas, has been particularly under my scrutiny because I am not an eastern suburbs silvertail (I happen to live in the western suburbs and am proud of it), so the Q.E.H. is my hospital. The matter has concerned me so much that immediately upon becoming Minister I set matters in train to do something about it (one of the joys of being in Government is that one can stop talking and start acting).

I set up, as I have said several times today, the Sax Committee of Inquiry. The whole thrust of that committee's terms of reference was about quality assurance, and one of the specific terms of reference talks about the units and the allocation of funding to units in the hospitals. Also, and more specifically, during the conduct of that inquiry I went to Dr Sax and asked that he specifically have a member or members of the inquiry particularly assess all the accident and emergency departments in our public hospitals. That is the sort of priority that I gave the matter; it could not have been higher. As a result of that specific request, Dr Ian Brand, a member of the committee who is also the Administrator of the Preston and Northcote Community Hospital in Melbourne, which I am told arguably has the best accident and emergency service in the country, attended the accident and emergency departments of every public hospital in the metropolitan area.

A few weeks ago I was sent a set of specific recommendations for each hospital—the Queen Elizabeth, Lyell McEwin, Modbury, Royal Adelaide and Flinders Medical Centre. They were specific and general recommendations as to the sorts of things that ought to happen in the accident and emergency departments of the hospitals and the reorganisation that ought to occur. Those directions were subsequently given to each of the sector Directors to present to the hospital for implementation. They will not form an integral part of the Sax Committee of Inquiry but are specific to each of the hospitals concerned.

The common theme that ran through all the recommendations was that the Sax Committee, and Dr Brand in particular, did not believe that any of the boards of management, or any of the administrations, were giving sufficiently high priority to the accident and emergency departments. These, as I have said, were then taken to each of the hospitals. To date, I must say with complete candour, I have not been satisfied overall with the responses that have been forthcoming from the administrations and boards of the hospitals. The Adelaide Children's Hospital was also included in the survey, and recommendations have been made concerning it as well.

I have asked senior officers in the Commission to prepare for me a major Cabinet submission, one of which I anticipate taking to Cabinet in the near future. One of the things which I will recommend to Cabinet and which appeared specifically in that document is that the hospitals so order their affairs as they must to the extent necessary to see that the recommendations of the Sax Committee, and of Dr Brand in particular, are implemented. I will not tolerate a situation where there can be any doubt about the fact that South Australians, when they attend the accident and emergency departments of those hospitals, will get the very best medical attention and the very best care available in this nation.

Mr BECKER: My personal experience is that that would be so at the Q.E.H., and that is why I was concerned to know whether or not the Q.E.H. was being subjected to unfair criticism in the past or whether it really was different from any other hospital. That is what I really wanted to know.

The Hon. J.R. Cornwall: It is fair to say that there is a degree of unacceptable variation between hospitals in this area. I do not think that it would be right for me, under Parliamentary privilege, to pick out any one hospital as against any other in this regard. However, with particular regard to the Q.E.H., I think it is fair to say, without reflecting on the quality of care that has been available in the accident and emergency department, that they have not had an adequate triage system.

There have not been sufficient resources devoted to the A. and E. departments. It is not appropriate regarding the Queen Elizabeth Hospital for me to comment further than that, as there are two coronial inquiries.

Mr BECKER: Are amendments being prepared to the Physiotherapists Act and, if so, will the Minister say when the legislation is likely to come before Parliament?

The Hon. J.R. Cornwall: I cannot think of anything at the moment to which I would give a lower priority than amendments to the Physiotherapists Act.

Mr KLUNDER: Given that there has been a degree of increase in cosmetic surgery in public hospitals in the past few years and that the self-same hospitals have lost a great deal of fat in that time and that they are under some pressure to cope with an enormous load of medical and surgical cases, is there any danger that the increase of cosmetic surgery will put some strain on the health services?

The Hon. J.R. Cornwall: I can only repeat what I said earlier. I am the Minister, not the Chairman, the C.E.O. of individual health units or a sector director. Dr McCoy may be able to comment further.

Dr McCoy: I referred earlier to the waiting list in a number of clinics and private hospitals, and I indicated that the longest waiting list was for the plastic surgery departments. People have to wait for about 12 months. That comment applied mainly to patients for cosmetic type surgery. I think it is fair to say that departments of plastic surgery in the major hospitals in metropolitan Adelaide place a high priority on plastic surgery in the treatment of cases that have been subject to trauma or for those who suffer from malignant diseases and a very low priority on cosmetic surgery. Personally, I do not believe that there is a major issue in that area.

Mr KLUNDER: Do hospitals have any power to defer such cases indefinitely, and does that power differ between the hospitals of the Health Commission and those that are only nominally under the Health Commission?

The Hon. J.R. Cornwall: I referred earlier to discretionary surgery, and I suppose that to that extent there is some discretion for hospital administrations or surgeons to put some cases on what might be called the long finger, so that they do not get a very high priority. I am unaware of any specific powers to defer indefinitely, other than the use of discretion. Dr McCoy, who has had vast experience in these matters, may be able to comment further.

Dr McCoy: I do not know of any specific power, but the Minister has stated that this area is given a lower priority, and I am told that some cases on the waiting list of the R.A.H., for example, may never be called for surgery.

The Hon. JENNIFER ADAMSON: With the ending of the hospital cost sharing agreement, a block grant from the Commonwealth will enable the State Government and the Health Commission greater flexibility, if they choose to use it, in transferring funds from institutional care to non-institutional care and preventive, rehabilitative and community-based services. Bearing that in mind, recognising that the State Government has been solely responsible for the mental health services in psychiatric hospitals, and looking at the comparison in terms of statistical collections between page 24 of the blue book for the recognised general teaching hospitals and page 20 of the blue book for psychiatric hospitals, I note that there is no provision under the table which is identified as page 3 of 6 and which lists under item 5 mental health and intellectually disabled hospitals (Glenside, Hillcrest and Enfield) for the staff to patient ratio, the bed occupancy, and the numbers of patients that are identified for the general teaching hospitals. Because those figures are not given, will the Minister or his officers provide for the respective institutions of Glenside and Hillcrest the number of patients for the immediate past year, the percentage bed occupancy and the staff to patient ratio?

The Hon. J.R. Cornwall: Those figures are not immediately available. The Information Services Division of the Commission is being constantly upgraded and its performance is constantly being monitored. We would not be able to produce those figures at this time without some considerable additional work. Nonetheless, I believe that the member for Coles has raised a very good point, and I am told that it would be possible, with some research, to obtain that information. I would be pleased to provide that information to members of the Committee when it is available.

The Hon. JENNIFER ADAMSON: I was particularly interested in the percentage bed occupancy at Glenside and Hillcrest for the years listed for the recognised teaching hospitals, namely, 1981-82 and 1982-83, as well as the staff to patient ratio, and the average length of stay for acute patients as distinct from the geriatric long-stay patients. In respect of the latter, I note from page 25 of the yellow book, under the subprogramme heading 'Services mainly for the aged suffering from mental and behavioural disorders', that the proposed expenditure for 1983-84 is a reduction on the actual expenditure for 1982-83.

In view of the Minister's statements made more than once today about the increasing problem of caring for the aged, both in terms of their increasing numbers and the severity of the disease (and members of the Committee would be aware of the almost epidemic proportions that are predicted for Alzheimer's disease), why has the recurrent expenditure for the current year for that critical group of the population requiring health services been reduced?

The Hon. J.R. Cornwall: It is only an illusion. First of all, as I explained to the Committee several times earlier today, round-sum allowances have not been taken into account. Secondly, in the 1982-83 outcome there was a 27th pay period, and we are talking about a very labour intensive industry, so that artificially inflates the sum for 1982-83. The variations in awards have not been taken into account in the 1983-84 proposed figures. Thus, it is just about as close as one could get to a standstill arrangement. There is certainly no expansion in the area (I admit that quite freely): it is a standstill.

The Hon. JENNIFER ADAMSON: I refer again to page 14 of the yellow book and recurrent expenditure for the Chairman's office and the sectors. Page 4 of the Government's health policy states:

> A Labor Government will establish regional offices of the Commission in key suburban and country areas throughout the State, using its existing staff and resources. Regional managers will be empowered and encouraged to consult with local communities and to make decisions at the local level.

When will the Government implement that election promise and what will it cost?

The Hon. J.R. Cornwall: We have already implemented it to a significant extent. Dr Brian Dare has been appointed as Regional Co-ordinator at Port Augusta. I think he took up that position from 1 July. We recently appointed a Regional Co-ordinator in the Riverland based at Berri: his name eludes me at the moment, but he was formerly Chief Executive Officer at the Waikerie Hospital. We propose to appoint a Regional Co-ordinator in Mount Gambier for the Upper and Lower South-East. I understand that Dr Brian

Dare was already employed by the Commission, anyway, so a new position was not created; it was a transfer. The position at Mount Gambier has not yet been filled, so that does not arise. I am sure that Mr Sayers of the Southern Sector can provide more information about the Riverland position.

Mr Sayers: The position in the Riverland was an upgraded position. The additional cost amounts to $8 000 per annum.

The Hon. JENNIFER ADAMSON: What is the relationship between the regional managers and the sector directors *vis-a-vis* the relationship between the regional managers and the health units within the sectors?

The Hon. J.R. Cornwall: The short answer to that would be 'a close and friendly one'.

The Hon. JENNIFER ADAMSON: Who is answerable to whom?

The ACTING CHAIRMAN (Mr Klunder): Order! I ask honourable members not to go too far into the area of supplementary questions. I will permit this further supplementary question, but that will be the limit.

Mr Sayers: The positions will differ. The Riverland position is a joint appointment and holds the executive officer classification of the Riverland Community Health Service. It was previously a classified job at CO5 level. When the person holding that position left, the position was upgraded with added responsibilities for the regional presence of the Southern Sector, resulting in the additional cost of $8 000. The position was advertised with dual responsibility: responsibility to the Riverland Community Health Service for the operation of its community health and domiciliary care service in the Riverland, and with responsibilities direct to the Sector Director in relation to co-ordination activities required for the sector. It is a joint appointment with joint responsibilities. I understand that other positions are different. The Port Augusta appointment is directly responsible to the sector Director for the management of health services in that region. A similar appointment will be made in the South-East.

Mr GREGORY: I refer to page 53 of the yellow book and the programme sector title 'Preventive and enabling services', where there is a reference to the Radium Hill Employees Study. How much has that study cost so far and what is its budgeted expenditure for the future? When will the study be completed?

The Hon. J.R. Cornwall: I think the Opposition indicated earlier today that questions in relation to public health, voluntary agencies and health promotion would be addressed following the dinner adjournment. For that reason I did not detain Dr Keith Wilson, the Director of Public Health. He could certainly answer the honourable member's question.

Mr GREGORY: I will repeat the question this evening.

The Hon. J.R. Cornwall: The other part of the honourable member's question related to the Radium Hill Employees Study. I recently discussed the study with our senior epidemiologist. I point out that the Epidemiology Branch of the Health Commission is arguably the best in the country. It is very good and its Director, Dr David Roder (as I am sure the previous Minister would agree) is quite outstanding in his field. He has recruited some excellent people into the area. The Radium Hill Employees Study has not been finalised and, of course, it cannot be finalised. One of the frustrating things about epidemiology studies is that by their very nature they take a long time. In this case, among other things, deaths from specified diseases are involved.

To get the study to a point where we can obtain hard data that stands up in relation to scientific literature, we have to wait for the majority, if not all, the former miners at Radium Hill to die from one complaint or another, whether it be old age and natural circumstances or complaints that may relate to their employment or from any other number of environmental factors. There is no way that we can hasten a final and definitive result on Radium Hill. There is a lot of on-going work. We have located many people who work there. It is becoming increasingly what looks like being an invaluable study in world terms in relation to the effects of radon on uranium miners under the sorts of slap-happy conditions that prevailed in the industry 30 or 40 years ago.

Mr GREGORY: To date, has the study given any indications of the direction that it may take?

The Hon. J.R. Cornwall: I take it that the member is asking specifically whether we will find a higher incidence of lung cancer, and so on. There is not enough data available or analysed at this time to provide an answer that would stand up to scientific scrutiny.

Mr GREGORY: I refer to page 7 of the yellow book. New initiatives outlined on that page include the development and implementation of a State-wide anti-smoking campaign. How much is budgeted for that campaign? How much money has been spent so far, and has that expenditure been effective?

The Hon. J.R. Cornwall: The sum of $160 000 was spent on a pilot programme in the Iron Triangle. That money included a follow-up study conducted up to three months later to gauge the campaign's effectiveness. That was a comprehensive study. A study was conducted after three-months because that appeared to be the period at which one could obtain reliable results as to how many people might have given up smoking on what might be termed a permanent basis.

The study also looked at recall rates so that we could assess how effective the whole campaign had been. By that, I mean the campaign in which community groups were involved, and I refer to pharmacists, the medical profession, paramedical workers, social workers, and schools—the whole gamit.

The results of that survey suggest that it was a very effective campaign indeed. I have recently released the results which show that, on extrapolation of a wide sample (and the figures have been very carefully checked), more than 2 000 people in that population gave up smoking as a result of the anti-smoking campaign. We intend, as you will see in the Budget estimates, to spend $400 000 in total in 1983-84 on an anti-smoking campaign on a State-wide basis and if we can replicate those figures on a State-wide basis we can be reasonably confident that something in excess of 20 000 smokers will give up the habit as a result of that campaign.

Of course, whether one looks at it in terms of a straight cost benefit analysis ($400 000 for 20 000 non-smokers) or from the more medical angle of the good that would be done by 20 000 people giving up, the results of the Iron Triangle study give us reason to be very optimistic indeed.

The other thing that we have not successfully grappled with yet—or certainly not to the extent that I would be satisfied with—is the question of the kids who are taking up smoking. It is estimated that 10 000 a year are taking up smoking, probably in the age range 12 to 15. It seems that there is quite an epidemic there; we most certainly will have to continue to look at the programme that we conducted in the Iron Triangle for years 7 and 8 kids to make sure that we make it as effective as possible in order to get reverse peer group pressure.

Mr GREGORY: Again on page 7:

Provision of additional funds to the Intellectually Disabled Services Council to increase the level and range of services available to the community.

Can the Minister tell the Committee how much has been made available and just how that additional money will be spent?

The Hon. J.R. Cornwall: I will find the figures for the total budget for the member in a moment. What I can tell the Committee immediately is that we did provide an additional $500 000 real new money in 1982-83. In doing that, I hasten to point out that we were meeting a commitment of the previous Government and, again, I give credit where it is due. Over and above that, we have made provision for yet another $500 000 in 1983-84.

In terms of the growth areas, if you like, in these very stringent and difficult times in which we live, the Intellectually Disabled Services Council has had more new money both *pro rata* and actual than virtually any other health organisation. The total funding that you will see in the Estimates at page 12 of the blue book for 1983-84 is $18.75 million.

The Hon. JENNIFER ADAMSON: Further to the question about regional offices which the Minister answered previously, I draw his attention to his Government's undertaking to abolish sectorisation and establish regional offices of the Commission, using its existing staff and resources. The A.L.P. policy states that the regional offices will be located in the eastern, western, northern and southern suburbs of Adelaide and in the major regions throughout the Lyell McEwin—that may be a misprint because it does not seem to make sense. It says, 'Construction of these regional suburban offices will begin in the Labor Party's first term'. What progress in the abolition of sectorisation and the construction of regional suburban offices has been made in the first term of the Labor Government?

The Hon. J.R. Cornwall: I do not have a policy document in front of me, although I did write it. The member may have a bad copy; there is a *non sequitur* there. It should say 'non-metropolitan areas' not 'Lyell McEwin'. I am subject to correction, but I cannot remember for the life of me giving an undertaking that we would construct offices (with or without an 'r'); I am not a bricks and mortar sort of operator. With regard to the abolition of sectors, I am quite happy to tell the Committee that that is the promise, albeit the only one in that policy document, which neither the Government nor I as Minister intends to implement. The sectors most certainly need some fine tuning—there have been recommendations along those lines in the Alexander Report, but in terms of abolition, no, I do not intend to proceed in that direction.

We are proceeding to appoint regional co-ordinators wherever that is deemed to be appropriate, and the first three areas where the Government did deem it to be appropriate were Port Augusta, the Riverland and the South-East. That will be done. We also have to acknowledge that there is something of a problem in having particular sectors responsible for State services, whether St John, C.A.F.H.S., R.D.N.S. and so forth. There is always the danger with sectorisation that the western sector is not telling the southern sector what the central sector is doing. So, we certainly need some co-ordination mechanism.

One of those, I think appropriately, is the executive panel—the old chairman's committee has been redesigned and streamlined somewhat. We are working on other mechanisms to make sure that there is a very high degree of co-ordination and integration of the State health services generally. The sectors must never be seen to stand in splendid isolation; nor, I hope, in a rational system, in competition. I am very happy to admit that it is not the Government's intention to abolish sectors.

The Hon. JENNIFER ADAMSON: I am pleased to learn that that is the case, particularly after the Minister's rather insulting remarks about sector managers when he was in Opposition. I am reminded of Churchill's words that eating one's words can be a wholesome diet. I do not know whether the Minister finds his diet wholesome or not.

I draw your attention to page 12 of the yellow book and to the support services category of the Commission: the proposed allocations to the Minister and the Minister's office, executive management, professional and technical support, and administrative and clerical support. From the figures given there and the increases implicit there, it would seem that after the Minister's criticisms, when in Opposition, of the Commission's being a bureaucratic body with not enough support services in the field—the previous Government certainly tried to reduce the total staff of the Commission's central office and to increase staffing out in the field—the process is being reversed and that staffing is being increased in the Minister's office, executive management, professional and technical support and administrative and clerical support. Can the Minister advise the Committee of what, if any, staff increases in each of those categories will occur in the coming year?

The Hon. J.R. Cornwall: First, apropos the remarks in that biting platform on health which was produced last year and the description of sector directors as bureaucratic flack catchers, it is remarkable how much they improve on closer acquaintance. With regard to the specific questions on those various categories on page 12, the only one to which I can respond specifically is the Minister's office. Certainly, there has been no expansion of staff at all in the Minister's office. In fact, it is marginally less than when the member for Coles was Minister, although I must admit that the honourable member also had the tourism portfolio. There has been a contraction, albeit not a marked one, rather than an expansion.

Dr Court: Over the past two years, the figures for employment, both in the Minister's office and in the central office of the Commission, have been reduced. In the Minister's office 12 people were employed on 30 June 1981, but only 10 on 30 June 1982. There has been a major reorganisation in the central office of the Commission over the past two years. On 30 June 1982, 283.1 persons were employed in that office, and on 30 June 1983, 283.8. So, there has been no increase in the overall total, although there have been fluctuations over that period.

The Hon. JENNIFER ADAMSON: On page 13 of the yellow book, the following statement appears:

> Additional health units are to be incorporated under the Health Commission Act.

Under the previous Government, incorporation was a matter for the voluntary decision of any health unit. Is that policy to be changed? If so, what are the cost consequences of implementing a policy whereby the Government requires any institution to become incorporated with all the attendant industrial consequences?

The Hon. J.R. Cornwall: At present, the Government is pursuing an active policy of persuasion. We believe that there should be a genuine partnership between the health units, especially the hospitals, and the South Australian Health Commission. For the hospitals and for everyone else there are distinct advantages in this policy, not the least being the possibility of transfer of staff throughout the South Australian system, as well as recruitment from within that system. More important, it is an indication of genuine partnership. There is no point in paying lip-service to co-ordination and integration on a State-wide basis and then having unincorporated hospitals doing their own thing and in extreme cases saying, 'Give us the money and let's get on with it.'

The present policy of encouragement may well be modified in the 1984-85 Budget to one of conditions of subsidy. I do not believe that we could have a responsible policy several years after passage of the South Australian Health Commission Act which would require anything less than that. There must be a high degree of accountability, and it seems

to me that in those circumstances incorporation is highly desirable but, if the health units and the hospitals (of which there are many) do not see their way clear to go as far as incorporation in the first instance, we will have to consider seriously the imposition of conditions of subsidy in 1984-85.

That is the recommendation of the Sax Committee of Inquiry. Although it has not been put to Cabinet and therefore does not have the endorsement of the Government at this time, I believe that the notion of accountability for taxpayers' money is such that to allow anything less than conditions of subsidies applying in the foreseeable future would be a dereliction of duty. As to the cost, there are implications regarding superannuation arrangements.

Mr MAYES: The tables provided show the allocation of grants to deficit-funded health services, such as the Julia Farr Centre, as well as many country hospitals. What progress has been made with the incorporation of these unincorporated bodies?

The Hon. J.R. Cornwall: That question is a logical follow-up to the question asked by the member for Coles. I have indicated my thinking and the recommendation of the Sax Committee in respect of incorporation, and I have pointed out what I would probably recommend to Cabinet before the framing of the 1984-85 Budget. Incorporation is highly desirable for the reasons I have given. As an interim measure, in the interests of accountability to the taxpayers of this State, conditions of subsidy should apply. Conditions of subsidy already apply in the case of the Julia Farr Centre. That system was accepted by that organisation following certain actions I had to take earlier this year in the lead-up to their substantial Budget allocation of $7.24 million.

In view of the generally unsatisfactory conduct of the Centre at that time, I believed that conditions of subsidy were well warranted, and they were accepted by the board. Now we have a most amicable arrangement with the Centre, and I expect that it will become an incorporated health unit this financial year with a new constitution and an optimistic future. The Julia Farr Centre accepted conditions of subsidy in 1983-84. In the metropolitan area, apart from the Julia Farr Centre, the major unincorporated units are the obvious ones—the Adelaide Children's Hospital and the Queen Victoria Hospital—and there are still many unincorporated country hospitals. Progress in this regard has been reasonably satisfactory.

This year, five years down the track, I question whether the speed at which incorporation is proceeding is satisfactory, and it is certainly something that the Government will have to examine in 1984. There is no correlation between Orwell's 1984 and the fact that the time may come for a higher degree of financial accountability.

Mr MAYES: My question is about repetition injury and is supplementary to one of the questions asked by the member for Florey about occupational health. I understand that a programme is under way and that there is a current internal review within the Commission. Will the Minister elaborate on this matter?

The Hon. J.R. Cornwall: The Commission's review is part of the overall review in the South Australian Public Service public employment area review that I described earlier. At this stage we have sampled 500 people by oral and medical history, and we are now proceeding to check on the third part of the survey. One of the factors that distressed me beyond all reason early in my days as Minister was to see in the lift in the Westpac Building at 52 Pirie Street, not one but two office girls with splints on their wrists.

We gave a firm undertaking in Opposition to mount a repetition-injury prevention campaign, anyway, but, if I needed any galvanising, that sight certainly spurred me on. To the best of my knowledge at this stage we have our own house in order. As I said earlier, we would need to put the State Public Service area in order so that we can tell private industry how it should be done. From an employer's point of view, to ignore repetition industry is extraordinarily stupid, because it is not something that will go away. Repetition injury can be prevented and, if prevention programmes are introduced, they will save huge amounts in compensation.

Repetition injury is no longer something that can be laughingly or disgracefully put away as 'golden wrist'. It is well recognised by reasonable medical practitioners, and employers who do not put their houses in order will increasingly find themselves facing enormous penalties through increased workers compensation premiums. It is something that can be put in order at a relatively small cost.

The Hon. JENNIFER ADAMSON: My question relates to incorporation and conditions of subsidy. As the Minister will acknowledge, conditions of subsidy were, in effect, imposed on the Julia Farr Centre by the previous Government, and there would be a letter on the Minister's file to the Chairman of the Centre requiring the tabling of the annual report of the Centre in Parliament and requiring the organisation to conform with Government health, industrial and economic policies; particularly health policy in terms of instituting rehabilitative policies within that unit. Does the Minister acknowledge that conditions of subsidy can be imposed quite properly on units such as Queen Victoria Hospital, Adelaide Children's Hospital, St John Ambulance Service or the Royal District Nursing Society without the necessity for incorporation, which essentially binds a health unit much closer to the Government and which can be legally and morally construed as relieving it of its voluntary status?

The Hon. J.R. Cornwall: I agree that conditions of subsidy can readily and appropriately be imposed on many of the unincorporated organisations. I am sorry to hear the member peddling some of the myths that are abroad in this State. Since I have been personally calling on literally dozens of these hospitals and health units both in metropolitan and country areas I have heard most extraordinary stories about how once they incorporate they lose their property, and it becomes the property of the Crown, the Government or the Minister of Health and so on, none of which is true.

As to their losing their independence, that is not true either. The reality, as distinct from the myth, is that in 1983-84 those institutions—it could be smaller country hospitals or Queen Victoria Hospital or Adelaide Children's Hospital—derived their recurrent funding almost exclusively from the public purse. They are funded in terms of recurrent expenditure 100 per cent. I do not believe that it is a question of ideology or hankering for the past implementation of specific political platforms or anything else. In blunt terms, it is a question of financial responsibility.

In the name of all that is good and holy, how can an institution which derives 100 per cent of its funding (to the order of between $14 million and $24 million a year) pretend that it is an independent voluntary organisation? That is stuff and nonsense, and it should be identified as such. I do not think that we should any longer try and perpetuate the myths for political purposes or otherwise.

The Hon. JENNIFER ADAMSON: Because of the cost consequences of this issue, which has been acknowledged by the Minister, particularly in terms of conforming to the industrial requirements of the Commission, it is an important issue for a number of the so-called voluntary bodies presently providing State-wide services at some saving to taxpayers over the cost to the Government had the services been provided by a solely Government-funded means. In what way does the Minister believe that Adelaide Children's Hospital, Queen Victoria Hospital, St John, Julia Farr Centre

and any other units are deficient in terms of their accountability to the Government and the Parliament? Can the Minister identify the means by which those organisations are deficient in terms of their accountability?

The Hon. J.R. Cornwall: First, let me be absolutely clear: when I talked about 100 per cent funding in response to the last question, I was talking specifically about the unincorporated hospitals, non-metropolitan and Queen Victoria Hospital and Adelaide Children's Hospital. I was talking about financial responsibility and accountability specifically in that sense. Those organisations do not use volunteers. Do not let us confuse the issue in regard to St John. In fact, I am not sure how appropriate it is for this Committee to even canvass the St John funding arrangements and the use of volunteers and the like, as that organisation is now the subject of a Select Committee inquiry in the Upper House, and I would seek your advice on that matter, Mr Chairman.

The CHAIRMAN: It is reasonable to make some reference to the organisation, but there should not be an extended debate. I am aware of the establishment of the Select Committee, but the House of Assembly is entitled to some information on the matter.

The Hon. J.R. Cornwall: In general terms, the point I was making is that the Government obviously accepts some of the organisations which use volunteers and which use them effectively to save the State and taxpayers money. There are a whole range of areas in which volunteers are used effectively and will continue to be used effectively. They range from the extraordinarily good volunteer service, for example, at Flinders Medical Centre, to the Lavender ladies at R.A.H. and to every hospital supporting organisation in the State.

Do not let us get confused in those areas. I repeat the point that, if we are charged with running an integrated, co-ordinated and rational health system, it is necessary for the Commission, under the terms of its Act, ultimately to have a co-ordinated overview of those health services, hospital and otherwise, that are provided around the State.

The CHAIRMAN: In regard to the last ruling that I made concerning St John, I believe it is allowable for members to ask questions in that regard because a Select Committee has been set up in the Upper House and it does not relate to the House of Assembly. Honourable members can ask questions about St John of a general nature but not of a specific nature that may relate to the Select Committee.

The Hon. JENNIFER ADAMSON: I simply want to repeat my previous question, which the Minister failed to answer, namely, in what way does the Minister regard the Adelaide Children's Hospital and the Queen Victoria Hospital and any other voluntarily based, unincorporated unit (that is, unincorporated under the South Australian Health Commission Act but incorporated under the Associations Incorporation Act), funded by the Commission, as being deficient in terms of their financial accountability to the Commission and to Parliament?

The Hon. J.R. Cornwall: I have not suggested that there are deficiencies at this time at the Adelaide Children's Hospital or the Queen Victoria Hospital, but there were manifest deficiencies at the Julia Farr Centre during the time that the member for Coles was Minister of Health, and she failed to do anything about it. I believe that organisations such as the Julia Farr Centre must ultimately incorporate. I do not want to go over the whole business of the irregularities or the funny deals that the old Home for Incurables had with a number of people and organisations, because I do not think there is anything to be gained in raking over those old coals.

More particularly, since the Government's intervention in, about, last March, the Julia Farr Centre is looking good. Morale is very high, we are talking to the board in a most constructive and co-operative manner, and Dr Peter Last, a distinguished physician, is now at the Julia Farr Centre on what is almost a full-time basis, although he remains a consultant to the Minister of Health and the Health Commission. We have put a lot of things in place in a relatively short time.

There is no doubt at all, as the member for Coles knows, that there were substantial irregularities in the conduct and accounting of the Julia Farr Centre during the period in which the member for Coles was Minister. In fact, she authorised an investigation at the Julia Farr Centre which showed those deficiencies, and these things can happen. They do not happen in units that are incorporated under the Health Commission Act, because of the direct access, in a co-operative partnership, which the South Australian Health Commission has with those units.

Mr PLUNKETT: What is the role of the Women's Advisory Committee, and when will an appointment be made?

The Hon. J.R. Cornwall: I cannot immediately recall the precise job specifications, but in general terms there are two principal roles. One is to consider the role and interests of women in the health work force and to assist in implementing the Government's equal opportunities programme in the health industry; the other role is to look at the needs of women in the wider community, and clearly there are special needs. A large number of those needs at this point remain unfulfilled.

The Women's Adviser will be appointed in the very near future. Interviews have been concluded, there is a short list, and I anticipate that the person who has been the successful applicant for the job of Women's Adviser will be named within a fortnight.

Mr PLUNKETT: What provisions have been made concerning the Rape Crisis Centre?

The Hon. J.R. Cornwall: The Rape Crisis Centre was specifically promised additional recurrent funding prior to the November 1982 elections, and we have met that promise to date. The specific terms of funding involved an additional $20 000 a year recurrent funding for the triennium. On a pro rata basis, that money was provided for the remainder of 1982-83. In addition, we provided funding for a new switchboard, which means that the centre now has the facility to redirect calls to volunteers or salaried officers on a 24-hour a day, seven-day a week basis, which, of course, is a vast improvement. Prior to the change of Government, the centre was virtually operating on a 9-to-5 basis, five days a week, because it lacked a sophisticated switchboard arrangement.

From memory, we have also provided $5 000 as a special grant from my special line to process the results of the incest survey, which was very wide ranging. I must say that I was distressed to learn how widespread that was. That $5 000 has been used to process the results, which are not yet complete, so the resources of the Commission have been offered for further processing. When the results are available, they will be made public. Notwithstanding the substantial addition of that $20 000 a year in total, the Rape Crisis Centre still relies very largely on volunteer labour, and I understand that representatives will see me in the very near future to reassess the position again. I have a great deal of sympathy for the situation and I have a great deal of admiration for the work done by the centre, as I said, very largely with a volunteer work force.

I will most certainly be asking senior Commission officers to reassess the situation to ascertain the real needs in the short, medium and longer term. At this stage I cannot give any firm commitments one way or another, because there are very few bickies left in the barrel for 1983-84, but I will most certainly treat any submission made by the centre in

a most sympathetic way. If more funds are required, once that fact is established, we will consider the matter sympathetically, if not this year then in 1984-85; but I would be less than responsible if I gave a firm commitment on the funding that will be provided.

Mr ASHENDEN: My question relates to the Barmes Report. One section of the report states:

> There is only one overall recommendation upon which all subsequent recommendations and options depend. That recommendation is that a standing committee be established with membership that ensures adequate representation of the private sector, the public sector, the training bodies and consumer groups. The authority of the committee should be such that its decisions are binding on all elements of the health sector, public, private or personnel production, which are responsible for their co-ordinated implementation.

Does the Minister agree with that recommendation? How does the Minister intend implementing all or part of that recommendation, depending on his attitude to it?

The Hon. J.R. Cornwall: I certainly agree with the general thrust of the recommendation, but I am not sure that I agree word perfectly. I have no problem with the general thrust of the recommendation. In fact, the Barmes Report has been sent to the Chairman. Obviously, that is the first and in the shorter term the most important recommendation with which the Chairman of the Health Commission, the South Australian Dental Services, the A.D.A. and everyone else concerned with the delivery of dental services, both in the public and private sectors in South Australia, will have to grapple. I have not rushed into a decision. There is nothing before me. When the Chairman returns in the middle of next month I anticipate that he will be making some recommendations that I will consider.

Mr INGERSON: I refer to page 17 of the blue book and deficit funding health services. The salaries and wages for the 1983-84 estimate, with one exception, contain an increase of about 3 per cent. Does the low wage increase suggest a reduction in staff in the areas shown and, if so, does that indicate a drop in overall general health care?

The Hon. J.R. Cornwall: We are back where we have been for most of the day. I do not seem to be able to get the message across to members of the Opposition. Budgeting at State level involves round-sum allowances.

Mr INGERSON: Deficit funding on round-sum allowances?

The Hon. J.R. Cornwall: The member for Bragg should probably stick to pharmacy, at which I understand he is very good, although he is not quite in the same league as some of my senior financial advisers. I point out that we still have award allowances, even with the figures produced in relation to deficit funding. Most of the areas are at standstill, as is the rest of the Budget.

Mr INGERSON: I refer to page 28 of the yellow book. Can the Minister provide the costing for domiciliary care services delivered by professional and non-professional health workers in relation to the Royal District Nursing Society?

The Hon. J.R. Cornwall: Those figures, because of (rather than despite) programme performance budgeting, are not available in detail. Mr Cooper will provide reasons for that.

Mr Cooper: Essentially, programme performance budgeting implies that the components are not all discreet organisations or parts of organisations that we fund. By a general policy of the Government (and indeed the previous Government) we only cost and make estimates to the subprogramme level. The information sought by the member is a component and includes some other elements. The cost of the subprogramme, 'Services mainly for the aged and the physically disabled living at home' is shown on the previous page: the outcome for 1982-83 was $13 million and $14.9 million is proposed for 1983-84. This format does not allow a breakdown below the component level. The blue book provides the cost of the Royal District Nursing Society as a figure, the cost of the various benefit schemes, and the cost of domiciliary care services as a whole. That includes professional and non-professional services.

Mr GREGORY: I refer to page 51 of the yellow book under specific targets/objectives: significant initiatives/improvements/results sought, as follows:

> A further study into possible radiation-induced illnesses, including cancer, amongst Aboriginals following British atomic weapon testing at Emu Junction and Maralinga between 1953 and 1957 is to be undertaken.

What is the Government's intention in that area, and how much will it cost?

The Hon. J.R. Cornwall: The cost of the proposed Maralinga study on the Aboriginal population is $100 000. The South Australian Health Commission is committed to providing $50 000. We have asked the Federal Minister for Aboriginal Affairs in particular, or the Commonwealth Government in general, also to provide $50 000. I have not received absolute confirmation that that money will be forthcoming, but we have been promised support. I hope that that promise will be translated into $50 000 worth of support. The survey is being conducted because there are still lingering doubts and stories told of a black cloud, misadventure, and so on, by the Aboriginal people who lived in the desert areas in question from 1953 to 1957.

A limited study was undertaken during the period when the member for Coles was Minister of Health. It was undertaken with good intent, but unfortunately it was so limited that it was inconclusive. We are proposing a substantially upgraded study in three parts. I will not provide details of the personnel involved in the study because, quite frankly, I cannot recall all the names. First, we will conduct an anthropological study which will involve the taking of oral histories and so on throughout the area. Having collected that data we will proceed to an epidemiological study. Stage three will be a review of the literature pertaining to the whole area and the whole era.

Following a somewhat shaky start, I am pleased to say that the study now has the support of the Pitjantjatjara Council. Initially, the Council was somewhat reluctant for a variety of reasons, not the least of which related to possible legal implications. Those matters have been satisfactorily and amicably agreed. We now have the support of the Pitjantjatjara Council. We have ensured that representatives of the Aboriginal community, particularly of the Pitjantjatjara people, will be represented on the advisory committee.

We have been at great pains to make sure that we have this involvement and this representation. The principal reason for that is that there is a real possibility, no matter how carefully controlled and how well done this study is, that the results may again be inconclusive. Or, of course, they may show that there are no identifiable, harmful effects. We will certainly not go in to do some sort of trumped-up political survey which will find the questions to the answers which we think we have already got; that is just not on. So, whatever comes out, whether it is a negative or positive finding, it will stand up. We want to ensure that, but, if it is inconclusive we must certainly want involvement of the Aboriginal people and any other interested parties, and we will ensure that on the Committee so that when those findings are delivered they will not be seen to have been politically tampered with in any way, shape or form.

Mr GREGORY: As a supplementary question, given that the Pitjantjatjara people—the people who will be surveyed because it is their lands on which the tests took place—have a propensity for wide nomadic travel into the eastern part of Western Australia and the southern part of Central Australia, will the survey extend into those areas to raise those issues with those people, because they do move around

very frequently? The advent of the motor car and the subsequent building of the Tarcoola to Alice Springs railway line has meant that these Aboriginal people are now travelling to their sacred areas more frequently, and consequently it is not impossible to find one person at Maralinga, three days afterwards to find that person at Ernabella, and a couple of weeks later one can be nearly to the Western Australian border and find the same person there. That is the normal travel that these people regard as customary.

The Hon. J.R. Cornwall: I would be very surprised on all the advice that I have received if we do not find it necessary to cross State borders, which are quite artificial as far as Aboriginal people are concerned—and I might interpose there that they are quite artificial as far as some intelligent white people in the States are concerned. They do not mean much to the Aboriginal people and that is hardly surprising. They are quite mobile, as the member for Florey has said, and I would anticipate that we would have to cross borders. It was for that reason among others that we approached the Federal Minister for Aboriginal Affairs, seeking his co-operation. It may well be that our people have to cross borders and that we will have to work in reasonably close liaison with the D.A.A. Yes, I would be very surprised if we did not have to find our way into the Northern Territory and into Western Australia from time to time, looking for the people who may have been about at that time.

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

Mr GREGORY: At page 51 of the yellow book, the first paragraph contains the following statement:

> The Aboriginal Health Organisation was assisted in preparing a health information system. Morbidity and mortality data relating to Aboriginals was collected and analysed.

What are the results of that survey and what did it cost?

The Hon. J.R. Cornwall: The report showed that the Aboriginal infant mortality rate was substantially higher than the corresponding rate for European infants. I cannot give more detail than that, or the costing.

Mr Cooper: The paragraph refers to two separate activities. The first refers to the development of an ongoing information system for the five or six clinics of the outback Aboriginal health services. The first site will be piloted in October, and we expect the system to be fully operational in all clinics at the end of the year or possibly into the early part of next year. I do not have, without asking for the information, the cost of that system. I am not familiar with the second reference, namely, the survey.

The Hon. J.R. Cornwall: My officer informs me that it is an ongoing survey, which is being carried out within the resources principally of the Aboriginal Health Organisation. The costing is difficult to ascertain in strict dollar terms because it is being carried out by salaried professional officers.

Mr GREGORY: Page 53 of the yellow book refers to the Radium Hill employees study. How far has that study proceeded, what has it cost, and are there as yet any indications emerging from it?

The Hon. J.R. Cornwall: I introduce Dr Wilson, who needs no introduction to most members, and who is the Director of Public Health within the Health Commission.

Dr Wilson: The Radium Hill employees study, which is an ongoing study that has been in progress for at least five years, is based on the records of the former Mines Department regarding miners who worked at Radium Hill and subsequently at the Port Pirie treatment plant. The study, the aim of which is to check the health of these miners, has involved extensive research of death registers. That search was completed in 1982-83 and $2 322 was spent on the search in that year, mainly as payment to registrars of births, deaths or marriages in other States to search their records.

The data is almost complete, and my last information was that about 90 per cent of the data from the death records had been obtained. The question now is whether the final 10 per cent can be found, because it relates to a population that worked 30 years ago. There is no real result as yet from that study. The study was advanced about four years ago when a preliminary review of the death records showed that there was an apparently higher prevalence of lung cancer in this group. However, that was based on very crude data and took no account of other factors, especially smoking.

The present aim is to identify the families, to check the history of those families, and to identify other factors, especially smoking, that could affect health. The estimated date of completion of the study is 1985 or 1986.

The Hon. JENNIFER ADAMSON: My question concerns one of the issues raised by the member for Florey prior to the dinner adjournment. On page 51 there is the description of a further study into possible radiation-induced illnesses, including cancer, amongst Aboriginals following British atomic testing at Emu Junction and Maralinga between 1953 and 1957. In reply to a question the Minister indicated that that study would cost an estimated $100 000, of which $50 000, he hoped, would be provided by the Commonwealth.

This is a substantial sum of money and, notwithstanding the merit and importance of trying to undertake a study of the kind outlined—and I note the three parts to the study, the anthropological study, epidemiological study and the review of the literature—my clear recollection of the advice given to me by the Health Commission in relation to this matter was that the epidemiological survey undertaken by the previous Government, notwithstanding its acknowledged inadequacy, was unlikely to be improved upon for simple reasons, some of which have been acknowledged by the Minister.

First, the event took place 30 years ago; secondly, I refer to the nomadic nature of Aboriginals; and, thirdly, I mention that there is no record of names—unlike Radium Hill—or any means of identifying people in the area at the time. In view of the large sum of money involved and the difficulty in establishing a cost benefit, will the Minister indicate what different advice has been provided to him by the Health Commission which persuades him to allocate that sum of money to an exercise that I was advised would be very difficult, if not impossible, to carry out?

The Hon. J.R. Cornwall: It is not surprising that there is no record of names. The treatment of the Aboriginal people at the time was completely disgraceful. The Aboriginals were rounded up and put into what was virtually a concentration camp at Yalata. I was criticised at one stage some months ago for using the term 'rounded up', as though it were my term. The fact is that the Aboriginals were rounded up; there is no other way to put it. The Aboriginals were treated in a sub-human way. Those who could be rounded up were taken out of the desert and put into Yalata as displaced persons, certainly as dispossessed persons. That is a wrong that we are trying to right 30 years later.

The member for Coles talks about the cost benefit analysis. Let us put it all in terms of dollars and cents. I think that a massive social wrong was done to the Aboriginal people of the Maralinga area. In particular, a massive social wrong was done to the Pitjantjatjara people. I do not need professional advice to know that that wrong was done. I am perfectly happy to use my social conscience. I believe that my comrades in the Labor Party are also happy and well able to use their social consciences in this matter. In terms of the so-called cost benefit analysis, I am far more concerned abut trying to repay the debts and trying, even at this late stage, to right some of the grievous wrongs that were done

to the Aboriginal people of the Maralinga region at that time.

As to what differing information I have received, I have been told on inquiry that it is well worth running an extended survey, if that is the Government's policy, because of the extraordinarily important social and moral issues that are involved. Basically, that is the information that I have received from a range of people, particularly people at the Institute for Aboriginal Studies at the Australian National University, and particularly from people like Dr Len Smith at the A.N.U., whom I flew to Canberra to see personally. I have received information from a range of people who are far more knowledgeable in this area than either the member for Coles or I.

The Hon. JENNIFER ADAMSON: Referring to page 51 and the introduction of the regulations under the Radiation Protection and Control Act, is the Minister satisfied that the Radiation Protection and Control Act is adequate to meet the health needs of people working in the industrial, scientific, medical and mining areas covered by the Act? What is the expected cost of implementing the regulations under the Act? Is the annual cost to be fully met in this Budget?

The Hon. J.R. Cornwall: I am still assessing the impact of the operation of the Radiation Protection and Control Act. The member for Coles would be aware that I was critical that the whole matter was introduced as one package when the legislation came before Parliament. I have not had any compelling evidence to suggest that I should change my attitude. On the other hand, I have not had a lot of evidence to suggest that there is tremendous merit in splitting the medical aspects of radiation control from what we might term the industrial aspects. I guess that I am exercising the lawyer's privilege in this situation in trying to keep a balance on the one hand and on the other hand sort of approach. I want to see the Act in operation and want to see more regulations developed.

Frankly, the matter is still very much in its infancy in many ways. Many regulations have not yet been developed. The Radiation Protection Committee is still relatively in its infancy. The expert subcommittees are still being developed. The legislation has a fair bit of growing up to do and will learn by experience. Certainly, it is a comprehensive piece of legislation, and I will not prejudge it at this time. I am going to Roxby Downs tomorrow morning with senior officers from the department to see how the regulations are applied in practice on a mixed uranium mining operation. I will be able to take that experience on board in assessing and further forming my opinions.

The short answer is that I am actively assessing and reassessing the position as it applies to the legislation at the moment. I know that this legislation was a particular baby and a source of pride and joy to the member for Coles. I remember the *Advertiser* headline 'The girls did it.' For that reason I know that it occupies a place very close to the affections and attentions of the member for Coles. I reassure the member that at this time it is not my intention to move to actively change the legislation until it has had a chance to operate one way or the other, until the regulations are in place and until we have had some practical experience with it. Obviously, then we would in a responsible way assess its efficiency. I ask Dr Wilson to comment on the cost.

Dr Wilson: The allocated funds for 1983-84 are $429 000 for the Radiation Control Branch. In essence, that branch is presently administering the old regulations but will administer the new Act and regulations when they are in place. In effect, that is the amount of money allocated for administration of the legislation.

The Hon. JENNIFER ADAMSON: Part of the question was not answered. I sought information not only about the sum but also about whether the sum was sufficient to meet the projected needs of the branch in administering the Act in the current year.

The Hon. J.R. Cornwall: I have not any evidence to suggest that it is inadequate. The short answer would be that if we have experienced any difficulties at all it has been in finding suitable experienced staff (perhaps they are in the Attorney-General's Department) who can draft the regulations with sufficient speed. I am anxious that the whole thing be expedited. I have talked to the Attorney about it. The matter is not directly in my area of Ministerial responsibility, but the Attorney is aware of the situation.

To put it in perspective, we certainly do not have some sort of crisis situation on our hands or a situation with which we cannot cope. In an ideal world, and if we were not subject to the economic stringencies and constraints of 1983-84, I would probably be urging that some additional staff be employed to assist with the drafting of the regulations.

The Hon. JENNIFER ADAMSON: Is $429 000 the sum allocated this year? What was the actual cost of administering the regulations in 1982-83?

The Hon. J.R. Cornwall: Again, I ask Dr Wilson to respond to that question.

Dr Wilson: The sum of $451 000 was spent last year. The two figures are a little difficult to compare because of changes in the financial administration within the Commission itself. I understand that pay-roll tax was originally in that $451 000 last year, but it has now been taken out of this year's allocation. So, it is less that amount. In fact, there has been an increase in staff in the Radiation Control Branch between 1982 and 1983, with an additional two scientific officers and an additional radiographer having been appointed. The actual staff has increased. Part of that staff cost was met in 1982-83.

Mr BECKER: I refer to page 29 and the programme title 'Services mainly for the Intellectually Disabled' and the statement headed 'Need being addressed', which states:

> A number of recent studies have shown that the prevalence rates for retardation can be fairly accurately estimated at between 30 and 35 per cent of the total population.

The Hon. J.R. Cornwall: Perhaps that survey was carried out at Parliament House. The decimal point is way out. I apologise profusely to the Committee for this error. I had a note and did intend to correct the error this morning. The decimal point has been transposed by three places, and I picked this up on first reading the document. The first figure should be .3, and the second should be .35. The figures in the table immediately following the paragraph show the totals of those suffering from mild, moderate, severe, and profound retardation at 4 969, and are accurate.

Mr BECKER: It is further stated:

> The vast majority of these people require special health, education, social welfare and vocational services. Currently, some gaps and inadequacies exist in services provided by Government and non-government organisations.

Can the Minister identify what those gaps are and what is being done to rectify the situation?

The Hon. J.R. Cornwall: Primarily, the gaps are adequate community-based accommodation services. We are actively involved in a programme of normalisation—a programme adopted following the completion of the Intellectually Retarded Persons Project, which was under the stewardship of the former Minister. It was a very good project. Following that, the Intellectually Disabled Services Council was established and the Chief Executive Officer and Chairman of the I.D.S.C. was appointed. The basic problem is that we need more funding if we are to move quickly enough. That is set against a background of conflicting interests and continuing pressures which are causing substantial difficulties.

To illustrate that, we have a group of parents who are in the past middle-age group, in other words, people over 60 years who have been used to and supported the development of the institution as a solution for a number of these intellectually disabled people who saw their support over the years as being some sort of insurance against the day when they were old and no longer able to cope as well as they had over the past 40 years of their marriage with an intellectually disabled son or daughter. They now believe that the programme of de-institutionalisation, normalisation, community-based accommodation is making them feel quite unstable *vis-a-vis* the situation to which they had become accustomed and worked for and which they had supported for many years. That is a problem for a start. Also, there are institutions like Minda, and especially those people again in the sort of age group to which I referred who have supported Minda very well, adequately, admirably and for a long time and who feel again that there is a threat to the established order and *status quo*.

There is little doubt on the balance of all the evidence available that the normalisation path is the one that should be pursued. It is the path adopted as a matter of policy by the previous Government, and that policy was picked up with little modification by the present Government. We had to modify the Director's direct approach a little, but we have now established an excellent working relationship with him. We have honoured the previous Government's commitment of $500 000 in 1982-83, and we have put up $500 000 in new money in addition for 1983-84. As I have said, we have given it the highest priority of any new funding available in the present climate, but we are still not without our problems.

An article in the *News* only yesterday stated that there are potential difficulties in regard to one of these normalisation programmes in a house in, I think, the Para Hills area. We will always have community backlash type problems, and one can only hope that we can minimise the problems, because we are putting in more money, the system is most certainly better, as I said, on all the available evidence, for the intellectually disabled and in the medium to long term it will certainly be better for parents, relatives and everyone associated with that area. We will always need institutions: I do not believe that anyone who has any common sense would suggest that we will empty Minda or Strathmont in the next five or 50 years. We can most certainly enhance the quality of life for those people if we continue to pursue what I believe is a truly bipartisan policy in this area.

Mr BECKER: Some of those institutions, about 12 months ago, were concerned that the council may be moving a little too quickly: they feared that people would be institutionalised at such a rate that there would be no-one left outside the institutions. Some of the aged parents were also worried. The yellow book at page 31 states:

> An adult is defined as being a person aged 20 years or more. A school age child is defined as being from six to 19 years of age inclusive. A pre-school child is defined as being five years of age or less.

I realise that we are dealing with a group that is difficult to classify from time to time, and that there are many grey areas. It has always concerned me that within the community an adult is a person who is 18 years of age, but, when it comes to his being disabled, he is an adult at 20 years of age. I know that some programmes cut out when a person is 20 years of age, and I have always thought that that was discriminatory.

If we can afford it, those intellectually retarded people should be educated for as long as possible, and I would like to see an investigation or a review undertaken of the age grouping to ascertain whether it is possible to recognise those people as adults when they reach 18 years of age, even if this action is forced on the State by the Commonwealth Government. We should also ascertain whether we can break the barrier so that we do not limit the school classification to those under 20 years of age. I realise that that may not come strictly under the Minister's control, but the Minister may be prepared to discuss the matter with other State or Federal Ministers.

The Hon. J.R. Cornwall: I must say that the member for Hanson is making very good sense. He is behaving far more characteristically than he was behaving earlier in the day. The honourable member has a real feeling for these areas, and I am delighted that he has raised these matters. I clearly recall that late in our days of Opposition in 1982 I had discussions with the then shadow Attorney-General, the then shadow Minister of Education and concerned parents in regard to the Norwood Special School, to name but one. As a result (and I do not have to make any apologies for this fact) there is a specific commitment in one of the Party platforms, whether it is education, health, or another area, to review, in government, the whole area of continuing education.

There is an artificial line at present whereby, on a person's 20th birthday, he is suddenly pushed out of the education system: that, in all justice and logic, is stupid and cannot be supported. I believe that the Minister of Education bears primary responsibility for this area, but it is certainly Government policy that there be continuing programmes for the intellectually disabled.

Of course, that is very different from the other vexed questions of the age of consent, guardianship, wards, whether we should appoint advocates, at what age a child should no longer be subject to a parent's having a direct say in his welfare, surgical treatment, medical treatment, and so on, in regard to intellectually disabled children. Those are vexed matters that both the Attorney and I have addressed, but I must say that at this stage we have not come down with anything firm. However, we have a commitment to try to reach at least some satisfactory solutions to a difficult problem area. The points made are very valid, but I certainly do not pretend to have the answers at this time. Those areas are under what we politicians call 'active consideration'. I will be very pleased if the member for Hanson keeps me honest in those areas.

Mr BECKER: The yellow book at page 36 refers to problems arising from drug and alcohol abuse. I accept the need for a substantial increase in funding in this regard. Will the Minister inform the Committee of the incidence of alcohol abuse and the problems, whether alcohol abuse is increasing, what can be done, and what is proposed in regard to community awareness programmes to reduce the incidence?

The Hon. J.R. Cornwall: I am not in a position to produce accurate statistics based on survey material in regard to the incidence of abuse. I will ask Dr Shea to comment in that area. In terms of what is happening at present, the honourable member will notice, as he quite rightly stated, that there is a proposed increase in funding, a substantial amount of which will be taken up with the proposal to decriminalise public drunkenness and to provide sobering up centres in whatever appropriate form. This also represents the Government's continuing commitment to upgrading drug and alcohol services. The future and role of the Alcohol and Drug Addicts Treatment Board is under active consideration at present. Whether the Board should be in the business of delivering services, or whether it should be the co-ordinating body in a mini-Health Commission type role are some of the matters being considered, and the whole question of policy in a range of areas from drug services to alcohol and back again is also under active consideration. The question

of drug education and the possibility of screening programmes for children, for example, in years 7 and 8 in regard to both alcohol and drugs are also under consideration.

Certainly, the Government intends, with very generous sponsorship from the State Government Insurance Commission, to run a programme also sponsored by the State Department of Transport and the Health Promotion Services Unit involving an anti-drink driving campaign for 16 to 24 year-olds in the pre-Christmas situation. That will be the first time something of this nature, specifically targeted at that very difficult age group, has been undertaken. There is no question that there are increasing problems in the alcohol field in particular. The best information that is available to me with regard to patients in acute care in our hospitals shows that probably 30 per cent of the adults in our hospitals suffer from diseases that are directly or indirectly related to the effects of alcohol. That goes right across the board from those who have been dried out, to those who have cirrhosis or pancreatitis, or those who are the victims of trauma. There is an enormous range of people involved, and the problem is increasing in our teenage population.

We have identified the problem and we hope that we can do something about it. In terms of actual figures, I will ask Dr Shea to comment. For anyone who has been around the system for a year or two Dr Shea requires little introduction. He is currently the Director of Mental Health Services within the South Australian Health Commission. Of course, he is also a former Chairman of the South Australian Health Commission and a former Director-General of the Hospitals Department, among other things. Dr Shea is also currently President of the Royal Australian and New Zealand College of Psychiatrists.

Dr Shea: There is little evidence that there has been an increased incidence in alcoholism as a disease entity or disorder in recent years, looking at it purely from a case finding aspect. The difficulty occurs in correlating some of the syndromes, because they do not appear until after 10 to 20 years of heavy drinking, and they include baychosis, cirrhosis of the liver, and so on. Of course, if one drinks hard enough, some of those disorders will occur within 10 years. It is hard to correlate the data. The fascinating thing is that there is clear evidence that alcohol consumption in Australia per capita has increased in recent years and in the last decade or so and, particularly in relation to beer consumption, for example, it is very much the same. Around 23 gallons of beer per head is consumed each year, and that includes every child and adult in Australia. That level of consumption has been relatively static over the last decade or so.

What has happened during that time is that wine and spirit consumption has increased dramatically without much reduction in the overall consumption of alcohol. In fact, we are drinking more. I suspect that in 10 to 15 years time we will have more case findings on alcoholism and its effects.

Mr Becker interjecting:

Dr Shea: Strangely enough, beer seems to have been maintaining a nice sort of plateau, while the others have increased.

Mr Becker interjecting:

The Hon. J.R. Cornwall: We must face up to reality in South Australia and acknowledge that we are a wine State. In other parts of the world there are problems that go with it. Of course, there are certain economic advantages, but there are also certain disadvantages, not the least of which is that the per capita consumption tends to be higher. It also creates a number of moral, legal and ethical dilemmas. What politician worth his or her salt in South Australia would be prepared to speak against the consumption of wine, for example? From what Dr Shea has said I think we are building up some big problems in the coming years.

The Hon. JENNIFER ADAMSON: I refer to pages 6 and 7 of the blue book and grants to health agencies and the I.M.V.S. The Minister will appreciate that, because of the implementation of the new Institute of Medical and Veterinary Science legislation, it is difficult to relate the current year's expenditure to that of previous years. Has the Medical Division of the Institute of Medical and Veterinary Science received an increased allocation or is it a standstill allocation? Secondly, is the Minister satisfied with the operation of the Institute under the new legislation and the quality of the services that it is delivering?

The Hon. J.R. Cornwall: I will refer the question of funding to Dr McCoy in a moment, because the I.M.V.S. is a State service located geographically in the Central Sector and to some extent it comes under his surveillance. Although the member would appreciate that the I.M.V.S., for better or for worse, came out of the traumas and the inquiries of the Tonkin Government, it is still intact with regard to its being a statutory authority with its own legislation. I think that it is too early to start making any definitive statements as to how well it is operating following reorganisation.

I have been especially careful to keep my powder dry. Certainly it is within my knowledge that there have been some substantial moral problems at the Institute. I would not suggest for one moment that they have been overcome. In a relatively short time we have been able to appoint Dr Brendon Kearney as Director of the Institute. I think that that has been a significant step in the right direction. I think that Dr Kearney will give the Institute a degree of certitude which has been sadly missing for quite a long time.

I need hardly tell those members who know Dr Kearney that he has substantial administrative skills that have been recognised by Governments, regardless of their political colour, in recent years. I am quite optimistic in those areas. I think that Dr Kearney's presence and impact on the Institute are already being felt. I have talked with the Chairman of the Council of the Institute and to Dr Kearney as the new Director and I have made it clear that I want the Institute to compete in the market place. I see no reason why it should not compete openly and frankly on competitive terms in the areas of service provision. I see no reason at all why it should be placed at any disadvantage *vis-a-vis* the private pathology firms.

Arising out of that, I see no reason in the longer term why it should not generate substantially more of its funding from its clinical pathology activities. All of these things are known to the Council and to the Director as matters of precise Government policy to be pursued. Of course, that will only happen in the medium to longer term. The important first steps are to raise morale and to get the I.M.V.S. functioning efficiently and humming along, and they are still being put in place. As to the actual Budget allocations and negotiations that have occurred leading up to those allocations for 1983-84, as I said at the outset, I ask Dr McCoy to make specific comment.

Dr McCoy: The I.M.V.S. has a standstill allocation for 1983-84. A substantial cost element has been removed from the I.M.V.S. budget this year; that is, nuclear medicine which, following a review of the I.M.V.S. conducted a year ago, has been transferred to the Royal Adelaide Hospital. That was $581 000 estimated cost in this financial year. Full account is being taken of a presumed increase in revenue that will accrue from an increase in the medical benefit rate, which is expected in November or December this year. To some extent there is an assumption in the I.M.V.S. budget which may have to be varied one way or the other, depending on the actual increase in fees when it is known.

The Hon. JENNIFER ADAMSON: Given the Minister's expressed optimism about the future operation of the I.M.V.S. under its new legislation, when does the Govern-

ment intend to repeal the Act and revert to the original structure in accordance with Mr Bannon's undertaking given during the third reading debate on the Bill on 2 March 1982? As Leader of the Opposition, Mr Bannon undertook that a future Labor Government would restore the I.M.V.S. to its former co-ordinated role in relation to medical and veterinary science.

The Hon. J.R. Cornwall: I led the debate in this Chamber, and I gave an identical undertaking. The short answer, I guess, is, 'When the time is right.' Perhaps just as, or more, important is the question of when we would reform the Act. In a courageous way, it should have been done when it was opened a couple of years ago to remove the anachronism which is the I.M.V.S. legislation under which it is a separate statutory authority. Quite obviously and manifestly, it would be far better to be integrated and co-ordinated into the system under the South Australian Health Commision Act. I do not want to impose any traumas on the I.M.V.S., as I said, or any thoughts of traumas until such time as the new Director has really got it on the road. At that time I will most certainly consider and recommend to Cabinet that we ought to review the I.M.V.S. Act and that we ought to give very serious consideration to implementing the promise that we made that we would put the 'V' back into the I.M.V.S. when the time is appropriate.

The Institute was unique in that respect, being an institute for both medical and veterinary science. It was certainly unique in Australia and one of the few institutes of its type in the world. The grave difficulty, of course, was that the performance of the Institute for many years had not matched the expectation. As a centre of research and excellence it had done very little of note for a very long time. So, it is important that it gets its performance together under the new Director. I do not know how long that will take—I am not clairvoyant—but if I am still Minister of Health when that performance has been upgraded I will certainly move to ensure that the Institute becomes a centre of excellence by world standards. Two of the ways by which I hope that we could expedite that as State Government would be, as I said, to put the 'V' into the I.M.V.S. and to completely rewrite its Act.

The Hon. JENNIFER ADAMSON: I refer to pages 51 and 52 of the yellow book and the allocation under the sub-programme title, 'Environmental, occupational and protective health services', which appears to be a slight increase. It is difficult to tell from the way in which the programme is presented what amount is allocated respectively to the Central Board of Health and other Health Commission central office functions. I ask the Minister what is his intention in relation to the Central Board of Health. Does he intend to abolish it and local boards and, if so, how will the present functions of the Central Board and the Metropolitan County Board and other boards be carried out, and what will be the anticipated difference in cost?

The Hon. J.R. Cornwall: Of course, to even comment on the anticipated difference in cost presumes that we will take the initiatives that the member outlined. I must say that I have learned a great deal from the experience of the previous Minister, which, with regard to the Local Government Association and the possible reform of the Central Board of Health, was all bad—not the initiative, but the experience—and, also, I would have thought, having looked at the long record, rather debilitating. It is not my intention at this time to make the reform or, more particularly, the abolition of the Central Board of Health something which is absolutely central to our reform of the food and drug legislation, for example, although there will clearly have to be amendments to the Health Act. We have already flagged that we intend to repeal the Narcotic and Psychotropic Drugs Act and that we intend to introduce a Uniform Food Bill. Those initiatives will all take place in the present Parliamentary session.

Clearly, to the extent that they impact on the Central Board of Health, local boards of health and the Metropolitan County Board, there must be some reform. There will most certainly not be revolution. I will not be diverted from the very important tasks ahead of this Government by getting locked into mortal combat with a recalcitrant Local Government Association, but that does not mean that we will not introduce significant reforms.

It raises the further question of the roles of local boards of health in the question of the surveillance of nursing homes. The member will be aware that under the previous Government there was a wide-ranging review of the regulations relating to nursing homes which was produced and circulated to interested parties, including local government bodies, for comment. Those regulations, as commented on, if you like, were ultimately passed to the Sax Committee of Inquiry and to the particular member of the Sax Committee of Inquiry who was looking at the question of aged care—who, incidentally, happened to be Professor Gary Andrews before I managed to persuade him to come to South Australia to run the Health Commission. I am able to reveal without breaching convention, I believe, that one of the recommendations—and a strong recommendation—of that committee is that the control of a range of activities, including inspections, standards and so forth, of nursing homes, ought to be centralised and handed over appropriately to the Health Commission, the Central Board of Health, or whatever appropriate body.

I agree with that wholeheartedly because my personal experience in Opposition was that I wrote to 29 councils to ask what procedures they adopted for inspecting nursing homes and I got 29 different replies. I have made it clear for quite some time that I regard that as intolerable. I agree with the Sax Inquiry that, in the interests of very substantially upgrading standards for nursing homes for the very elderly people who are unable to care for themselves, I and the Government have a duty to ensure that the highest reasonable standards are maintained. I certainly will recommend to the Government that we should centralise inspection services for all those purposes.

Radically changing the Central Board of Health is in practice, perhaps, the most difficult thing that we could attempt in the near future because it would certainly involve trying to please 127 local government bodies and, for practical purposes in the immediate future, perhaps would be one of the least important of our priorities.

With regard to costs, to the extent that they are not hypothetical in the event that the Board was abolished or otherwise, and to the extent the Board currently is a cost on the State Government and the taxpayers (perhaps any modification which might be envisaged and which would impact on costs or inspection procedures), I ask Dr Wilson to comment.

Dr Wilson: The actual costs incurred by the Central Board last year were $7 598. There has been an estimate allocation this year of $6 062. The variation often occurs because of the number of appeals to the Central Board of Health each year.

The Hon. JENNIFER ADAMSON: It seems apparent that the costs of the Central Board of Health are not calculated on a programme performance basis. The working time spent by the Chairman is not allocated to the Board because that seems to be a small sum as payment for administering such important functions. Although I indicated to the Minister, by message early this morning, that the time after dinner would be spent on State-wide services (that is, public health and voluntary organisations), there is

a question that does not come within the ambit of the description and relates to teaching hospitals.

Regarding the education of nurses, the blue book identifies the budgets of the recognised teaching hospitals, in which are included the cost of nurse education. The Minister would be well aware of the wish of the nursing profession, both in South Australia and thoughout Australia, for nurse education to be progressively transferred from hospitals to college-based training with appropriate clinical experience in hospitals. What provision is there in this Budget to ensure that that occurs? Would the South Australian Government consider ceding to the Federal Government funds presently used for nurse education so that they could be transferred to the Minister of Education for use in colleges of advanced education for the professional courses which the nursing profession in Australia so badly wants?

The Hon. J.R. Cornwall: I am sure that the former Minister has had the opportunity to read the history of the Central Board of Health, which was formed in 1873. The Board is a fine body that has remained essentially in a similar form for the past 110 years. It has done a good job and is much beloved by local government, but at some stage it will have to be reformed to meet the needs of the 1980s, 1990s and beyond.

Regarding the provision that we may have made to implement programmes for nurse education in this Budget as it relates to any proposed moves to tertiary-based nurse education, the short answer is 'None'. There is no provision that we could make without dramatically changing present funding arrangements, because any tertiary-based education programme is a Federal responsibility.

I am aware of the wish of the majority of the nursing profession to move to tertiary-based education. I am also aware that this is a contentious subject and that there are people in the medical profession in particular who do not believe that we should move with any alacrity into this area until it has been proven in other places. I am further aware of the feeling in the Australian Labor Party (South Australian Division) that the present hospital-based nurse education gives a daughter or, increasingly, a son of an ordinary working class family the chance to get into a para-professional area, and there is a deep feeling within a section of the A.L.P. that we should at least maintain that opportunity. Some good examples, particularly of girls, are cited to show that they made it into the nursing profession and did extremely well whereas, in other circumstances, if they had had to make it through a tertiary-based course they would not have got into nursing.

I respect that point of view just as I respect the view of those in the profession who wish to move (I think inexorably) to tertiary-based training. It is not my intention, nor that of the Government, that the change should be rushed. In fact, the present precise policy of the Bannon Government is that we should work towards an intake of 300 trainees a year to tertiary-based training for the triennium 1985-87. Whether we can realistically attain that figure I do not know.

Clearly, it will depend on Federal Government initiatives, because tertiary education is obviously a Federal-funded area and has been since the time of the late Sir Robert Menzies. We are happy to co-operate in a situation that would see an intake of up to 300 a year tertiary nursing trainees in the 1985-87 triennium. This would mean a total intake of about 500 a year into our hospital-based schools. The Government intends to re-evaluate the position toward the end of the triennium.

The Hon. JENNIFER ADAMSON: Will the South Australian Government, acknowledging that tertiary education is a Federal responsibility, transfer the funds currently used for nurse education back to the Federal Government so that it can transfer those funds to tertiary institutions, thus meeting nurse educational needs in the way in which the profession wishes them to be met?

The Hon. J.R. Cornwall: That is a hypothetical question because this Government has not been propositioned by the Federal Government. If the Federal Government wanted to talk to us on that basis, it would not be a question that I could address in splendid isolation: it would be a matter for Cabinet and (I believe rightly) for Caucus. I have not been approached on that basis by anyone in the Federal Government, nor have I approached anyone in the Federal Government. Therefore, it remains a hypothetical question at this time.

The Hon. JENNIFER ADAMSON: At page 15 of the blue book, reference is made to grants to health agencies, specifically Windana day care and Windana nursing home, about which the Minister had much to say when in Opposition. It would seem that, for the nursing home, the allocation for this year has been reduced from last year's actual figure of $254 412 to a preliminary Budget allocation of $175 500. Further, the figure for day care seems to be almost at a standstill. In view of the Minister's statements about the acute need for expanding services to the aged, can he explain the reduction in the Windana allocation?

The Hon. J. R. Cornwall: This could be better explained by Mr Sayers. There is a question of income as well as payments if one looks at the figures. The question of Windana and Magill seems to be close to resolution because of the active co-operation that the Government has received from the Federal Government, particularly the Federal Minister, Dr Neal Blewett. It seems to me that we are close to a position where honour will be preserved and truth, justice and the South Australian way will be seen to prevail in the arrangements that we are able to make at both the Magill Home and Windana with the private voluntary sector, the public sector, the unions and everyone else involved. I do not want to prejudice the final stages of negotiations in this area by saying any more at this time.

Mr Sayers: The Windana Nursing Home is managed on behalf of this State by Southern Cross Homes and is in a commissioning phase at present. As the nursing home is progressively commissioned the deficit reduces. It is anticipated that upon full commissioning the Windana Nursing home will be operated with no net cost to the State. What we see now is a phase in that total commissioning role.

Mr ASHENDEN: My first question concerns the drug dependency treatment clinic at Norwood, have there recently been a number of staff resignations from that clinic?

The Hon. J. R. Cornwall: I am vaguely aware that there has been some dissatisfaction at Osmond Terrace. I have deliberately refrained from becoming actively involved at that level, first, for reasons which I explained earlier today—I am not the Chief Executive Officer for the 178 health units—and, secondly, because there are some major wide-ranging, one might almost say sweeping recommendations, which will be coming forward in the Smith Report regarding the reorganisation of alcohol and drug services. For that reason I have been inclined to keep my powder dry until the report is tabled, which I anticipate will be some time within the next month. I am aware, and it is almost a grapevine awareness, that there has been some dissatisfaction among the staff at Osmond Terrace; whether specifically regarding the resignations, I am unable to say.

Dr Shea: I know of no excess resignations at Osmond Terrace. I am aware that the Board has been concerned about some of the staff facilities in the physical sense and that a new staff amenities block is being erected at the moment. I do not know of any specific staff resignations.

Mr ASHENDEN: I have been advised that there have been resignations from the clinic and that the problems are a little deeper than have been outlined. Apart from amenities,

are there any other problems that you are aware of? If so, what are the problems and the plans to overcome them?

The Hon. J. R. Cornwall: I think that there are problems in the basic approach that has been taken by the Alcohol and Drug Addicts Treatment Board over a number of years. It was this concern that caused me to make that one of the specific terms of reference of the Smith inquiry into mental health services. This concern caused me to look around the world to find who might best be able to advise us in this area.

As a result of this search we eventually brought Dr Bob Newman to South Australia from the Bethesda Israel Hospital in New York. He is a person who has had vast experience in the field of drug problems and narcotic addiction in particular. Dr Newman has been a consultant to numerous Governments around the world and has made very wide-ranging and, in some areas, sweeping recommendations which have been incorporated in the Smith Report. I cannot say any more than that and the Committee will have to wait until the report is tabled in Parliament some time during the next month. Concerning the allegation, there does not appear to be any substantiated evidence.

Dr Shea: I do not have any specifics concerning it.

Mr ASHENDEN: To allay the concern of persons involved with people receiving treatment through the clinic, could the Minister indicate what he sees as the future of that clinic?

The Hon. J. R. Cornwall: Clearly, there is a future for a clinic. Whether it ought to be hospital-based or whether it should continue to be at Osmond Terrace, I have not decided at this stage. There is a school of thought that believes we ought to challenge the medical profession generally by putting people who need acute treatment of both alcohol and drug related problems in the general hospitals, thereby forcing 98 per cent of the medical profession to confront the large and growing problems of both alcohol and drugs. This programme has been actively followed by people like Dr Newman and has something to commend it. There has been no Government decision on this.

When the Smith Report is brought in it will not be like the Ten Commandments handed down in stone from the Mount; it will be tabled in Parliament and will be the subject of wide-ranging public discussion and, arising out of that discussion and consensus, the Government will act in 1984. At this stage, while I am attracted to the sort of programme that Dr Newman is obviously a part of, I would not pre-empt anything in view of the fact that there has been no public debate in these areas and no Cabinet decisions. I give an absolute and unqualified undertaking on behalf of the Health Commission and the Government that the services currently provided at Osmond Terrace will in no way be diminished, whether they are provided at Osmond Terrace or elsewhere.

The Hon. JENNIFER ADAMSON: I refer to page 16, item 10 'Special Benefit Schemes' as set out in the blue book and the item 'Programme for aids for disabled people'. Most members would have dealt with constituents who wanted to apply for assistance under this programme. The Minister may be aware that the previous Government was reluctant to accept a grant from the Federal Government that, whilst limited in terms of its amount, was open ended in terms of its application and could easily have run out within the first month or two of the financial year in which it was granted. I cannot relate this item to the previous blue book for the 1982-83 Estimates of Expenditure, and the current book does not identify any sum as having been provided in 1982-83.

Will the Minister refresh my memory about what amount was accepted from the Federal Government last year and administered by the State Government? What are the conditions that the Commission is now placing on that programme? Will the Minister identify those conditions and forward them to all members of Parliament so that we can advise our constituents of methods of application and what aids are available for people under this scheme?

The Hon. J.R. Cornwall: The reason that suddenly appears on that line is that previously the fund was kept in a trust account. The member correctly recounts that the previous Government and the previous Minister were reluctant to enthusiastically take the PAD scheme on board. The problem that she correctly identified was that the then Government was being asked to act as an agent for the Federal Government, the difficulty being that the State Government was seen to be the provider through acting as an agent, and there was no guarantee that, once funds ran out, whether it should be in December, March or whatever part of the financial year, the State Government would not attract the odium or that the Federal Government would be willing to advance any additional funds.

I inherited that situation at the time when Jim Carlton was the Federal Liberal Minister for Health. I recall taking up this matter in an immediate pre-election situation with some of my colleagues, State Labor Ministers of Health, and the then Federal shadow Minister Neal Blewett. I also recall that as a result of very strenuous representations that I made to Jim Carlton by telex and other means that South Australia was awarded (from memory) an additional $170 000 in the immediate Federal pre-election situation. Subsequently, we have been notified by the present Federal Minister (Dr Blewett) as recently as about 10 days ago that the amount of money allocated to the PAD scheme for South Australia in 1983-84 has been increased in real terms by an additional 23 per cent, and the total amount available under that scheme in 1983-84 will be about $740 000.

The Hon. JENNIFER ADAMSON: In clarification, did the Minister say that $500 000 identified on page 16 should be $740 000?

The Hon. J.R. Cornwall: Yes.

The Hon. JENNIFER ADAMSON: On a point of further clarification, will the Minister send to every member of Parliament details of what is available and who is eligible under the scheme to save members having to seek information continually from we know not quite who in the Commission in order to advise our constituents?

The Hon. J.R. Cornwall: I have two responses. First, when the document was compiled, we did not know about the Federal Budget allocation, which I am sure the honourable member appreciates. It is more difficult in the health area than elsewhere. Secondly, in regard to her request that I issue an information sheet to members about the conditions of what is available under the PAD scheme and how to apply it and the like, I see no difficulty in doing that and I give the Committee a firm undertaking that it will be done in the near future or at least as soon as Mr Bansemer and others involved in policy and projects are able to do it in their spare moments, which the previous Minister would realise are very few. It has not been kept a military secret; conversely, even with the 23 per cent increase we will still have some difficulties in meeting all of the applications that we are likely to receive in 1983-84. I share many of the previous Minister's thoughts and in this area at least we have a substantial degree of empathy. Certainly, we do not want to turn back what is now almost a $750 000 programme. There will continue to be difficulties with it while we simply act as agents for the Federal Government. We will certainly get an information sheet or letter out to members of both Houses of the South Australian Parliament.

The Hon. JENNIFER ADAMSON: I refer to page 17 of the blue book and 'Deficit Funded Health Services'. The Royal District Nursing Society is another voluntary body

which, in effect, provides a State-wide service upon which the Government, taxpayers and patients depend for much needed domiciliary care and nursing services. In the last Budget the previous Government allocated a substantial additional sum to the the society to enable it to extend nursing hours (I think, from 5.30 or 6 p.m. to about 9 p.m.) so that district nurses on their rounds could put patients to bed, change their dressings and provide a service to enable patients to be discharged from hospital where otherwise that would not have been possible.

In other words, the additional funds (I think, about $180 000) effectively enabled hospitals to discharge patients earlier than they otherwise could have done and thus provide a pronounced cost benefit to the health system by transferring funds from institutional to community-based care, enabling them to go much further in terms of treating patients. An assessment of the costs, the actual payments and receipts and net payments last year and this year indicates that there is no significant change or significant increase. Can the Minister indicate whether the Government has a policy of expanding community based care in order to take the pressure off high-cost institutional care? If that is so, why has not the Royal District Nursing Society additional funds for that purpose?

The Hon J.R. Cornwall: Within the constraints of the difficult economic times in which we live, the Government has an active policy of funding, to the maximum extent possible, non-institutional health services. The Government does not accept the rhetoric nor the conventional wisdom of the previous Government that this necessarily means that non-institutional care can be provided on the cheap. A substantial amount of evidence is available to show that it may not be significantly cheaper to provide an adequate range of services to keep senior citizens and frail, aged people in their own home, in the community, or in their natural environment.

Having said that, I point out that this year we have been able to find an additional $74 000 specifically for that additional out of hours arrangement or the additional shift, to which the honourable member referred. It is fair to point out to the Committee that half of that $74 000 is provided by the State and the other half by the Commonwealth. In regard to what may be termed the illusion of the figures in the blue book, I come back again to the old question, as I have said all day, of round-sum allowances and shifts in awards.

The Hon. JENNIFER ADAMSON: At page 51 of the yellow book, reference is made to the problems of lead contamination and pollution in Port Pirie. I know that the member for Florey referred to this matter earlier. What has been the cost so far of the epidemiological studies and the inquiries that the Minister has instituted, and is there an estimated capital cost that the Commission has been able to determine not for the treatment of children but for the treatment of the sites, so to speak, in either removing contaminated material and replacing it with fresh material or in removing housing or any other facility that is in a contaminated area?

The Hon. J.R. Cornwall: I will answer the second question first, and Dr Wilson will refer to the cost and the epidemiological and other studies. We now have the report of the task force into environmental lead contamination in Port Pirie and the report of Dr Phil Landrigan, the world expert in environmental heavy metal contamination whom we brought here from the united States quite recently. I am afraid that the honourable member and other members of the Committee will just have to be a little more patient and wait until those reports have been before Cabinet with my comments and recommendations.

I intend, as in regard to the Sax Report and the Smith Report, that those reports will be made public documents. Unlike the Sax and Smith Reports, however, it will be necessary that we have, at least in part, a strategic plan for implementation of the recommendations or a combination of the recommendations which have been made by both the lead task force and Dr Landrigan. I can indicate to the Committee that the capital cost of adopting the recommendations of either or a combination of both reports will be extremely high. As to the cost of the studies so far, I will ask Dr Wilson to provide information in that area.

Dr Wilson: The actual cost for the Port Pirie lead study in 1982-83 was $7 000, and $4 000 has been allocated for 1983-84. Those costs are essentially for travel and accommodation. The apparent low level can be explained in part by the major contribution made to blood lead examinations by Broken Hill Associated Smelters. The company has also undertaken rainwater studies, and the actual number of analytical studies carried out by the Commission is relatively small. The cost of Dr Landrigan's visit was $11 605.

Mr INGERSON: Regarding the disposal of low level radioactive waste, I have been advised that the South Australian Health Commission, which provided a radioactive waste disposal service to the users of radioactive substances in the form of medicine and research, is now planning to discontinue this service because of the transfer and non-replacement of the staff member who performed these duties. Concern has been expressed to me that the hospitals that have been asked to take up this request do not employ radiation safety officers. What does the Minister believe should be done in this instance?

The Hon. J.R. Cornwall: It would be far better if I asked Dr Wilson to answer this question. I am pleased that this matter has been raised: not the specific aspect but the general aspect of disposal of radioactive medical wastes was raised with me very recently by a couple of concerned members of the public and, quite frankly, to date I have not had a chance to obtain a completely up-to-date brief. This will be an opportune time for members of the Committee and me to obtain such a concise briefing, with particular reference to the matters raised by the member for Bragg.

Dr Wilson: The alteration has really occurred through Government policy—the 'user pays' principle. The Commission, through the radiation control section, has in the past actively organised the disposal of very low level wastes mainly at the Wingfield dump, under supervision. We consider that this is quite safe if adequately carried out. With the slight change of policy, we have written to all the users of this service and suggested that it would be more equitable if the Health Commission staff simply supervised the disposal at the dump site. We have offered to try to co-ordinate a single disposal bay. The supervision of the dumping will not be lessened: the involvement of the Health Commission staff will be lessened, in the sense that one officer will be relieved of having to approach the various users and to supervise the packaging and transport of waste to the dump.

The Hon. JENNIFER ADAMSON: In regard to the South Australian Dental Services, while reference is probably made to this matter in the yellow book, I refer to page 10 of the blue book. What analysis, if any, has the Health Commission been able to undertake of the savings that have been made through the amalgamation of the South Australian Dental Hospital and the provision of dental services to pensioners and the South Australian School Dental Service in the South Australian Dental Services, thus enabling co-ordination of resources and the use of facilities that was expected to result in cost savings?

I recognise that probably in the first year of operation, rather than there being savings, some costs might have been

incurred through amalgamation. I would like to know in terms of staff numbers, particularly administrative staff and administrative costs, what savings, if any, are built into the Budget for the current year in terms of expanding services with the same amount of staff.

The Hon. J.R. Cornwall: It is early days in the marriage, as I am sure the member for Coles would appreciate. I am quite unable to respond accurately to what is a very specific question. I am able to say that we will be involved in a substantial amount of capital funding to the Dental Hospital. Many areas are badly in need of upgrading, and some areas are desperately in need of upgrading. For example, one entire floor of the Dental Hospital requires the physical upgrading of facilities and the provision of new equipment. In the short term, that is obviously a significant capital cost, and the member quite rightly acknowledged that that might occur in the short term.

I would be surprised if we were able to quantify in precise terms any actual savings to this moment because of the changed arrangements. However, I never fail to be amazed by the extraordinary capacity of many of my senior officers in the Commission. In the absence of Dr Kennare, who is unable to be present, I ask Dr McCoy, as Executive Director of the Central Sector, to provide any additional statistical information. In the event of consideration of the matters raised by the honorable member, we may have to provide a considered response, and I am happy to give that undertaking.

Dr McCoy: Some information can be provided, although a detailed answer would require consultation with Hugh Kennare. The number of staff employed by SADS has reduced from 656 in 1981-82 to 616 in 1982-83. In the financial year 1983-84, a standstill allocation has been provided to SADS. This has been sufficient to provide for a vastly increased number of persons who are attending the Adelaide Dental Hospital. I am advised that the number has increased by 35 per cent from 759 per month to 1 027 per month. This is attributed to the increased number of persons who are unemployed and who are requiring a range of dental treatment from the Adelaide Dental Hospital.

So, from within a standstill allocation, the reallocation of resources principally from the School Dental Service to the Adelaide Dental Hospital has enabled SADS to cope with a vastly increased workload. As was mentioned earlier, a standstill provision of $1.125 million has been provided for the pensioner denture scheme, which is a 6.5 per cent increase on last year. Further information would have to be obtained from officers of SADS.

The Hon. JENNIFER ADAMSON: I am glad that I asked that question, because it confirms the belief that I had when my Party was in office that that was what would occur. It also gives me an opportunity to pay a tribute to the people who I regard as very efficient administrators who head the South Australian Dental Services operation.

As the Minister would know, when the Government of which I was a Minister came to office, the waiting time for dentures was, I think, in the region of three years, and when we left office it was three months. What is the waiting time for dentures at the moment? Also, is there any waiting time for spectacles in hospitals, if any of the teaching hospitals still provide spectacles, despite the establishment of the pensioner spectacles scheme, which enables pensioners to obtain spectacles from private practitioners?

The Hon. J.R. Cornwall: I am pleased to hear the former Minister speak well of the people in the South Australian Dental Service. There are many people in that Service who, I may say, speak well of the former Minister. I regret to say that they do not speak well of the former Government because of its decision to abandon the expansion of the School Dental Service into the secondary school area. They thought that that was a most regrettable decision taken by the Tonkin Government.

With regard to the denture scheme operted by the A.D.A. in co-operation with the Health Commission, I pointed out earlier today, and I will continue to repeat it as often as I need or am asked to, that I think it was the significant initiative that was undertaken by the previous Minister in the health area. If the member for Coles is heavily into monuments, I think that is a reasonable one on which she could hang her hat. However, I note that she is shaking her head: like me, she obviously believes that monuments are not the thing but that the provision of services is, that is, looking after people.

The denture scheme continues to work well. I think it is probably fair to say that it is under some degree of pressure at the moment. I am not able to get entirely accurate figures. Obviously, the waiting time depends a great deal on where the applicant resides. It is fair to say that overall the waiting period on a State-wide basis varies somewhere between three months and six months.

Certainly, it is always made clear to local dentists and to dentists in country areas who conduct the assessments for pensioner dentures in school dental clinics that, if they think there is any valid clinical reason why there is a degree of urgency, they should contact the hospital directly, put the case and have the applicant's name advanced to the top of the list, where appropriate.

In summary, I think it is fair to say that it is a very good scheme that continues to operate cost effectively. It provides a lot of dentures and, therefore, a lot of comfort for a lot of aged pensioners in South Australia. It is perhaps under a little stress at the moment. I have asked that the situation be carefully monitored. If there is any evidence that the waiting period is starting to stretch out again to anything that might be considered on average to be unacceptable, we will most certainly look at an adjustment to the extent necessary in the 1984-85 Budget.

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

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

Chairman:
Mr G.T. Whitten

Members:
The Hon. Jennifer Adamson
Mr E.S. Ashenden
Mr Becker
Mr R.J. Gregory
Mr G.A. Ingerson
Mr Mr J.H.C. Klunder
Mr M.K. Mayes
Mr K.H. Plunkett

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

Departmental Advisers:
Mr A.J. Bansemer, Director, Policy and Projects, South Australian Health Commission.

Mr E.J. Cooper, Deputy Chief Executive Officer, South Australian Health Commission.

Dr M. Court, Director, Corporate Finance and Administration, South Australian Health Commission.

Dr W.T. McCoy, Executive Director, Central Sector, South Australian Health Commission.

Mr R.J. Sayers, Executive Director, Southern Sector, South Australian Health Commission.

Dr K.J. Wilson, Principal Health Commission Officer, Public Health Service, South Australian Health Commission.

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

The Hon. JENNIFER ADAMSON: I note that the annual provision for minor additions and alterations is $1.5 million, and I take it that that includes provision for fire protection in Government hospitals and health units. I ask the Minister what component of that $1.5 million is for the purpose of fire protection, and what is the aggregate sum required on current estimates to provide fire protection for health units under the control of the Government?

The Hon. J.R. Cornwall: I do not have that aggregate sum immediately at my fingertips or in my mind, but the quick summary of that would be an enormous amount. We still have a lot of fire protection works to do, as I am sure the member for Coles is aware. A substantial proportion of that $1.5 million is allocated for fire protection, principally still at this stage on patient protection works rather than building and property protection works. We have not, by any means, in our Government funded or recognised hospitals and health units reached a stage where we can possibly hope to do other than mostly patient protection segments of the fire protection programme. I am unable to accurately say what proportion of that $1.5 milion is directly for fire protection, but it is listed here somewhere, and I am hopeful that Mr Cooper can dig it out and respond.

Mr Cooper: I could perhaps just read out the fire protection works that are provided in this year's programme. They are not all provided within the $1.5 million. That allows for a whole range of minor works and alterations which are committed during the course of the year under the delegations of the Commission's sector Directors, but fire protection money will be found in the $13.5 million as well as in the $1.5 million.

Briefly, we are proposing $64 000 at Berri Hospital; $61 000 at Balaklava Hospital; $81 000 at Burra Burra Hospital; $360 000 at Glenside Hospital; $130 000 at Gumeracha Hospital; $250 000 at Hillcrest Hospital; $3 000 at Meningie Hospital (that is a very small one); $75 000 on fire protection works at Queen Victoria Hospital; Southern Districts Hospital, $65 000; and Riverton Hospital, $73 000. I did not actually add all that up as I went along, but it is clear that a very substantial amount of money is being spent on fire protection. Further, there is Strathalbyn Hospital, $63 000; Strathmont, $20 000; and Thebarton Community Hospital, $18 000; giving a total of $1.263 million.

The Hon. J.R. Cornwall: I hasten to point out to the Committee that all those programmes of fire protection are described in the accompanying documents as 'Fire protection, Stage 1'. As I pointed out, they are at this point involved only in the more necessary and vital area of patient protection, but there is still a lot of money to be spent in the fire protection area.

The Hon. JENNIFER ADAMSON: I would appreciate on notice the Minister providing the information originally sought: namely the total estimate of capital works for fire protection, as at this year's figures, for all Government health buildings and units under the Commission's control. I would also like to know what component of either the $1.5 million or the $13.5 million, or both, accounts for asbestos removal in Government health units and, in particular, in the Adelaide Children's Hospital and the Port Lincoln Hospital which, as I recall, both have very costly estimates of work needing to be done. I also recall the Minister and his colleagues being very vociferous about the urgency of the work.

The Hon. J.R. Cornwall: There is no specific provision for asbestos removal in the Adelaide Children's Hospital this year, particularly in the Rieger Building. What we hope to do at some time in the near future is to get a proposal in to Cabinet for the further major redevelopment stage of the Children's Hospital. If members of the Committee have done their homework and have good memories, as I am sure they will, a story was run in the *Advertiser* many months ago—back in the time when the member for Coles was Minister of Health—which talked about certain initiatives that might be taken in regard to the Rieger Building at the Children's Hospital to overcome the asbestos problem. The Rieger Building probably has asbestos in about as poor a shape as any building in Adelaide That building, as the member would know, is all but unoccupied at this stage. In the area that is occupied, of course, we have been very careful to make sure that it is totally sealed so that no asbestos gets into the environment at all.

That part of the programme is not on the Estimates for 1983-84. We will spend money at the Adelaide Children's Hospital on developing the next major programme through its initial stages. Eventually, the Clarence Rieger Building and the asbestos removal will be part of that multi-million dollar programme.

At Port Lincoln, interim measures were taken last year. Offhand, I cannot remember the precise amount of the contract, but I believe that it was for about $70 000.

Regarding the Royal Adelaide Hospital, another potential problem area, one or two relatively small programmes are proposed for 1983-84, but again I have not those details with me. The most satisfactory summary I can give this time is that there are no major asbestos removal programmes specifically in this Budget that would be in the multi-million dollar bracket.

There will certainly be preparation for a major asbestos removal programme at the Children's Hospital, at the Clarence Rieger Building. Provision will be made for continuing the planning of a substantial multi-million dollar upgrading at the Port Lincoln hospital which will involve asbestos removal, and some work will be done at the Royal Adelaide Hospital during 1983-84, probably at a cost of about $100 000.

Dr McCoy: No work will be done this financial year at the Adelaide Children's Hospital. Minor projects are being undertaken in the East Wing of the R.A.H., but they are being funded not from the capital works programme but from the hospital's own resources.

The Hon. JENNIFER ADAMSON: A former Liberal Minister cannot but reflect on the irony of the present Minister's describing the situation at the R.A.H. as a potential problem, considering that, when in Opposition, he and his union colleagues regularly made headlines on this matter. Indeed, less than a week before the 1982 State election I was accosted by officers of the Builders Labourers Federation demanding action.

At page 146 of the Estimates, $300 000 is proposed for the Central Linen Service. I assume that that sum is for the replacement of machinery at the Central Linen Service. What will be the cost impact of that expenditure on the recurrent budget of the Central Linen Service? Recalling the Minister's undertaking that the recommendations of the committee of inquiry, which called for a substantial reduction in the staff of the Central Linen Service, would be progressively implemented, I take it that that staff will be reduced this year with the installation of new machinery.

The Hon. J.R. Cornwall: I remind the honourable member that I was not involved in accosting the then Minister a week before last year's election over the matter of asbestos

at the Royal Adelaide Hospital or anywhere else. That has always been the baby (I believe commendably so) of a well-known organiser of the Builders Labourers Federation (Mr Jack Watkins), who has a single-minded dedication to solve the problem.

The Hon. Jennifer Adamson interjecting:

The Hon. J.R. Cornwall: Jack Watkins has given me a hard time, so much so that I have administratively transferred all the asbestos monitoring to the Minister of Labour. That was done for a variety of reasons, one being that Jack Watkins believed that, as Minister of Health, I had vested interest perhaps in taking a low-profile approach to some of our hospital buildings. That is not true, of course: I would defend to the death my integrity in this as in all other matters. Nevertheless, officers of the Builders Labourers Federation, and Jack Watkins in particular, are far more comfortable to have the asbestos monitoring and policing with the Minister of Labour, to whom those functions have been referred.

Concerning the Central Linen Service, it is true that I made a major announcement approximately three months ago that the Government was upgrading the service by an extensive capital works programme involving, from memory, $3.3 million over a period of five financial years and that we intended to reduce staff numbers in that period by attrition. We have had amicable discussion and have reached agreement with the unions concerned. The $300 000 in this financial year has to be set against, from memory, an amount of money held in an account by the Central Linen Service which is of the order of $700 000. So, the actual upgrading in terms of the purchase of capital equipment in 1983-84 will be closer to $1 million. I am unable to say, without directly consulting management, how quickly that will result in attrition of staff. Certainly, we are well on target as far as the programme I announced on 3 June, a little more than three months ago.

The Hon. JENNIFER ADAMSON: The line 'hospital and institution buildings, $13.5 million' I take it will include provision for the start of the Noarlunga health village and hospital which is expected to be opened in June 1985, according to a release from the Minister in the *Southern Times*. How does the Minister reconcile the commencement in February next year of the health village and hospital with the recommendation of the Metropolitan Hospitals Planning Framework Proposals which on page 35, as part of its conclusions, states that planning should allow for possible establishment of a public hospital at Noarlunga towards the end of this decade? It is proposed that a decision, if and when to proceed, be deferred until 1984 or 1985. Is that public hospital referred to in the conclusions of the planning study additional to the health village or is it one and the same?

The Hon. J.R. Cornwall: The member for Coles, as a former Minister of Health and someone who was involved with the very early planning of the proposed Lyell McEwin health village, should have a better knowledge or recollection of what a health village is all about. Stage I of the Noarlunga health village will provide a range of services, including a 24-hour casualty service (not a full A. and E. service, because it will not have the back-up of a hospital). Apart from the 24-hour casualty service, it will fill a large range of needs that have been defined by survey and by the steering committee in the Noarlunga region. It has been taken from a concept of 10 November 1982, when I was sworn in as Minister, to a firm proposal in six months. That report was on my desk in May. It is now going through the further and final planning stages. The architectural consultants are Lawrence Nield, a firm well known to members with an interest in the health area.

Stage I is on target. Cabinet took the decision to give approval in principle to stage II, which would be the construction of a 100-bed community hospital in the recognised hospital category, a public hospital, as the member technically and correctly described it; a community hospital, available to both public and private patients. Cabinet gave approval in principle for stage II to be revised in November when the Sax Committee reported and the matter had been open for public discussion and appraisal. The Sax Committee clearly indicated that there is a need (it was described as a relatively urgent need) for a 100-bed hospital in the Noarlunga region. That substantially firms up what was the recommendation of the Commission's master plan in the first instance. There is a very much firming commitment, both on the grounds of what is practically and politically sensible, to build that hospital to stage II of the Noarlunga Health Village proposal.

The Hon. JENNIFER ADAMSON: I do not believe that the Minister has satisfactorily answered the question about conflict between his decision to proceed with stage I and the conclusions in the Metropolitan Hospitals Planning Framework proposals that such decisions should be deferred until 1984 or 1985. However, in view of the time constraints, I will leave that aspect and go on to the line dealing with the purchase of equipment and the provision of $3 million. Earlier today the Minister castigated the former Government for transferring capital funds to recurrent account and failing to replace equipment. I remind him that during the decade of the Dunstan Government, whilst there was much construction of new buildings, there was little replacement of equipment in hospitals, particularly high technology equipment. Therefore, when we came to office, certainly in the area of cancer treatment at R.A.H., linear accelerators and so forth were in a state of dramatic disrepair. What little capital funds were available had to be directed to those urgent areas. A *News* report of 2 May 1983 states:

> World leukaemia expert, Professor C. Haanen, says South Australian doctors are top with skills but starved of adequate equipment.

He went on to say that he was sorry to see doctors here struggling with out-dated and makeshift equipment. He stated:

> A cell sorter urgently needed by Queen Elizabeth Hospital had been available for Professor Haanen's patients in Holland for 12 years.

Given that it was not possible in three years to compensate for the failure over 10 years to progressively upgrade high technology equipment in hospitals, can the Minister advise whether the cell sorter referred to by Professor Haanen is one of the equipment items that will be purchased with the $3 million? If not, what items are listed for acquisition or replacement under that $3 million line?

The Hon. J.R. Cornwall: The former Minister is a veritable tiger. I am amazed by the energy that she shows for someone of her age, continuing the tit for tat with regard to each of the little blows that she strikes as she opens a new question. I believe that the matter of the Noarlunga Health Village was handled adequately in the understanding of any average reasonable person.

The honourable member also referred to the purchase of a linear accelerator or something similar at the Royal Adelaide Hospital that was installed during her period as Minister. I am also very pleased to say that if one looks behind the $13.5 million that has been allocated for hospitals, institutional buildings and so on, somewhere there is provision for the purchase of an additional linear accelerator at a cost of $1.3 million. We are very anxious that the whole area of radiotherapy and the training of radiotherapists should be upgraded as rapidly and as efficiently as possible, because that area ran down for a number of years. In fact,

according to my recollection, it had its accreditation as a teaching centre taken away some years ago. I cannot quite recall whether that was during the brief Tonkin interregnum or prior to that.

Regarding the Queen Elizabeth Hospital cell sorter and the saga of Dr Sage, I am aware that people have been raising funds for a cell sorter at the Q.E.H. It is not a matter that has come across my desk: it is more a recollection, because of my attendance at a function, or perhaps I read somewhere that a cell sorter was required. It is also my recollection, although I cannot vouch for it absolutely, that the actual capital cost of the cell sorter at the Q.E.H. is not remarkably high in the scheme of things and is something which if the hospital saw as a high priority it could probably purchase within the flexibility of its budget arrangements. I am also not entirely *au fait* as to where the Q.E.H. as a teaching hospital fits into the haematology scheme of things, but Dr McCoy, being one of the most senior physicians present, would know more about the haematology situation.

Dr McCoy: My recollection is that the cell sorter is not on the capital programme. The Q.E.H. has a department of haematology that would rank with that of the I.M.V.S. and the Flinders Medical Centre. Of course, there is also a major unit at the Adelaide Children's Hospital.

Mr INGERSON: It has been reported to me that the autoclaves at the Mount Gambier Hospital are 22 years old and grossly inadequate for daily needs. Will the Minister provide funds urgently to upgrade these facilities as they are of critical importance for surgical hygiene?

The Hon. J.R. Cornwall: It is entirely possible that the autoclaves at the Mount Gambier Hospital are 22 years old because, according to my recollection, the hospital was opened officially in 1961, the first year in which I practised as a veterinarian in Mount Gambier. I recall the official opening with great clarity. Although I have followed the fortunes of the hospital since then, I am not specifically aware of the state of the autoclaves at the Mount Gambier Hospital. However, I am fortunate in being able to call on the Executive Director of the Southern Sector, Mr Sayers, who I am sure has first-hand knowledge of the state of the autoclaves at that hospital.

Mr Sayers: The autoclaves are as old as is the hospital, and the programme to replace them has been taken into the consultancy that was recently let for the upgrading of the hospital. Because the autoclaves are located in more than one point, that is one of the things wrong with the physical facilities of the hospital.

It has been agreed with the hospital that the replacement of the autoclaves should be deferred and taken into consideration when the new central sterile department is designed. We have been monitoring the situation and they are still functional and they are still safe. However, they are slow. Modern technology has passed them. Nevertheless, whilst they urgently need replacement, they can continue for another year or two.

The Hon. JENNIFER ADAMSON: I am interested to find out what proportion of the $13.5 million is an allocation for the restoration and reconstruction of the Wallaroo Hospital. I know that it is always heartbreaking for health planners and, although they may not know it, backbreaking for taxpayers, when sound health planning decisions are disturbed for political purposes. I think that health planners probably understand that sometimes that occurs in terms of a Government making decisions as to its electoral priorities. I have never known it to occur before in terms of a Minister succumbing to union pressure to ensure his continued pre-selection. Apparently, that was the deciding outcome in the case of the reconstruction of the Wallaroo Hospital. What proportion of the $13.5 million is to be used in the current year for the reconstruction of the Wallaroo Hospital? What will be the recurrent cost outcomes of the decisions to rebuild the Wallaroo Hospital and continue to use it when the construction of a regional hospital at Kadina would have resulted in a much improved health service for the people of Northern Yorke Peninsula?

The Hon. J.R. Cornwall: The honourable member never fails to amaze me. The allegation was that I did some sort of dirty political deal with the Wallaroo sub-branch in order to ensure my continued pre-selection. I never did a deal with anyone to ensure my continued pre-selection at any stage. I was never raised or lowered on the ticket except, very sadly, by the untimely death of my very good friend and comrade, Jim Dunford. The Wallaroo Sub-branch of the A.L.P., on my recollection, probably has a membership of about 35. The South Australian Branch of the A.L.P. has something in excess of 100 000 affiliates. It would hardly be in my interests if I wanted to start doing dirty deals of any description to begin with Wallaroo, even for practice. That is absolutely absurd and does the honourable member little credit.

I would have thought that, by and large, although she is something of a political animal, she is normally better than that. The hospital will be built at Wallaroo. That was a firm pre-election undertaking of the Bannon Government. It is based on the old trade union maxim, 'You may add, but you may never take away'. There has been a Government hospital facility in some shape or form at Wallaroo for more than 100 years. It was never our intention to allow that to be demolished. Nor was it our intention to allow the member for the district, the present Leader of the Opposition, Mr Olsen, to do any deals with private nursing home proprietors for the continued use of the Wallaroo Hospital building. In the first instance, there will be 30 new beds in a new building. There will be a substantial refurbishing of the existing building and substantial upgrading of the existing building. I am sure that I can produce quite substantial statistics to show that there will be some saving for taxpayers in relation to the Wallaroo option.

The new hospital planning this year will continue. The architects—Berry, Polomka, Riches, *et al*—have been appointed by the board. The planning, as I understand it, is advanced and will continue through 1983-84. I am unable to locate the precise details of just how much will be spent this year, although I have seen it documented somewhere. More importantly, I am unable to locate the Executive Director of the western sector who, I am sure, if he were here could give me the precise figures. The foundations will not be poured this year; that will occur in the next financial year. However, I can assure the members of the Committee that the building and the refurbishing of the Wallaroo Hospital will be so advanced by March 1986 that, even in the unthinkable event that there were a change of Government, those plans will be irreversible.

The CHAIRMAN: There being no further questions, I declare the examination of the vote completed. I thank the Minister and his assistants for their assistance today and for the frank manner in which they have answered the questions asked of them. I also thank members of the Committee for the manner in which they have conducted themselves.

ADJOURNMENT

At 9.58 p.m. the Committee adjourned until Wednesday 28 September at 11 a.m.