HOUSE OF ASSEMBLY

Wednesday 24 October 2007

The SPEAKER (Hon. J.J. Snelling) took the chair at 11:00 and read prayers.

STATUTES AMENDMENT (POLICE SUPERANNUATION) BILL

The Hon. K.O. FOLEY (Port Adelaide—Deputy Premier, Treasurer, Minister for Industry and Trade, Minister for Federal/State Relations) (11:01): Obtained leave and introduced a bill for an act to amend the Police Superannuation Act 1990 and the Southern State Superannuation Act 1994. Read a first time.

The Hon. K.O. FOLEY (Port Adelaide—Deputy Premier, Treasurer, Minister for Industry and Trade, Minister for Federal/State Relations) (11:02): I move:

That this bill be now read a second time.

I seek leave to have the second reading explanation inserted in *Hansard* without my reading it.

Leave granted.

This Bill seeks to make amendments to the superannuation arrangements for police officers and in particular the arrangements for those police officers who are members of the Police Lump Sum Scheme. This scheme is established under the Police Superannuation Act 1990, and is referred to in that Act as the 'new scheme'.

The Bill also seeks to make changes to the arrangements under the Police Superannuation Act 1990, relating to the administrative arrangements for the supplementary investment accounts, rollover accounts and co contribution accounts established for members of the Police Pension Scheme and the Police Lump Sum Scheme.

This legislation makes amendments to the Police Superannuation Act 1990, that establishes and maintains the Police Pension Scheme and the Police Lump Sum Scheme, and the Southern State Superannuation Scheme 1994, that establishes and maintains the Triple S Scheme. The main feature of this legislation is the proposed transfer of the existing members of the Police Lump Sum Scheme to the Triple S Scheme. The Police Lump Sum Scheme is a closed scheme with about 380 remaining active members. The legislation makes no changes to the benefit structure and rules of the Police Pension Scheme.

The Government is proposing to transfer the Lump Sum Scheme members to the Triple S Scheme so as to rationalise the Government's superannuation arrangements, and provide the members with the real possibility of having a larger benefit on retirement. Members are expected to be better off in the Triple S Scheme because of that scheme's more attractive features and options. In Triple S the transferred police officer members will be credited with the actual investment earnings on the balance of their accounts, as opposed to a long term conservative rate of return that makes up the defined benefit in the Police Lump Sum Scheme. As members of Triple S, the transferred police officers will also have greater death and disability insurance cover. The legislation also provides a guarantee that members will not receive a lesser benefit on retirement from Triple S than the benefit that would have been payable from the Police Lump Sum Scheme. These transferred police officers will therefore not be disadvantaged by the transfer and only stand to be better off under the new arrangements. The Police Association has sought this guarantee to be written into the legislation, notwithstanding the retirement benefit comparisons indicating that all members are expected to receive greater benefits from Triple S.

The outcome from the implementation of this legislation is that police officers will be served by two schemes rather than the current three schemes. This has been sought by the Police Association and the Government is pleased to have been able to work with the Association to deliver this outcome.

The legislation effectively dissolves the Police Lump Sum Scheme, after transferring the members of the scheme to Triple S. At the same time as members are transferred, the legislation provides for an amount equivalent to the balance in each member's contribution account, and an amount equivalent to the present value of the employer financed share of the accrued defined benefit, to be transferred and applied to establish a starting balance for each member in Triple S.

The transferred police officers are becoming members of Triple S with the standard mandatory five units of death and disability insurance, and this cover is being provided without limitation and irrespective of the health of the police officer.

As the transferring members have an existing option to retire and be paid their accrued benefit after age 50, this option is being maintained in the Triple S scheme. In fact the Bill also proposes that the age 50 retirement option will be made available to all police officers who are members of Triple S.

All those members in the Police Lump Sum Scheme who are no longer in employment with the Police Department and have a preserved account will have those preserved accounts also transferred to Triple S. This action is being taken to enable the dissolving of the Lump Sum Scheme.

As I mentioned earlier, the Bill also includes a proposal that the responsibilities for the administrative arrangements for the supplementary investment accounts, rollover accounts and co contribution accounts will be transferred to the Triple S Scheme, that is administered by the South Australian Superannuation Board. A member of the Police Pension or Police Lump Sum Schemes would have an investment account where the member is salary sacrificing additional money, or paying additional money from after tax income, into either of the schemes. A member would have a rollover account where they have rolled a lump sum benefit over from some other scheme, and a co contribution account would be established for a member who has received a co-contribution benefit from the Commonwealth Government.

Whilst the Police Superannuation Board is currently responsible for administering these accounts, which are accumulation style accounts, it is considered more appropriate for these accounts to be held in the Triple S Scheme where members will be able to select an investment strategy option that meets their individual needs. As the Police Superannuation Board will be left with the administration of the Police Pension Scheme which is a defined benefit scheme, and does not have a need for investment choice options for members of that scheme, it is considered more practical to have the police accumulation style accounts held and maintained by Triple S. As a result, those police officers with a supplementary investment account, a rollover account, or a co contribution account, will have the benefit of being able to choose an investment strategy option of their choice.

The Bill also contains some amendments that address technical matters.

In relation to the technical amendments, an amendment is being made to the provisions in section 4(6b) of the Police Superannuation Act, that deal with the determination of “salary” for a member who has been seconded to serve with another police force or a prescribed body. The proposed amendment will address a deficiency in the current provisions that do not provide for the recognised salary with the external SAPOL body to have its real value maintained where the person is no longer working for that body at the time when an entitlement is to be paid.

A new provision is also being inserted into the Police Superannuation Act, to provide clarification to the issue of the delegation rights of the Police Superannuation Board. The new provision that is being inserted will make it clear that the Board has the power to delegate any of its powers or functions to any person or body.

A technical amendment is also being proposed to section 50 of the Police Superannuation Act, which is the provision dealing with the Board’s powers to resolve any doubts and difficulties. The amendment that is being proposed will bring the provisions of the Police Superannuation Act into line with the recently updated provision dealing with the same matters under the Superannuation Act 1988 and the Southern State Superannuation Act 1994.

The Police Association fully supports these proposals.

I commend the Bill to Members.

Explanation of Clauses

Part 1—Preliminary

1—Short title

This clause is formal.

2—Commencement

This clause provides that operation of the measure will commence on a day to be fixed by proclamation.

3—Amendment provisions

This clause is formal.

Part 2—Amendment of Police Superannuation Act 1990

4—Amendment of section 4—Interpretation

Definitions of a number of terms that are no longer required because of the transfer of new scheme contributors to the Triple S scheme are deleted. Consequential amendments are also made to some existing definitions that are to be retained.

The definitions of old scheme contributor and new scheme contributor are removed because, as a consequence of the amendments being made, the Act will apply to only one type of contributor. A new definition of contributor is substituted.

An amendment to section 4(6b) clarifies the operation of paragraph (d) of that subsection in relation to a contributor who has been seconded to another police force but is not employed in another police force at the relevant time.

5—Insertion of section 9A

This clause inserts a new section.

9A—Delegation by the Board

This section authorises the Board to delegate any of its powers or functions under the Act to any person or body. The section provides that a delegation must be by instrument in writing and may be conditional or unconditional. A delegation does not derogate from the power of the Board to act in a matter and is revocable at will by the Board.

This provision is based on similar sections in the Southern State Superannuation Act 1994 and the Superannuation Act 1988 that authorise the South Australian Superannuation Board to delegate powers or functions.

6—Amendment of section 10—The Fund

Section 10(4) requires the Treasurer to pay periodic contributions reflecting the contributions made by contributors, and co contributions paid in respect of contributors, into the Police Superannuation Fund from the Consolidated Account or from a special deposit account established for the purpose. Section 10 states that the Fund is to be made of three divisions. This clause amends section 10, as a consequence of other amendments, so that the section provides for the Fund to be made up of two divisions, one of which will be for contribution accounts. The other will be proportioned to the aggregate balance of co-contribution accounts to the extent that they hold the amount of any co contributions paid to the Board. As a consequence of these amendments, the Fund will no longer include a division relating to new scheme contributors or a division relating to accounts under Part 5A (which is to be repealed—see clause 18).

7—Substitution of heading to Part 2 Division 3

This clause substitutes a new heading for Division 3 of Part 2 and inserts a new Subdivision heading. These amendments are made as a consequence of the insertion into Part 2 Division 3 of new provisions relating to investment and rollover payments.

8—Amendment of section 13—Contributors' accounts

This amendment is made as a consequence of changes to the Act that mean that there will no longer be two categories of contributor.

9—Insertion of Part 2 Division 3 Subdivision 2

This clause inserts a new Subdivision into Part 2 Division 3 of the Act. The new Subdivision includes provisions relating to the establishment of investment accounts, rollover accounts and co contribution accounts. (Similar provisions currently appear in Part 5A of the Act.)

Subdivision 2—Investment option, rollover payments and co contributions

13A—Investment option

Section 13A authorises the Treasurer to accept monetary payments, in addition to contributions under section 17, from a contributor whose employment as a police officer has not terminated.

If a monetary payment under the section consists of a salary sacrifice amount, the Treasurer must pay an amount equivalent to the payment into the Southern State Superannuation (Employers) Fund. Unless the contributor who made the payment is already a member of the Triple S scheme, he or she will be taken to have elected to become a member of that scheme under section 15C(1)(a) of the Southern State Superannuation Act 1994.

If a monetary payment under the section consists of some other amount paid from the contributor's salary, the Treasurer must pay an amount equivalent to the payment into the Southern State Superannuation Fund. The contributor will then be taken to have elected under section 15C(1)(b) of the Southern State Superannuation Act 1994 to have elected to become a member of the Triple S scheme.

13B—Rollover accounts

This section authorises the Board to accept the payment of money for a contributor from another fund or scheme. Money that is rolled over from another fund or scheme is to be paid to the Treasurer who must then pay an amount equivalent to the amount of money rolled over into the Southern State Superannuation Fund.

13C—Co-contribution accounts

This section requires the Board to establish a co contribution account in the name of a contributor for whom a co contribution has been paid to the Board. The account must be credited with the amount of any co contribution paid to the Board in respect of the contributor.

When a co contribution account is credited with the amount of a co contribution, the amount is to be transferred to the South Australian Superannuation Board and credited to a co contribution account maintained in the name of the contributor.

10—Amendment of section 14—Payment of benefits

These amendments are made as a consequence of the repeal of Part 5A, the insertion of section 13C and changes to the Act that mean that there will no longer be two categories of contributor.

11—Amendment of section 16—Contributors

This amendment is made because the Act will no longer apply in respect of police officers who are currently new scheme contributors. A police officer will be required to contribute to the Police Superannuation Scheme only if he or she became a contributor to the Police Pensions Fund before the commencement of the Police Superannuation Act 1990.

12—Amendment of section 17—Contribution rates

This clause amends the section of the Act prescribing the rates of contributions to be made by contributors. Those rates are currently prescribed in Schedule 2. However, because police officers who are currently new scheme contributors will no longer be contributors to the Police Superannuation Scheme, the determination of contribution rates is simplified and Schedule 2 is repealed by clause 29. The provisions of Schedule 2 relating to old scheme contributors are incorporated into section 17, which will now state that a contributor must make contributions to the Treasurer at the rate at which he or she was contributing immediately before the commencement of the Act. If the contributor was a police cadet immediately before the commencement of the Act, he or she is required to contribute at the rate at which he or she would have been contributing to the Police Pensions Fund if he or she had been a police officer immediately before the commencement of the Act.

13—Repeal of Part 4

This clause repeals Part 4 of the Act. Part 4 applies only to new scheme contributors. As those contributors are to become members of the scheme of superannuation established by the Southern State Superannuation Act 1994, there is no need to retain Part 4.

14—Amendment of heading to Part 5

This amendment to the heading to Part 5 is made because there will no longer be two categories of contributor.

15—Amendment of section 27—Application of Part to police cadets

This amendment is also made because there will no longer be two categories of contributor. Part 5 of the Act will apply to all contributors.

16—Amendment of section 31—Invalidity

The amendment made by this clause clarifies the operation of section 31, which applies to a contributor whose employment terminates on the ground of invalidity before the contributor reaches the age of 60.

17—Amendment of section 34—Resignation and preservation of benefits

Under section 34 of the Act, a contributor who has resigned from employment and elected to take an amount equivalent to the total balance of his or her contribution account is also entitled to a superannuation payment under section 34(1a). The contributor may elect to preserve the payment or to carry the payment over to another fund or scheme.

Under section 34(1a)(c) in its current form, if the contributor elects to preserve the payment, the payment will be preserved in the Police Superannuation Scheme. This clause substitutes a new paragraph (c). Under the new provision, the payment will be transferred to the credit of the contributor in an account in the name of the contributor in the Triple S scheme. The amount of the payment to be transferred will be determined under the section as if the payment were to be made to the contributor on the day that the transfer takes place and will be taken to be a preserved employer component under section 32 of the Southern State Superannuation Act 1994.

An additional provision inserted into section 34(1a) provides that a contributor who fails to inform the Board in writing within three months of his or her resignation whether he or she elects to preserve the payment or carry it over to another fund or scheme will be taken to have elected to preserve the payment.

18—Repeal of Part 5A

Part 5A, which includes provisions relating to investment accounts, rollover accounts and co contribution accounts, is repealed. Those provisions have been recast because investment, rollover and co contribution payments are to be transferred to the Southern State Superannuation Scheme. The recast sections are inserted by clause 9 into Part 2 of the Act.

19—Repeal of heading to Part 5B Division 1

20—Amendment of section 38J—Reduction in contributor's entitlement

21—Repeal of Part 5B Division 2

22—Repeal of heading to Part 5B Division 3

23—Repeal of section 38O

24—Repeal of heading to Part 5B Division 4

These amendments to Part 5B of the Act, the purpose of which is to facilitate the division under the Family Law Act 1975 of superannuation interests between spouses who have separated, remove provisions that operate only in relation to new scheme contributors.

25—Repeal of sections 47 and 47A

This clause repeals sections 47 and 47A of the Act. Section 47 authorises the Board to provide annuities on terms and conditions fixed by the Board. Section 47A authorises the Board to accept money from police superannuation beneficiaries for investment with the Superannuation Funds Management Corporation of South Australia.

26—Amendment of section 49—Confidentiality

Section 49 of the Act currently prohibits members or former members of the Board or the board of directors of the Superannuation Funds Management Corporation of South Australia (the Corporation), or a person employed or formerly employed in the administration of the Act, from divulging information as to the entitlements or benefits of any person under the Act except in certain circumstances. This clause amends subsection (1) by extending the prohibition to information of a personal or private nature. This amendment is consistent with an amendment recently made to the corresponding sections of the Superannuation Act 1988 and the Southern State Superannuation Act 1994.

27—Amendment of section 50—Resolution of difficulties

The amendments made by this clause are consistent with amendments recently made to the corresponding sections of the Superannuation Act 1988 and the Southern State Superannuation Act 1994. The section as amended will authorise the Board to give directions if the Board is of the opinion that the provisions of the Act do not address particular circumstances that have arisen. The directions must be reasonably required to address the circumstances (but only insofar as the Board determines it to be fair and reasonable in the circumstances). Any such direction will have effect according to its terms. (The section already authorises the Board to give directions reasonably required if any doubt or difficulty arises on the application of the Act to particular circumstances.)

Under new subsections inserted into section 50, the Board may, in certain circumstances, extend a time limit or waive compliance with a procedural step. The section lists matters that the Board must have regard to in determining whether to extend a time limit or waive compliance with a procedural step. If such action is taken by the Board, the Board's report to the Minister for the year in which the action occurs must include details of the action.

28—Amendment of Schedule 1—Transitional provisions

This clause inserts a definition of old scheme contributor for the purposes of the transitional provisions because the term is no longer used in the main body of the Act and the definition has therefore been removed from the interpretation provision.

29—Repeal of Schedule 2

Schedule 2, which prescribes contribution rates, is repealed because those rates are to be prescribed by section 17. (See the amendments made to that section by clause 12.)

Part 3—Amendment of Southern State Superannuation Act 1994

30—Amendment of section 3—Interpretation

This clause inserts a number of new definitions into the interpretation provision of the Southern State Superannuation Act 1994.

A police member is a member of the scheme who is a police officer or police cadet. However, police officers and cadets who are members by virtue of section 14(10a) or 15C (that is, they are members of the Police Superannuation Scheme for whom a contribution, co contribution or rollover benefit has been paid to the Board) are not police members for the purposes of the Act.

A definition of retirement age is also inserted. For a member who is a police officer, the age of retirement is 50. For other members and spouse members, 55 is the retirement age.

31—Amendment of section 4—The Fund

This amendment is made as a consequence of the fact that co contribution amounts paid in respect of members of the Police Superannuation Scheme are to be transferred to the Board.

32—Amendment of section 7—Contribution, co-contribution and rollover accounts

The amendments made by this clause to section 7 will have the effect of requiring the Board to maintain a co contribution account in the name of a member of the Police Superannuation Scheme for whom a monetary payment has been made to the Treasurer. The monetary payment may have been made under section 13A(3) of the Police Superannuation Act 1990 or section 15C(3) of the Southern State Superannuation Act 1994. The Board must also maintain a rollover account in the name of a member of the Police Superannuation Scheme for whom an amount of money rolled over from another fund or scheme has been accepted by the Police Superannuation Scheme and paid to the Treasurer under section 13B of the Police Superannuation Act 1990. The rollover amount must be credited by the Board to the account. The Board will also be required to maintain a co contribution account in the name of a member of the Police Superannuation Scheme for whom the amount of a co contribution has been transferred from that scheme to the Board. The Board is required to credit the account with the amount of any co contribution paid to the Board in respect of the member.

33—Amendment of section 9—The Southern State Superannuation (Employers) Fund

The amount of any payment to the Treasurer for a member of the Police Superannuation Scheme under section 15C(2) is to be paid into the Southern State Superannuation (Employers) Fund.

34—Amendment of section 14—Membership

Section 14 of the Act, which relates to membership of the Triple S scheme, is amended by this clause so that a person who is a new scheme contributor within the meaning of the Police Superannuation Act 1990 immediately before Part 4 of that Act is repealed will be a member of the Triple S scheme.

A member of the Police Superannuation Scheme who has made an election under section 15C(1), or is taken to have made an election under that subsection, is a member of the Triple S scheme.

Also, if a contribution, co contribution or benefit rolled over from another superannuation fund or scheme is paid to the Board for a person who is a member of the Police Superannuation Scheme but not, at the time of the payment, a member of the Triple S scheme, the person will become a member of the Triple S scheme by virtue of section 14(10a) when the Board receives the payment.

35—Insertion of section 15C

This clause inserts a new section.

15C—Salary sacrifice and voluntary contributions by members of Police Superannuation Scheme

Section 15C(1) provides that a police officer who is a contributor to the Police Superannuation Scheme may elect to become a member of the Triple S scheme. He or she may do this in order to establish an entitlement to the employer component of benefits by way of salary sacrifice. Alternatively, the officer may establish an entitlement to the employee component of benefits by making monetary contributions from his or her salary under section 25.

36—Amendment of section 16—Duration of membership

This clause amends section 16 of the Act so that a person who is a member of the Triple S scheme solely by virtue of being a member of the Police Superannuation Scheme for whom payments have been transferred to the Board will cease to be a member of the Triple S scheme when the balance of each of his or her accounts has been paid.

37—Insertion of section 20

A new defined term is inserted for the purposes of Part 3 Division 2.

20—Interpretation

This section defines prescribed member to mean a police member, or a member prescribed, or of a class prescribed, for the purposes of the definition.

38—Amendment of section 21—Basic invalidity/death insurance

As a consequence of this amendment, a police officer who is a member of the Triple S scheme will not be entitled to basic invalidity/death insurance.

39—Amendment of section 22—Application for voluntary invalidity/death insurance

40—Amendment of section 23—Variation of voluntary insurance

These amendments are made as a consequence of the insertion of new provisions relating to the provision of voluntary invalidity/death insurance to prescribed members (including police members).

41—Insertion of sections 23A and 23B

Clause 41 inserts 2 new sections.

23A—Voluntary invalidity/death insurance—prescribed members

Section 23A provides that prescribed members have such voluntary invalidity/death insurance as is prescribed by regulation and are liable for premiums in respect of that insurance fixed by or under the regulations. A prescribed member may apply to the Board for additional voluntary invalidity/death insurance.

An application under the section is to be made in a manner and form approved by the Board, and an applicant is required to provide the Board with prescribed information as to the state of his or her health. The Board may require an applicant to provide satisfactory evidence of the state of his or her health.

The Board is authorised to refuse an application, or to grant an application on conditions authorised by the regulations, if it appears to the Board that an applicant's state of health is such as to create a risk of invalidity or premature death, or that an applicant has in the past engaged in an activity of a prescribed kind that increases the risk of invalidity or premature death, or that an applicant is likely in the future to engage in such an activity.

A regulation made for the purposes of the section may make different provision according to the various classes of members, matters or circumstances to which the regulation is expressed to apply.

23B—Variation of voluntary insurance—prescribed members

Under section 23B, a prescribed member may apply to the Board to increase or decrease the level of his or her voluntary invalidity/death insurance. However, a prescribed member cannot apply to reduce his or her insurance below the level applicable to the member prescribed under section 23A.

42—Amendment of section 25—Contributions

Section 25(3) is amended by this clause to change a reference to "police officer" to "police member" because the subsection is not to apply to police officer members of the Triple S scheme who are not police members. Subsection (3a) is recast to make it clear that subsection (3) does not apply to police cadets.

43—Amendment of section 26A—Interpretation

This consequential amendment will have the effect of allowing members in respect of whom payments are being made to the Treasurer under new section 15C (see note to clause 35) to apply to the Board to make payments for the benefit of his or her spouse.

44—Amendment of section 26J—Benefits for spouse members

This amendment is made because of the insertion into the Act of a definition of retirement age.

45—Amendment of section 27—Employer contribution accounts

Section 27 is amended by this clause because of the payment of employer contributions on behalf of contributors to the Police Superannuation Scheme who become members of the Triple S scheme under new section 15C(1)(a).

46—Amendment of section 31—Retirement

47—Amendment of section 32—Resignation

These amendments are made because of the insertion into the Act of a definition of retirement age.

48—Amendment of section 33A—Disability pension

As a consequence of this amendment, the Board will be required to consult with the Police Superannuation Board before authorising the payment of a disability pension to a police officer.

49—Amendment of section 34—Termination of employment on invalidity

As a consequence of this amendment, the Board will be required to consult with the Police Superannuation Board before authorising the payment of a benefit following termination of employment for invalidity to a police officer.

50—Amendment of section 35—Death of member

This amendment to section 35 is made so that a contributor to the Police Superannuation Scheme who is a member of the Triple S scheme by virtue of section 14(10a) or 15C is not entitled to a benefit under the section.

51—Amendment of section 36—Information to be given to certain members

Section 36 as amended by this clause will require the Board to advise a person who becomes a member of the Triple S scheme by virtue of section 14(10a) or 15C of his or her membership of the scheme. The Board will also be required to provide the person with information, including any prescribed information, as to the management and investment of his or her payments and the benefits to which he or she is entitled under this Act.

52—Amendment of Schedule 3—Transitional provisions

This clause inserts a number of transitional provisions connected to the transfer of new scheme contributors to the Police Superannuation Scheme to the Triple S scheme.

14—Interpretation

This clause includes definitions of various terms used in the transitional provisions. The prescribed date is the date on which Part 4 of the Police Superannuation Act 1990 is repealed by the Statutes Amendment (Police Superannuation) Act 2007.

15—Accounts for certain police officers

New clause 15 applies in relation to persons who become members of the Triple S scheme by virtue of section 14(2a) of the Act, which says that a person who was a new scheme contributor within the meaning of the Police Superannuation Act 1990 immediately before the repeal of Part 4 of that Act will be a member of the Triple S scheme.

The clause provides that the Board is to establish an employer contribution account and a member's contribution account in the name of each such member. The balance of the contribution account will be an amount equivalent to the amount standing to the credit of the member's contribution account maintained under the Police Superannuation Act 1990. The balance of the member's employer contribution account will be determined in accordance with subclause (4).

If the Police Superannuation Board is maintaining an investor's account, a rollover account or a co contribution account in the name of the member, the Board is to establish a rollover account in the name of the member. The balance of the rollover account will be the aggregate balance of the amount standing to the credit of the member's investment account, rollover account and co-contribution account immediately before the prescribed date.

If the member's accrued superannuation benefits, or a payment to which the member is entitled, have been preserved under Part 4 of the Police Superannuation Act 1990, a rollover account will be established in the name of the member and an amount equivalent to the accrued benefits or payment will form the balance of the account. The amount of the preserved benefit will be calculated on the basis of the payment to which the member would be entitled if the payment were being made to him or her on the day on which Part 4 of the Police Superannuation Act 1990 is repealed. The provisions of section 32(6), which describe what happens where a member has preserved a component of his or her benefits, will then apply in relation to the amount.

An application made by the member for a disability pension under the Police Superannuation Act 1990 that has not been determined before Part 4 of that Act is repealed will be taken to be an application for a disability pension under the Southern State Superannuation Act 1994.

When a member to whom clause 15 applies retires from employment, he or she is entitled to the benefits payable to him or her under section 31 of the Southern State Superannuation Act 1994 or, if they would be greater, to benefits determined in accordance with the prescribed method.

When benefits determined in accordance with the prescribed method are to be paid to a member, the Treasurer must pay into the Southern State Superannuation (Employers) Fund from the Consolidated Account the amount by which the amount of benefits payable to the member exceed the amount of benefits to which he or she would have been entitled under section 31.

16—Police officers in receipt of disability pension

If a member to whom clause 14 applies is temporarily or permanently incapacitated for work immediately before he or she become a member of the Triple S scheme, and is in receipt of a disability pension under section 24 of the Police Superannuation Act 1990, section 24 will be taken to continue in force in relation to the pension and the member will not be entitled to a disability pension under the Southern State Superannuation Act 1994.

If, immediately before the repeal of Part 4 of the Police Superannuation Act 1990, a police officer is temporarily or permanently incapacitated for work and entitled to a disability pension that is suspended because he or she is in receipt of paid leave or workers compensation, the provisions of clause 15 will operate in relation to the member from the day on which he or she ceases to be entitled to paid leave, workers compensation or a disability pension. Until that day, the Police Superannuation Act 1990 will be taken to continue in force in relation to the member.

17—Accounts for certain contributors to Police Superannuation Scheme

This clause makes provision for the establishment of a rollover account in the Triple S scheme in the name of a person for whom the Police Superannuation Board is, immediately before the repeal of Part 5A of the Police Superannuation Act 1990, maintaining an account under that Part. The balance of the new rollover account will be an amount equivalent to the aggregate balance of the amount standing to the credit of the person's investment account, rollover account and co contribution account. If the account in the Police Superannuation Scheme was a rollover account or a co contribution account, he or she will be taken to be a member of the Triple S scheme by virtue of section 14(10a) of the Southern State Superannuation Act 1994. If the account was an investment account, he or she will be taken to have elected to become a member of the Triple S scheme under section 15C(1).

18—Amounts preserved for certain contributors to Police Superannuation Scheme

This transitional provision is necessary as a consequence of amendments to be made to section 34(1a) of the Police Superannuation Act 1990. The Board is to establish a rollover account in the name of each person for whom a payment is preserved under that section, or for whom benefits are preserved under section 34(1)(b), immediately before the prescribed date. The balance of the rollover account will be an amount equivalent to the superannuation payment to which the person would be entitled under section 34 if the payment were to be made on the prescribed date. The provisions of section 32(6), which describe what happens where a member has preserved a component of his or her benefits, will then apply in relation to the amount. The person will be taken to be a member of the Triple S scheme.

19—Balances of accounts

This clause makes provision for payments from, and reimbursement of, the Consolidated Account or special deposit account in relation to the creation of new accounts as required for the purposes of the transitional provisions.

20—Other provisions

This transitional provision authorises the making of regulations of a saving or transitional nature consequent on the enactment of the Act.

Schedule 1—Statute law revision amendment of Police Superannuation Act 1990

Schedule 1 makes various statute law revision amendments of the Police Superannuation Act 1990.

Debate adjourned on motion of the Hon. G.M. Gunn.

The SPEAKER: I apologise to the house. We should have called on private members' business straight away rather than proceeding to Notices of Motion.

PARLIAMENTARY COMMITTEE ON OCCUPATIONAL SAFETY, REHABILITATION AND COMPENSATION: WORKPLACE INJURIES AND DEATHS

Mr KENYON (Newland) (11:04): I move:

That the 10th report of the committee, entitled Inquiry into Law and Process relating to Workplace Injuries and Deaths in South Australia, be noted:

The 10th report of the committee provides an in-depth and thorough analysis of the laws and processes relating to workplace injuries and death in South Australia. The report has been prepared in consequence of the committee resolving on its own motion to conduct a review of the current occupational health and safety laws in South Australia. As many members are aware, members of this committee are unpaid for their work. Nonetheless, the members spent a great deal of time and effort on conducting this inquiry and producing the final report. All committee members worked cooperatively, trying to achieve consensus on the best way to improve occupational health and safety in this state.

In doing so I believe they have shown great dedication to this cause and have contributed significantly to this vital area of employment law. The committee has met on 16 occasions in relation to this inquiry. In total, the committee received more than 20 written stakeholder submissions and heard from eight witnesses. Thus it can be said that all relevant stakeholders had sufficient opportunity to comment on this inquiry. Furthermore, the committee gave careful consideration to all stakeholder submissions and viewpoints during its deliberations. The submissions have been clearly outlined in the report, and all attempts have been made to reflect fairly the different viewpoints expressed.

In 2003 the Occupational Health, Safety and Welfare (SafeWork SA) Amendment Act introduced a central face to occupational health and safety in South Australia, namely, SafeWork SA. Many of the occupational health and safety responsibilities previously held by WorkCover and Workplace Services were vested in this newly created government agency. Therefore, as part of this inquiry the committee sought to examine the practical operation of occupational health and safety in South Australia following these changes. In order to do this the committee examined the laws and processes concerning prevention, investigation, detection and prosecution of workplace accidents. Areas on which the committee focused in this respect included employee responsibility and occupational health and safety, right of entry for union officials, improved assistance for businesses and a general educational and assistance role of SafeWork SA.

Another factor behind the committee's current inquiry was the Occupational Health, Safety and Welfare (Penalties) Amendment Bill currently before the house. The committee assessed the penalties in South Australia and examined penalties in other jurisdictions in order to benchmark the South Australian approach. It would appear from all accounts that, in the past, penalties in South Australia have been far less harsh than in other states and territories, and it is time for South Australia to consider not only the quantum of penalties under the act but also the penalty regime more generally.

The committee also wished to address serious offending under the act. Occupational health and safety breaches that result in serious injury or death of an individual have a devastating impact on the lives of victims and their families. Consequently the committee is concerned that victims and their families receive adequate information and support when such an incident occurs. The committee recommended that in certain circumstances the victims and their families should have access to a dedicated counselling service and be able to submit a victim statement to the court and be eligible to receive part of the monetary penalty imposed on the offender.

Clearly all committee members agree that incidents of serious injury and death are entirely unacceptable and should not be tolerated under any circumstances. Where there is wilful failure by companies to comply with their OH&S responsibilities, the law must provide for appropriate penalties. The majority of the committee advocated the introduction of tougher measures, including a new aggravated offence provision, imposing a reverse burden of proof on directors and managers and increasing penalties for repeat offenders.

Finally, the committee considered South Australia's position with respect to other Australian jurisdictions and the commonwealth. Obviously an important aspect of any federal structure is cooperation between the states and the national government. In the case of occupational health and safety it is particularly desirable to achieve consistency between the laws in different states and territories so that the conflicting laws in different jurisdictions do not unduly burden national companies. While South Australia, on its own, can do little to improve the national consistency of occupational health and safety laws in Australia, consistency should be a paramount consideration when amending existing state legislation.

The committee framed broad terms of reference, which in turn have allowed for a comprehensive analysis of OH&S laws and processes within South Australia. The impact of past legislative changes, the operation of present laws and processes and the future direction of OH&S have all been considered. In this way the committee hopes its tenth report is of much assistance to both members of parliament and the public when considering occupational health and safety issues.

Finally, I take this opportunity to thank all who have contributed to this inquiry. I thank those people who took the time and made the effort to prepare written submissions for the committee and to appear as witnesses and speak before the committee. I extend my sincere thanks to members of the committee: the members for West Torrens and Unley and the Hons Nick Xenophon, Bernard Finnigan and Terry Stephens. I also thank the staff: Mr Malcolm Lehman, Mr Rick Crump (the secretary to the committee), Mr Joseph McIntyre and Ms Kathryn Bion (the research officers) for their efforts and assistance in conducting this inquiry and producing this report.

Mr PISONI (Unley) (11:09): I echo the remarks of the chair, the member for Newland, and congratulate him on chairing a successful committee. The committee was well balanced, as we had members of the Labor Party representing the trade union movement and the Hon. Terry Stevens and myself with small business experience, so we were able to go into this committee with a broad breadth of experience.

Many of the recommendations were passed unanimously. However, I would like to comment about some of the recommendations that we on this side of the house had difficulty with.

First, in relation to recommendations 2 and 2A, we felt it was fair and reasonable, if we were serious about ensuring that workplace safety be paramount, that random drug testing should be an option available to employers who felt it was necessary to use such measures to establish where there are difficulties dealing with certain behaviours within the workplace.

The chairman's report goes on to say that it was argued that, whilst employers can do much to improve occupational health and safety in the workplace, ultimately they rely on employees to implement the safety measures on the ground. Of course, if employees are in a state where they may be intoxicated through either alcohol or drugs of some description, it makes it very difficult, of course, for them to understand their responsibilities at the time and have the response time they may need to look out for each other or make decisions to shut off a machine or not take a step backwards at a particular time.

I have had a lot of practical experience in my workshop through being on the factory floor, and I think this applies to most occupations. Obviously, we already have those provisions for people who drive or operate machinery in their workplaces but, if this was approved, it would extend to workplaces such as building sites and the factory floor where forklifts and machinery could be operated, or even trolleys are pushed or steps need to be climbed. Obviously, when you are in that sort of position and operating in that environment, you need to be fully aware and mindful. So, the Hon. Terry Stephens and I felt it was a tool that employers could use to implement improved safety measures in their workplaces.

Recommendation 4, that there be an audit in respect of the adequacy of numbers and training of health and safety representatives, we felt was probably reasonable, but we did point out that the current provisions for health and safety already cover that, and perhaps it would be better that workplace safety used the tools it has already rather than imposing more bureaucracy onto business.

Of course, the recommendation of greatest contention for those members on my side of the house and also the Labor Party is the right of union officials to be granted entry on safety grounds. Currently, my reading of the act is that if a union member would like to discuss occupational health and safety with their union, the union has the right to enter the workplace in order to do that. We feel that is adequate. However, the Labor Party wants to take that further and allow the entry of trade union officials into workplaces that do not have union members, on the ground of occupational health and safety. Who says they have a monopoly on understanding occupational health and safety? Why should they be given an unfair advantage over any other group or business that is out there offering occupational health and safety advice?

We see this for the cynical exercise that it is, and that is to get unions into non-union workshops. Using the process of occupational health and safety is an old trick, and has been used for years to get in the door of a workshop. I know in my own factory I had to deal with union officials wanting entry to my building on occupational health and safety grounds, and it is a very effective tool, because it gives union representatives an instant audience, and one that they would not have access to under normal situations.

They have a number in the phone book which people can ring if they want to join a union but, as we know, union membership has dropped to about 15 per cent in the private sector. That is happening because people do not feel they are getting value from the services which unions are providing. The reason they are not getting value is that there has been legislation to put unions in the front seat, if you like, in industrial relations for decades in this country—and they have grown lazy. They have relied on the industrial relations law to give them access to workplaces and workers. What has happened over the past few years is that the law has been removed and they are out in the open market, offering their services.

Quite frankly, their services are not attractive to workers because workers are not renewing their membership. They are not joining unions. Basically, they are saying, 'What value am I getting from the union movement?' In other countries, where unions are not protected by the industrial system, they offer all sorts of benefits to their members, including discounts on credit cards, insurance and mortgages. They use their mass of numbers to make it worthwhile for people to be part of the membership.

Union membership in Australia has been designed over the years on the Amway model, where the more members there are at the bottom the better, and the less active they are the better, because the unions just want them as numbers. They are the customers of the union movement and they just want them as numbers. The wider the base of the pyramid, the more people can be

pushed up to the top of the pyramid and, at preselection time, into safe Labor seats—usually at the expense of women and hardworking local members.

Ms Ciccarello: Where are your women?

Mr PISONI: There is a lot of that happening in the current election. Senator Linda Kirk had every intention of continuing but she had no choice; she was dumped. I believe that she was not aware that the SDA's policy was against stem cell research. I have not seen it on the SDA's website. I have spoken to a few checkout operators who are not aware that the SDA is against stem cell research and, unfortunately, neither is Linda Kirk—but she had to pay the price. She got flicked out of her seat, the safest seat possible in South Australia, the No. 1 Senate position, in favour of SDA secretary Don Farrell.

One can see why the Liberal Party is concerned about recommendation No. 5, which gives a right of entry to union officials on occupational, health and safety grounds. It is a government protection at a time of free markets, and at a time when we are removing protections from industry and encouraging them to be efficient and competitive. The Treasurer in this house has said, 'We are not into industrial welfare or business welfare. We do not pay businesses to get them to stay in South Australia.' But the government is more than happy to put legislation in place to give unions an unfair advantage to sell their services compared with other businesses in the community.

We see this as a threat to small business, in particular. This will allow unions to go into people's home. If it is a home-based business, the legislation will allow trade union officials to go into someone's home and into their lounge room.

Time expired.

The Hon. R.B. SUCH (Fisher) (11:19): I would like to commend the committee on its report. It is a topic that often does not receive the attention it deserves, but it is very important. Sadly, in South Australia, even in recent years, there have been quite a few fatalities in the workplace, and people—both employees and employers—need to be ever vigilant. We know that life is full of risks; working is a risky business, and we need to manage the risk, reduce it and, if possible, eliminate it.

There are a couple of aspects that I think need to be looked at. We have had people coming around to electorate offices to check power cords. I am not saying that it is an unworthy activity, but I do not know how many people have ever been electrocuted in an electorate office. There are a few people who some might wish would suffer that fate, but how many people have been electrocuted in an electorate office? Yet we have people going around diligently checking power cords and putting a tag on every one of them. The cost must be enormous.

I know a lad in my electorate who is working for a plumbing firm and drives around in a van with no safety barrier in the van whatsoever. There are gas bottles, tools, and so on, in the back of the van. No-one ever seems to worry about whether someone in that situation is at risk. I would say that, if someone in a van stopped suddenly on the freeway while travelling at 110 km/h, the gas bottles would keep travelling at that same speed.

One can argue that conducting zealous inspections in electorate offices is not justified, but I think that one has to keep some sense of balance and proportion in this whole exercise. One of the most dangerous areas would definitely be on the farm, and particularly in farm workshops, where in many cases there are open pits for servicing vehicles, welding equipment and power saws around the place, and all sorts of things happening. I believe that a lot of effort needs to be made to keep focusing attention on safety in the farming sector because, as I have indicated, they are potentially very dangerous places.

I go to the Mallee quite a lot (whenever I can, to escape from this place), and I still see little kids (and when I say 'little', I mean three year olds) sitting on the back of a quad bike (the dad probably thinks he is doing the right thing), whizzing around the farm, and also even on tractors—and if someone falls off a tractor, they are history. Sadly, a family at Blackwood lost two of their boys, I think, because their father used to let them ride on the Caterpillar tractors when he was doing earthmoving. It is a very dangerous practice.

The point is that, ultimately, with respect to safety in the workplace, it clearly comes back to employer responsibility, but the employee also has to take responsibility not to do silly things or to take shortcuts. We still see people speeding past road workers. I fully support tough police action against people who speed past road workers, whether they be Telstra technicians or Department of

Transport employees. One sees people whizzing past them with almost reckless abandon and absolutely outrageous disregard for the welfare of those employees.

Talking about danger on farms, I remember as a student working at Keith during the university vacation (I think the property owner is a relative of the member for Mount Gambier, so I have to apologise to him). The owner was fairly impatient, and on one occasion I ended up putting one of the wheels of the tractor in the pit in the workshop, but I managed to retrieve it after some period of time.

The point is that, wherever you are, there are inherent dangers, and that applies in all work situations. However, I come back to the point that I made at the start. We seem to have an obsessive focus on what I would call minimal risk safety in electorate offices, in terms of possible frayed power cords, and yet at the same time there are people out there driving vans for plumbers with no protection whatsoever in the form of a safety barrier within the van. Maybe it is time for the appropriate authority to have a look at some of those issues. There will always be a conflict in this area between those who speak for employers and those who speak for employees, but the bulk of the population is not concerned about any ideological battle.

They are concerned that their family member—whoever they may be—is safe at work and that any risk to that person is kept to an absolute minimum. In some institutions—it happened in TAFE—the desire to protect students was taken to such a point that, in many cases, you could not even operate a machine because it was virtually impossible with the protective cage put on some of the machines. You have to have some common sense in applying some of these rules. You do not want people at undue risk, but you also have to be able to go about your daily business in a way which is sensible and productive. Teachers tell me that, even in tech. studies, they are so hampered by some of the occupational health and safety provisions that they hardly ever end up doing much effective training because they are so shackled by requirements in terms of occupational health and safety. I mean, if people do not want to take risks, the answer is for them to stay in bed in the morning, stay at home, do not do anything and do not go anywhere.

Mr KENYON (Newland) (11:26): I have nothing further to add, other than to thank members for their contribution.

Motion carried.

RODEOS, FEES

The Hon. G.M. GUNN (Stuart) (11:26): I move:

That the regulation made under the Prevention of Cruelty to Animals Act 1985 entitled Fees, made on 7 June 2007 and laid on the table of this house on 19 June 2006, be disallowed.

This is a particularly nasty, ill-considered regulation. Why should volunteers conducting rodeos on behalf of their communities and raising money for the Flying Doctor or other worthwhile organisations be charged a fee for their trouble? What a miserable act in a society such as ours. Why would you want to slug volunteers? When I came into this place, we had government departments that were keen and interested in helping people and cooperating with them—the department of lands, the department of agriculture. Now we have the tentacles of the Department for Environment and Heritage wanting to make life as difficult as it can for people. What justification has the Minister for Environment and Conservation for bringing in a regulation to slug people $65 so that they can provide entertainment for people at rodeos?

In my constituency, we have a rodeo at Spalding, Wilmington, Peterborough and Carrieton. We also have the Marrabel rodeo and various other rodeos. It takes a great deal of effort and work from a dedicated band of hardworking people to run these particular events. They provide a great deal of responsible entertainment for the community and now we want to put these unnecessary bureaucratic controls in their way. The Premier has been loud in his comments about getting rid of red tape, but he has a minister who wants to create even more red tape and implement more bureaucratic controls. I put it to the house: what will they do if people decide not to pay? Will they put them in gaol? Will they send out their Sir Humphrey Applebys one, two and three—which one is it? Will they send out the director of the Department for Environment and Heritage to tell them?

I look forward to going to the rodeos this year and telling the people that this government talks about helping people in drought-affected areas, but what it wants to do is make life more difficult for them. I say, heaven help us if this is the best the government can do to help people in small rural communities but to slug them again. What will they do with the money? How much will it cost to collect this money? Here we have the minister and her advisers pretending that they are

friendly towards people in rural areas and they are in favour of rodeos when they have a program to get rid of rodeos and these other sorts of events. Could the government and the minister at the table please tell me why the biggest rodeo in the world at Calgary (also the huge one at Edmonton) does not have to deal with any of this nonsense, but here in little South Australia a group of radicals (who do not like farmers, miners and most things and want to make life difficult) has infiltrated the department of environment.

I call on the government to provide a proper explanation. The speech which the minister made in the other house was the weakest effort you would ever hear. For a minister of the Crown to give an explanation like she gave, heaven help the people of South Australia! I am looking forward to going to the rodeos, and I may even be forced to say a few words because a lot of people go to these events. This is the sort of stuff that Kevin Rudd wants to force upon the people. They not only want to put a capital gains tax on people's houses and tax four-wheel drives, but there will also be more of this. We will make sure that in a few weeks the people of South Australia and the people of Grey clearly understand that they will get more of this: more controls, more charges, more bureaucrats trying to interfere with their daily lives. I commend the motion to the house.

Debate adjourned on motion of Mrs Geraghty.

RODEOS, REGULATIONS

The Hon. G.M. GUNN (Stuart) (11:31): I move:

That the regulation made under the Prevention of Cruelty to Animals Act 1985 entitled Rodeos, made on 16 August 2007 and laid on the table of this house on 11 September 2006, be disallowed.

This regulation is another exercise of Sir Humphrey Appleby's South Australian division in making life difficult for the people of this state.

Ms Breuer: Back in 1971.

The SPEAKER: Order!

Ms Breuer: You've made the same speeches for the last 30 years.

The SPEAKER: Order!

The Hon. G.M. GUNN: I can guarantee one thing to the member for Whyalla: I have been elected here 12 times, but you will not have that privilege.

Ms Breuer interjecting:

The SPEAKER: Order!

The Hon. G.M. GUNN: This particular document is a bureaucrat's paradise. It deals with the regulation of rodeos and states that only horses and cattle are to be used. If the people running the rodeos wanted to have a parade of camels or some of the participants wanted to have their dogs there, they would not be allowed to. The regulations refer to a permit to conduct a rodeo. I say to the minister: just give us one reason why people should have to have a permit. A few weeks ago I was very fortunate—

Mr Pisoni interjecting:

The Hon. G.M. GUNN: Just listen to this. A few weeks ago I had the pleasure of meeting the board that runs the Calgary Stampede. They had 1.2 million people attend that event. They had no permit from the Alberta provincial government, none from the federal government and none from the City of Calgary. They were appalled and amazed at this sort of nonsense when I showed them.

The Hon. S.W. Key: They're real cowboys.

The Hon. G.M. GUNN: Well, it is one of the biggest sporting events in the world. It attracts people from all over the world. They are not hindered and harassed in the way this government intends—

Ms Breuer: They support capital punishment over there.

The SPEAKER: Order!

The Hon. G.M. GUNN: I suggest to the honourable member that she obviously is a friend of the bureaucrats. She wants to put controls on people and she wants to go along with all this nonsense which will mean that people will have to fill out forms. She is part of a program to make

life so difficult that these people will have to shut up shop. That is all it is about. I challenge the member to read these regulations and see whether it is a good idea. I doubt that she has taken the trouble to do so. You have to have a permit. Listen to what it says:

(1) An application for a permit to a conduct a rodeo must be made at least 28 days before the day on which the proposed rodeo is to be held.

(2) The application must contain the name and address of—

(a) the designated permit holder; and

(b) the designated rodeo judge; and

(c) the designated veterinary surgeon; and

(d) the designated stock contractor,

and be signed by the designated permit holder.

We have already had the disgraceful action taken against one of the permit holders. It was disgraceful the way that person was prosecuted, and those responsible should be ashamed of themselves. The government should compensate him for the way in which he was treated by those malicious people involved in this sort of nonsense. These are volunteers at Carrieton and Spalding—they are doing some good, raising money for the Flying Doctor—and there is only a small band of them. I do not know whether members have ever been to a place like Carrieton a few days after Christmas, but it is a great evening event. For a little community like Carrieton, there are these regulations, which state:

General requirements for conducting rodeos

(1) A person must not conduct a rodeo at which there is not sufficient fencing.

Well, that is common sense. There are penalties involved, and you want to slug these people. It goes on to provide for `inspection by designated rodeo judge' and `regulation of the care of rodeo animals'. These people do not need this type of bureaucracy: the people who own the animals make a living from them , so they are going to look after them. Then a report must be made to the minister. Does the South Australian National Football League make a report to the minister about the conduct of the South Australian National Football League Grand Final? Of course they don't—and they would laugh at the government at such a suggestion. As the chap said to me at the Calgary Stampede, 'We wouldn't put up with this nonsense. It is so stupid and so condescending.' It is a reflection on the attitude they have toward volunteers, particularly people living in isolated rural communities.

If you think you are going to get away with this without giving us a free kick in the goal square, you have another think coming to you, because I intend to make sure that people in rural South Australia clearly understand the vindictive nature of these regulations, the vindictive attitude of those malcontents who are trying to make life so difficult, and the foolish bureaucrats in question. The minister is so weak to go along with this. Where is the government? Why has the honourable minister at the table, who claims to be a conservative person, gone along with this sort of nonsense?

Surely, if people took the trouble to look at these regulations, they would know that this is just another encumbrance on volunteers and people in rural areas. I am appalled that this house would have sat idle and let these regulations come into being. It is a reflection upon those who are administering the affairs of the Department for Environment and Heritage that they should want to make life so difficult. The worst aspect of this is that, when they announced what they were doing, on the day of the budget estimates committee the minister indicated that she had spoken to the RSPCA. However, the government had not even had the courtesy to discuss these matters with the people running the rodeos before she issued her press release. It is all right for the Government Whip to throw her hands in the air and look dumbfounded; these are the facts.

Mrs GERAGHTY: On a point of order, Mr Speaker, I did not look dumbfounded; I was just amazed at the member's comments.

The SPEAKER: There is no point of order. The member for Torrens will take her seat. The member for Stuart.

The Hon. G.M. GUNN: Well, it is obvious that government members are fairly touchy about this subject to react so quickly. Obviously, they are not comfortable with having been dragged along kicking and screaming about this. The member for Giles has picnic race meetings in her electorate. Remember that some of the events they have there are going to come under this

umbrella. In the future the honourable member hopes to represent Oodnadatta: what about the programs they have up at Oodnadatta? They will come under this umbrella. What about William Creek? People there raise money; it is a small, hard-working group of volunteers.

There is no need for this sort of nonsense. Common sense ought to apply, and we should have the minimum amount of bureaucracy affecting these things so that hard-working volunteers are not encumbered with unnecessary paperwork which takes time and effort. At the end of the day, if we are not careful, it will be so difficult that they will not want to be involved. I commend the motion to the house.

Mr VENNING (Schubert) (11:41): I rise briefly to support the member for Stuart and to congratulate him on his dedication to the cause in relation to the rodeo movement right across South Australia and, indeed, you could say, Australia. I am involved, of course, with the Marrabel Rodeo (or I was, when it was in my electorate) and, in earlier days, in Spalding and Crystal Brook—when they had one. All I can say is that, over the years, there have been very few incidents that would concern people in relation to cruelty to animals.

The member for Stuart has gone to a lot of trouble to bring information to this house. In fact, he has travelled all over the world researching this subject. The information he brings to the house is valuable and ought to be listened to and considered by the government because, after all, he has taken that interest and he represents these people. I have not heard from anybody from the government side campaigning against what the member for Stuart is trying to do. Indeed, I do not believe that the RSPCA and the Cruelty to Animals Act have been raised with me or with anybody else. It is just a matter that has crept up on us in this house.

I was very much aware of what happened at Marrabel (I think 12 to 18 months ago) when a person or persons were interfering with the activities on the day. All I can say, for those who do not know, is that there are always registered veterinarians present at these functions—always. You can be assured that the horses that are used are professional rodeo horses and know exactly what to expect, and very few of them have any discomfort or any marks of injury. Occasionally it does happen, particularly with the leg roping of calves, but that can also happen when cattle are yarded on farms. It can happen there, too; there is no difference at all.

People on the rodeo grounds are very experienced in the handling of stock, sheepdogs and cattle dogs. Yes; I agree that if electric prodders are used I certainly would have some concern, but in some instances you have to be cruel to be kind. I have used a cattle prodder on the farm over the years, particularly with pigs and cows, just to move them through, rather than them getting excited in the bail, jumping over the side and injuring themselves. Rather than belting them with a stick, a quick zap with a prodder can certainly remind them where you want them to go.

Again, I want to pay a very high tribute to the volunteers who raise a lot of money for our various communities through the rodeo associations and those people who put their names up, and particularly the officials at the Marrabel Rodeo, who personally took the brunt for the activity that was taken against them by the RSPCA. When individual people are singled out and named in a public arena purely because they are public officers of a rodeo but they have done nothing wrong, I think it is despicable. It is not fair; it is just blatantly not fair. These people know who they are and, again, I pay tribute to them for the work that they do to raise money and for the entertainment they provide because—

The Hon. G.M. Gunn: We will be naming those other people in the parliament and moving to censure the bureaucrats next time it happens.

Mr VENNING: I agree with Mr Gunn that they should be named in the parliament. I commend these people. They have contacted me about the frustration of being publicly named purely because they are public persons representing the association. I do not think is fair and, really, it flies in the face of a fair go.

Finally, I want to commend and sincerely thank the rodeo movement for the money it raised for the Royal Flying Doctor Service and all these other very worthwhile charities, not to mention the money raised in the small communities. Even the local hotel at Marrabel does extremely well on rodeo days. If it were not for these types of events, there would not be a hotel at Marrabel, because there would be very little trade. Those big events keep that hotel there; they are a most important part of the community; indeed, without them there probably would not be a Marrabel community.

All the volunteers work by carting the stock and the fodder, and they prepare the grounds. All this work is done by volunteers. The fuel used to cart the stock is all donated. We should not sit

here and be judgmental about these people purely because some goody-two-shoes from the RSPCA—some malcontent—says, 'This is cruel.' In the end, we will not be able to eat meat!

The Hon. G.M. Gunn: Next time they put her in the trough they should put detergent with it.

Mr VENNING: I heard the comment from the member for Stuart. I will not necessarily agree with that one, sir—in relation to the malcontent in the trough. I want to pay tribute to my colleague the member for Stuart. If there is a stoush in this place and I have to pick a combatant to go with me, give me the member for Stuart every time—not only in this place but outside! Members can enter this debate and all have a say, but you have to admit that the Hon. Graham Gunn, the member for Stuart, flies against the political swing.

Labor thought it would have the seat at the last election—well, it did not get it. It is with issues such as these that the fearless activity of the member for Stuart gets him re-elected. So let it be a lesson to all of us: go in to bat for people whom this system squeezes or ignores and you will get your reward. As members would know, the member for Stuart is a survivor in a very marginal seat. Labor will not win the seat for as long as he occupies it, because he is who he is. I commend the member for Stuart for what he is doing for the rodeos. I support him and I support this issue, and I hope that the house will, too.

Ms BREUER (Giles) (11:47): I want to speak briefly on this matter, because I admire the member for Stuart's passion. When it comes to new legislation or regulations, he repeats the same speech and manages to adapt it very well. I wish I had the ability to do that. I do actually support rodeos. Certainly, in my part of the state, rodeos are an important part of the culture and a way of life. I certainly appreciate the amount of money that rodeos have raised. I also appreciate the work of the volunteers involved, and the amount of work that has to be done prior to the day: it is a very important part of each event. I would hate to see rodeos banned. I certainly do not agree with the stand of the 'no rodeo' people who emerged at the last election. I thought that some of the material that was produced by them was emotional; indeed, some of it was ridiculous and way over the top. I had a number of run-ins with the people involved in that and certainly do not support anything they say.

However, I do support some regulations and legislation applying to rodeos. I think we have to be very careful. As the member for Stuart pointed out, it is a long way out there and things could happen if we did not have certain regulations. I am quite comfortable with the regulations that have been introduced, because I always believe that if you are doing nothing wrong then you have nothing to worry about, whatever is legislated, whether it involve speeding fines or murder penalties. If you are not doing anything wrong then do not worry about it. When people complain to me about restrictions that come in regarding speed limits, road rules, etc., I say, 'Well, if you're not doing it wrong, what's your problem?' It is the same with this matter. I cannot see that there is an issue there. If people are behaving responsibly and the animals are well looked after, then what is the issue with having some regulations behind it?

People have to write reports; I am sorry about that, as I know it is a chore, but that is the way of the world nowadays. You cannot get anything for nothing; you must produce material. If you want a grant of some sort, you have to write a submission, you have to report on issues and on a whole number of things. That is the way of the world. So, I do not think that any of these regulations will upset too many people if it is necessary for them to write a report. If they are doing the right thing, it will not be an issue for them.

I think that the member for Stuart is over the top here. I appreciate that he has been to Calgary and seen the biggest rodeo in the world. That sounds like a wonderful study trip and well worth it for the member for Stuart. I cannot say that I have ever considered doing something like that; however, we all have different views on the world. I think that, if I went on a trip overseas, I could find more important things to do than look at what happens in Calgary. However, he has brought back some knowledge to us, and that is important.

I support the regulations. I cannot support the member for Stuart's motion. I admire what is happening out there in our communities and I appreciate the work they do, but I still believe that you must have some controls and standards. We can look at some of the farming practices of the past. We have now changed some of those, and some were very dodgy in their day. At the time, people believed they were fine, but we have come a long way since then and now realise that perhaps the way things were handled was not quite correct. I support what is happening, and I certainly do not support the member for Stuart's motion.

Mr GRIFFITHS (Goyder) (11:51): I support the member for Stuart in his motion, and I thank him very much for the information he has imparted to us in our party room about the important role rodeos play. I am not a big rodeo person but, from 1993 to 1998, I was lucky enough to live in Orroroo, very close to Carrieton, which has a fantastic community event each year between Christmas and new year—the Carrieton Rodeo. I know the people in Carrieton quite well, even though I have been gone from there for nearly 10 years. In the time I lived in that community it was really obvious to me that, although the town itself had only 50 people who lived in it, and probably about 300 people who lived in what was defined as the old council district, they all had a passion for their community.

They saw that, in order for them to ensure that they had some form of future in services provided in their town, the greatest opportunity was to hold the rodeo, because all the profit from it went back into the community. It kept the garage alive, it kept the shop going and it made a big difference to the hotel. It was not just the fact that a few people might work there at the time of the rodeo; everybody of every age demographic—no matter how old or young you were—you were doing something. You were on the gate, you were cooking the barbecues, or you were running the bar. It really demonstrated to me that small communities are the ones who work the absolute best, and there is no doubt about that.

Carrieton itself does not necessarily have a lot to offer, other than its personality and the people who live there. However, it does very well in Tidy Towns competitions. I used to think that Ross Swayne, who was the Tidy Towns judge, must have been a love child of Carrieton, because he voted for it so often. It really demonstrates that they want to make sure that they have a future. Each year, something like $50,000 or so was retained by that group, and money was made available to the tennis club and the cricket club (whom I had the pleasure of playing against quite often; they are very sociable and hospitable when you play there). It takes a while to get home when you go to a game at Carrieton, as it is normally dark and a bit dangerous because you have to run through kangaroo-infested territory. It is a great place.

I know also that there is a need for a review to ensure the safety of all participants in rodeos, be they the riders or the animals. From what I understand, the intention to increase the weight to 200 kilograms is wrong. Our advice is that it should be what it was before, that is, 100 kilograms. I support the member in his motion. My first exposure to the Hon. Mr Gunn was when I was lucky enough to be the district clerk in the Orroroo council area, and he was the local member. He would drop in and talk to me about a lot of different things, and it was very clear to me that he had a passion for the whole of the community he served, and Stuart is an enormous electorate. He does not look after just one community, he looks after all of them. To him, it is symptomatic of what occurs in that northern part of the state.

These people do it tough for a lot of different reasons. They need some support. They, and all of us on this side, see rodeos as an important opportunity for them still to be proud of themselves after some very serious financial issues over the years, with drought, grasshoppers, locusts and floods at the wrong time of the year. They need something to pin their hopes on, and the rodeo is part of that. I would hate to see any regulation that affects the ability of that community or, indeed, all communities across South Australia that run rodeos very successfully, to ensure that they have a chance to be there in the future. I commend the motion, and I hope that the house supports it.

Mr RAU (Enfield) (11:55): I have a very brief contribution to make on this subject. I think that, probably, the two members in this chamber who have the most information about this are the members for Stuart and Giles. I think that their points do not become improved in any way by being repeated by me. I am concerned as a person who has great respect for the member for Stuart that what we have seen today is the beginning of a campaign launched by the member for Schubert to compel the member for Stuart to run yet again at the next election. I think that the member for Stuart, if he wishes to do so—and I emphasise that I am not wishing to judge this; it is a matter entirely for him—and if he wishes to enjoy the fruits of his many years here and relax with his family and everything, he should not be persuaded by the member for Schubert to come back here again. I think the member for Schubert is actually drafting him. That is the way that I understood his speech.

Whilst I understood what the member for Schubert was saying, and I understand that he is a formidable campaigner, I think that the member for Schubert should be kind enough to the member for Stuart to let him make up his own mind about these important matters. The member for Stuart does have people who wish to see more of him at home, and I think that he should be given that opportunity if he wishes to take it.

Mrs GERAGHTY (Torrens) (11:56): Everyone in our community expects all animals to be treated humanely, whether they are domestic animals—dogs, cats and birds, and what have you—

The Hon. G.M. Gunn interjecting:

Mrs GERAGHTY: We probably will not go there. It is an important issue—

Mr Venning interjecting:

Mrs GERAGHTY: That is true; there are issues about cats. My understanding is that this move has been supported by the rodeo clubs. I think minister Gago—

The Hon. G.M. Gunn interjecting:

The SPEAKER: Order! The member for Stuart will have his opportunity.

Mrs GERAGHTY: I think that minister Gago has been somewhat maligned in here. My understanding is that it was at her request that the near final draft (I think that is what it was called) of the regulations was sent to the people who were at the Marabel meeting who had left their names and addresses for future contact. Those people were actually aware of what the regulations may look like and were given an opportunity to comment. I will also put on the record some facts.

As far as I am aware—and I am sure that this is quite accurate—senior officers of the RSPCA were extensively consulted in the development of the proposed regulations, and the rodeo industry was consulted at a meeting in July 2007. Those clubs and the Australian Professional Rodeo Association attended that meeting, along with officers of the Department for Environment and Heritage and the RSPCA. Minor changes were made to the regulations as a result of the issues that were raised by those people at the meeting. I think it is unfair to say that there was no consultation at all because, clearly, there was.

Mr WILLIAMS (MacKillop) (11:59): The regulations that are before us presuppose that the people involved in rodeos are people who do not actually work and live with these animals in their daily lives, and are the people who in some way want to harm and hurt animals. The people who are involved in rodeos are, in fact—

The Hon. J.M. Rankine interjecting:

Mr WILLIAMS: This presupposes that people's default position would be to do something wrong to these animals; I am arguing that the default position of these people is actually to love and look after these animals. These are the very people who work with these sorts of animals on a daily basis. This nonsense that the member for Stuart often rails against is because there are groups within our communities who want to see us stop doing anything associated with animals. In the first instance they want us to stop eating animals.

Well, as I always say, if humans were not meant to eat animals we would not have these teeth in our head known as canines, because they are principally there so that we can tear flesh—the member for Goyder has the idea. We are inherently designed to eat other animals, but there are a number of people in our community who want us to refrain from eating animals, and this is part of the process upon which they are intent. They want to stop every activity. This is not about cruelty to animals; this is about changing the society we live in, that is what it is about.

As I said, people involved with rodeos are people who work with animals on a daily basis. They mainly come out of the cattle industry, and on a large number of pastoral properties across northern South Australia the horse is still the main piece of machinery used on the property to do the daily work of mustering and moving stock, checking waterholes and things. These people work with these animals every day, and they know what would happen if they injured one of them. The animals are not only their friend, they are absolutely essential to their survival in their place of work and they do whatever they can to look after the animals.

The regulations are principled on something that is totally wrong and totally flawed, and that is the first instance where I think they get it wrong. What they are designed to do is to make the running of a rodeo as difficult as possible. This is an incremental movement, and we will see more and more regulations; it will be an incremental shift to try to make it impossible for someone to run a rodeo in the future. That is why the member for Stuart says that we should draw a line in the sand and stop this nonsense. There are plenty of powers in existing legislation to bring people to justice if they are doing the wrong thing.

Debate adjourned.

CRIMINAL LAW (SENTENCING) (VICTIMS OF CRIME) AMENDMENT BILL

The Hon. M.J. ATKINSON (Croydon—Attorney-General, Minister for Justice, Minister for Multicultural Affairs) (12:02): Obtained leave and introduced a bill for an act to amend the Criminal Law (Sentencing) Act 1988. Read a first time.

The Hon. M.J. ATKINSON (Croydon—Attorney-General, Minister for Justice, Minister for Multicultural Affairs) (12:03): I move:

That this bill be now read a second time.

At the last election the Rann Labor government made a number of promises for the enhancement of victims' rights. Some of them can be found in the Criminal Law (Sentencing) (Dangerous Offenders) Amendment Act 2007; others are in the Victims of Crime (Commissioner for Victims' Rights) Amendment Bill 2007 and the Statutes Amendment (Victims of Crime) Bill 2007 currently before the parliament.

Since coming to office in 2002, the government has been focused on tilting the balance in the criminal justice system in favour of victims. The government believes that victims are not bystanders to crime, so they should not be bystanders in the court process. This bill is part of the pledge that victims who no longer have a voice will still be heard in court. The bill deals with further proposals, which require the amendment of the Criminal Law (Sentencing) Act 1988. The first promise with which the bill deals is this:

For the first time in our legal history, the Rann government will give victims of crime advocates the legal right to make victim impact submissions at the sentencing hearing in cases that result in the death or total permanent incapacity of the victim.

The second promise with which the bill deals is this:

The Sentencing Act also will be amended to enable the prosecution to obtain, and present, community impact statements to court during sentencing submissions. The community impact statements will be used to inform the sentencing court about the effects on the community of the crimes before the court. For example, with regard to drug production or sale offences, evidence of medical professionals could be called to establish the harmful effects of drugs on individuals and the long-term health consequences of drug abuse. In cases of death by dangerous driving, expert evidence could be called to establish the human and financial cost of road deaths.

The interim Commissioner for Victims' Rights has also asked for some legislative change. His recommendations are:

> Amend the Criminal Law (Sentencing) Act to make it clear that victim impact statements can be given in person, via closed circuit television, audio or audio-visual recording, etc. I have had several requests to cover the costs of victims coming to court to read or listen to their impact statements. This will provide another option, especially for vulnerable victims.

And:

> Section 52 of the Criminal Law (Sentencing) Act provides for restitution orders (i.e. a court order that the convicted offender return misappropriated property to the victim-owner). Unlike section 53, which provides for compensation orders that can be enforced like any other pecuniary order, an order made under section 52 appears to be unenforceable. The Premier and the Attorney-General pledged to strengthen victims' rights including their right to compensation.

The purpose of this bill is to enact these proposals. I seek leave to have the remainder of the second reading explanation inserted in *Hansard* without my reading it.

Leave granted.

Election Promises

First Promise

Before the 2006-2007 election, the Government promised to amend the law on victim impact statements so that the Commissioner for Victims' Rights has the authority to make submissions at the sentencing stage (either personally or through counsel) on the impact of the crime on victims and on victims' families in cases resulting in the death or permanent total incapacity of the victims. Funding was allocated for the Commissioner to engage counsel as part of the 2006-07 budget. The Government also proposes that victims be given rights to read their victim impact statements in cases resulting in death or permanent total incapacity as a result of non-indictable summary offences. The Hon Nick Xenophon MLC had also proposed that a similar

provision be incorporated in the legislation. The Government said, at that time, that this provision was best placed in the context of the entire victims-oriented reform package.

Section 7 of the Criminal Law (Sentencing) Act now obliges prosecutors to furnish particulars of any injury, loss or damage suffered by a person as a result of the offence for which the defendant was convicted or, in short, any associated offence. Section 7A allows the victim of an indictable offence to read his or her statement to a court before it passes sentence, or the victim can ask the court to permit another person to read the victim's statement. This policy is to enact legislation to extend the right that is currently confined to indictable offences to summary offences where death or total permanent incapacity to the victim has resulted. For these purpose, 'total and permanent incapacity' is defined to mean: 'the victim is permanently physically or mentally incapable of independent function'. The Bill also amends the Act to assist the giving of victim impact statements by the prosecution in minor summary offences and so that a court may require company officials to be present when a victim impact statement is given in person under section 7A of the Act.

The second pledge is to allow a victim's advocate to read out the victim impact statement to the court on behalf of the victim. The right should be exercised by an officer of the court, an immediate family member or close relative, a person who, in the opinion of the Commissioner for Victim's Rights, is suitable for the role, or an employee of a group or organisation devoted to victim support, or the Commissioner for Victims' Rights (or a person acting for the Commissioner).

Second Promise

Two kinds of community impact statements are proposed. The first type is a type of collective impact statement to be called a 'neighbourhood impact statement'. A common example is a drug dealer in a street. The neighbours suffer the effects - discarded syringes, much traffic at all hours, increased levels of street and petty property crime and so on. Under the proposal, they would be allowed to give a collective impact statement on how this drug dealing offence has affected them. The second type is more a policy-justification statement - to be called a 'social impact statement'. In the drug dealing instance, evidence could be given of the harmful effects of drugs generally or this drug in particular (for example). The Bill proposes that both kinds of statements can potentially be given in a sentencing hearing for any offence. It should be possible to collate the statements of individuals into a group statement. The Bill proposes that the provision of these statements be up to the Commissioner for Victims' Rights and that the prosecution or the Commissioner be authorised to place the material before the court.

Commissioner for Victims' Rights Suggestions

First Suggestion

Section 7A(3a) of the Criminal Law (Sentencing) Act says: that if the court considers there is good reason to do so, it may exercise any of the powers that it has with regard to a vulnerable witness to assist a victim who wishes to read out a victim-impact statement to the court. This suffices to bring CCTV into play. But the Act should be amended so that it is possible for victim-impact statements to be given via audio or audio-visual recording where there are facilities available for the purpose. The defendant should be present except where the court is satisfied that a real threat has or is being made to the safety of the defendant or the defendant's representatives or family or where the presence of the defendant will otherwise cause undue disruption. In such cases, the court is authorised to take such steps as are available to it to ensure that the offender is exposed to the message of the victim-impact statement.

Second Suggestion

Section 53 of the Criminal Law (Sentencing) Act provides for orders for compensation on sentence. That sum is defined to be a pecuniary sum and therefore can be enforced in the same way as any order for a pecuniary sum - that is - effectively as a fine. Section 52 of the Act is different. It is about giving back particular property, not a sum of money. This is about returning the particular item stolen (for example). It follows that this cannot be defined as an order for a payment of a pecuniary sum and cannot be enforced in that way. The Criminal Law (Sentencing) Act deals with the matter by providing for default imprisonment. The Commissioner for Victims' Rights says that this does not work effectively. In some ways that is not surprising, since the analogous old method of collecting pecuniary sums by default imprisonment did not work well either - which is why it was replaced. The Bill will add remedies for restitution orders short of imprisonment. The Bill will give an authorised officer of the Court authority to seize and remove the property where there is

default on the order, or quantify the order so that it may be enforced as a pecuniary sum. Once that is done, all the remedies of fine enforcement come into play.

This is the third Bill that forms part of a victims oriented package of reforms to carry out the Rann Government's pledge to increase victims' rights in our justice system.

I commend the Bill to members.

Explanation of Clauses

Part 1—Preliminary

1—Short title

2—Commencement

3—Amendment provisions

These clauses are formal.

Part 2—Amendment of Criminal Law (Sentencing) Act 1988

4—Amendment of section 6—Determination of sentence

This clause amends section 6 to make it clear that in sentencing proceedings the court must act according to equity, good conscience and the substantial merits of the case without regard to technicalities and legal forms.

5—Amendment of section 7—Prosecutor to furnish particulars of victim's injury etc

This amendment makes it clear that a court dealing with an offence that is not an offence to which section 7A applies may nevertheless, if it considers it appropriate, allow particulars to be furnished in the form of a victim impact statement.

6—Amendment of section 7A—Victim impact statements

This clause amends section 7A of the principal Act in several ways. The inclusion of new subsections (3a), (3b) and (3c) enable a court to assist a person who wishes to read out a victim impact statement to the court to do so by means of a prerecorded reading of their statement, or to exercise the powers the court has in relation to vulnerable witnesses. Subsection (3b) requires that the court ensure that the defendant (or, where the defendant is a body corporate, a representative of the defendant) is present when the statement is read out to the court if the person providing the statement so requests. Under subsection (3c), the court may decline to do so for reasons set out in the provision, but in such a case the court must nevertheless endeavour to ensure the defendant hears the statement being read out via audiovisual link or audiolink or, if that is not possible, by making an audiovisual recording.

The clause also amends the section to enable an appropriate representative (a definition of which is included in new subsection (5)) to request that a statement be allowed to be read out in court and read out such a statement following a request.

The range of offences for which a victim impact statement can be provided is also extended to include certain summary offences (namely one that results in the death of a victim or a victim suffering total incapacity).

7—Insertion of section 7B

This clause inserts new section 7B into the principal Act, providing for written community impact statements to be provided to the court. The Commissioner for Victim's Rights is responsible for compiling a statement under the section, and either the prosecution or the Commissioner may provide a sentencing court with the statement.

The statements consist of 2 types. The first is a neighbourhood impact statement, which is a statement about the effect of the offence, or of offences of the same kind, on people living or working in the location in which the offence was committed. The second type is a social impact statement, setting out the effect of the offence, or of offences of the same kind, on the community generally or on any particular sections of the community.

The clause also sets out procedural matters related to the provision, and reading in court, of such statements.

8—Insertion of Part 9 Division 2A

This clause inserts new Part 9 Division 2A into the Act. The Division provides for action by authorised officers in the situation where a restitution order under the Act is not complied with. The clause sets out the actions that can be undertaken (including seizure of the property or payment of an equivalent amount by the defendant) and the powers an authorised officer can exercise in doing so.

Debate adjourned on motion of Mr Griffiths.

HEALTH CARE BILL

Adjourned debate on second reading.

(Continued from 23 October 2007. Page 1280.)

Mr GRIFFITHS (Goyder) (12:08): It is a pleasure to be able to contribute to the debate on this important bill, and I will take but a few minutes. I certainly recognise the importance of this measure, as it will impact upon the provision of health services. So, it is an absolutely key area, and I am confident that the majority of opposition members will choose to speak. Today I wish to focus my comments on it as it relates to the 70 communities within the Goyder electorate that I am lucky enough to serve as their member of parliament, and the hospitals that are within those communities. I will leave the statewide comments on this bill to our very capable shadow minister, who I think spoke for nearly four hours yesterday on the bill.

Ms Ciccarello interjecting:

Mr GRIFFITHS: The member for Bragg did a very good job. She was very professional and detailed many of the issues about which the Liberal opposition is concerned. I have lived in a regional community since the age of four, and luckily all of those towns that I have lived in have actually had a public hospital in them. In fact, I am a bit of a hospital brat, as my mother is a nurse. She is 64 and works at Flinders. What has happened in hospitals has been a major part of my life for as long as I can remember.

The electorate of Goyder has hospitals at Yorketown, Maitland, Wallaroo and Balaklava, with the former Minlaton Hospital now not only being an aged-care facility but also providing accident and emergency services. In addition we have the Moonta, Mallala, Ardrossan and Hamley Bridge private hospitals. I have never been involved in the management of hospitals via being a board member, but my previous local government roles have required me to have good relationships with the administrations of hospitals and, in many cases, their board members.

In every case I express nothing but gratitude for the work that was done by these people, not just the generation I have known since I entered the workforce in 1979 but also the thousands of people who have contributed to the development of the public and private hospitals in Goyder since the settlement of the region. All these hospitals would have started as very small private affairs. The communities, the real people who live there, saw a need for the doctors, nurses and health care. They worked very hard to provide these facilities and services and, over generations, upgrade them as funds become available.

Governments at all levels have supported these efforts in the last 150 years, and there is no doubt about that. Now, however, we find the scenario whereby the government is proposing to take away the efforts of locals by removing any vestige of authority that the hospitals or health service boards have had and turn them into health advisory councils. Via becoming an incorporated body, these health advisory councils will continue to have ownership of the assets gifted locally by previous generations. What else will they have to do? Community people can talk to these health advisory council (HAC) members about issues, and the HAC members will dutifully raise them at their meetings, but what will then happen? That is my concern.

The HAC members can make decisions, but if the powers that be above them do not want to do anything about it, what can happen? From the information provided to me, very little. Whereas previously the health and hospital service boards provided direction and policy advice, reviewed staff performance and made strategic planning decisions, now this ability to influence what happens locally appears to have gone. I recognise that successive governments since the mid 1970s have looked to make changes to the running of the health services, but this bill takes that level of change and central control to a new level.

This bill proposes that all responsibility for the provision of health services in South Australia will rest with the minister and the chief executive officer. With respect to employment issues, I find it amazing that the CEO will accept responsibility for and have total control over some

25,000 employees. The responsibility that now rests upon the person who holds this CEO role is enormous. I have never met the incumbent, Dr Tony Sherbon, but I wish him luck in his role. In reviewing the second reading explanation, the government claims that this bill:

- is necessary to meet the challenges and demands of health services in South Australia (and I think I heard yesterday that unless changes occur by 2042 it will consume the total state budget of the state);
- will result in the creation of a unified single Public Service system which will improve coordination and integration of services; and
- is justified because the Department of Health has direct responsibility and accountability to fund health, so therefore it should manage it.

Whilst all those reasons are interesting, I want to take up the last point, which is of particular interest to me because of my commitment to communities. If we extend the position that the government now appears to be pushing that, as it funds it, the department should have control of it, one must ask: what will happen in all the other areas of service provision across the state into which the government puts funds that revolve around the management of services by volunteers?

Another real concern I have with this bill is what will happen to the volunteers who support the hospital so much—the people who run the local auxiliary to raise money; the people who talk to those who may not have many visitors; the people who volunteer to upgrade the grounds and improve the amenity of the hospital; and the people who put the nice decorations on the wall—the people who truly make a difference to our public hospital system? These people all volunteer their time willingly because to them it is their hospital. They live within that community. They have a commitment to it and they want it to be the best possible facility it can be, and they understand that for that to happen it needs volunteer support.

The trouble is that it will no longer be their hospital: it will be the government's hospital, as it will run it totally, and that is my fear. The current generation of volunteers will no doubt continue with some degree of frustration but out of a sense of duty. My fear, though, is how will they be replaced? People of my generation have a lot of pressures upon their lives. So many families have both partners in the relationship working—

The Hon. J.D. Hill interjecting:

Mr GRIFFITHS: No; I am still a baby boomer—1962. However, the X and Y generations are a little more selfish. While a lot of people have had influence from parents along the lines that they need to volunteer their services to the community, it is becoming harder to do this. If our older volunteers, who have done such a tremendous job for so many years, can no longer take on that responsibility and fewer people are now coming through in this respect, there is a fear of what may happen in the hospital system. It will be a sad situation, and one of the triggers for this reduced volunteer effort is the fact that the local hospital board is losing its power and losing its ability to have a say in the management of its hospital.

I recognise as much as anyone the need to create efficiencies, and anyone who looks at the budget for the state and reviews the Auditor-General's reports understands that there are enormous financial pressures. It is not clear to me, and I ask the minister whether the changes will save money. The second reading explanation did not refer to this. Will these changes improve the range and quality of the services provided? I am aware that petitions objecting to this bill and its intention have been lodged with the house. In my own electorate of Goyder, I note that comments on the bill were made by the Balaklava and Riverton District Health Service and the Yorke Peninsula Division of General Practice.

The Balaklava and Riverton District Health Service stated that it supports in principle the intended repatriation of patients to country SA for their medical needs wherever possible and conducting elective surgery closer to the home of country residents. Secondly, it does not support the abolition of local boards of directors in country health services. They believe the loss will be detrimental to the state's country health services in years to come. Thirdly, they believe that if it is necessary to have health advisory councils instead, which will also allow for links to the local community, they want to ensure they are incorporated so that local ownership of assets can be retained, and I understand that has been covered.

The Yorke Peninsula Division of General Practice concerns related, first, to the abolition of hospital boards and replacement with health advisory councils. They state that the decision on whether or not to incorporate must remain locally, not with the minister. They have also alluded to

the lack of enthusiasm of local volunteer bodies that will be jeopardised if they do not have control over the assets and funds they have raised over many years. The strong point they have made is that there appears to be no reference to GPs. Their comment here is that it may be irrelevant for the metropolitan area where hospitals are staffed by doctors, but country hospitals rely on local GPs to provide clinical services.

The Hon. J.D. Hill interjecting:

Mr GRIFFITHS: The minister has just confirmed that there will be a representative on the council. Fourthly, it is expected that demand will increase in the area of tourism growth and ageing, as indeed it will, as Yorke Peninsula is a very popular spot. That will require greater services, so they cannot condone the downgrading of the non-delegated regional hospitals. They allude to the investments that will occur in the forward estimates period in focusing on Port Lincoln, Whyalla, Berri and Mount Gambier. They want to ensure that hospitals in the Yorke Peninsula area have access to the full range of services. I find it interesting that in 2004 the Rann Labor government said that it would not get rid of hospital and health service boards. Guess what! We are now in 2007 and it is happening in a big way.

I firmly believe that many of the hospital and health service boards have been worn down. They have no more energy to fight the intentions of the government. People want to ensure that local management is retained, but they know the fight is lost; the government has made up its mind and has not consulted with them but has told them what will happen. In closing I put on the record my sincere thanks for the people over generations who have volunteered their precious time to support their local hospitals. These efforts have built the health service centres, the envy of many nations. Sadly those volunteer efforts appear to be no longer required.

The Hon. L. STEVENS (Little Para) (12:19): In contributing today, I will focus on some of the comments made by the deputy leader in relation to the Generational Health Review and those reported in the paper and attributed to John Menadue in relation to hospital boards. Probably along with most other people in the house, I attempted to listen to the deputy leader. I thought the first hour or so was okay, but after that it went off into a fairly wide-ranging muddle.

She made some comments that I think need to be clarified in terms of what the facts are, particularly when referring to a document. So, I encourage people who talk about the Generational Health Review actually to read it. It is on the internet through the Department of Health website, and I suggest that people read it. I will focus on what John Menadue said in his report, and I quote from chapter 2 of the Generational Health Review entitled 'Population Health and Governance'. He said:

> Existing legislative protection of individual health unit boards has stood as a clear barrier to health system reform. Structures designed for the needs of an earlier time have not been able to address increasing complexity and the difficulties experienced by both consumers and providers. These difficulties include poor communication across the health system, rivalry rather than cooperation between organisations, and inadequate alignment of services to population priorities.

He goes on to say:

> [The Generational Health Review] has received strong representations that local hospital boards provide a powerful voice for the community. It is important not to confuse corporate governance and community participation. Current corporate governance roles of incorporated hospital boards involve ensuring safe clinical outcomes within the hospital, responsibilities in employment and industrial matters, legal requirements, probity, budget management and risk management.

Further, he states:

> GHR is of the view that hospital boards can over-emphasise their role as a voice for the public and their level of community representativeness. GHR believes community participation is better achieved in a different way.

In that chapter there is further discussion along those lines, and I suggest people who are interested in the detail read that. Further down, there is a number of ways forward that Menadue proposes in discussion. He says:

> [The Generational Health Review] has adopted the following approach to promote a greater focus on population health in the South Australian health system—

population health being having responsibility for a geographical area of citizens. These are the points: first, planning for defined geographical populations in metropolitan, rural and remote areas; second, a population approach to health funding (an overall population approach); third, population service planning; and, fourth, population based health governance arrangements. Again I will quote what the report says for the way forward:

The power to direct and control resources and health services lies principally at ministerial level. However, in creating a balance between central control and direction and responsiveness to local communities, there is a need for a principal governing body at the regional level. This body should have adequate authority and responsibility for promoting the health of a defined geographical population and managing the health services within that region in accordance with regional health care needs.

At the same time, there is a clear need to maintain and strengthen local community participation in health care agencies and health issues. It is also important to recognise the continuing interest of local communities in assets that they have funded, and to support and encourage ongoing fundraising and contributions in kind.

Finally, in the final recommendations the Generational Health Review, under 'A population health approach', states:

2.11 The state government ensure that regional health service board members will:

(i) have the expertise and experience essential to the business of regional health services

(ii) be paid an appropriate sitting fee

(iii) be provided with an intensive induction and ongoing education program

2.12 [Department of Human Services] develop the governance arrangements outlined in chapter 2, which include:

(i) regional health services in each of the geographic regions

(ii) dissolution of separate incorporation of all hospitals, health services and regional health services currently incorporated under the SAHC Act, including statewide services

(iii) broad roles and responsibilities for the Minister for Health, DHS, regional health services and health units as defined

(iv) appropriate bodies to administer community resources in line with regional health service priorities

(v) regionalisation of all other incorporated and unincorporated services within three years, giving due regard to the specific nature of organisation service provision in each case

(vi) funding for all other incorporated and unincorporated services to be incorporated in the population health funding model and allocation targets set for each region.

I put that on the record so people know the facts of what was said. The government at the time accepted the majority of the recommendations from John Menadue. In relation to what John Menadue is reported to have said yesterday, he is quoted in *The Advertiser* as saying:

'The key to reform in SA was getting rid of the hospital boards—they maintain little fiefdoms, silos, they look after their own patch and resist integration.'

The issue of the dissolution of unit boards did occur voluntarily in the metropolitan area by all boards (except the Repatriation General Hospital Board), and that process occurred as a result of a lot of consultation, involvement and agreement. People would know there was no fuss and bother. It just occurred in the metropolitan area, but it did not occur in the country area.

Some processes needed to be put in place (just as Menadue said) in order to achieve a balance of corporate governance and community participation, but, again, adopting the regional population approach. I want to clarify that point because I do not think the deputy leader understands it—amongst many other points she does not understand. Certainly, Menadue was referring to the voluntary dissolution of all the unit boards in the metropolitan area, which occurred two or three years ago. Finally, I point out that Menadue is quoted as saying:

The key to reform [in health] is primary health care. That's the substantial reform area that's necessary to take pressure off hospitals and to strengthen general practice.

It is critical to get a governance model in place to enable this to occur, and that is where we have to put our energies. The issue of the federal Minister for Health suggesting that a way forward would be to have separate arrangements with every hospital and the federal government in relation to their funding flies in the face of all that we know about how to manage health services today. Clearly, that is what John Menadue was speaking about when he spoke with reporters from *The Advertiser*. I conclude my remarks by suggesting that those people who talk about the Generational Health Review perhaps should read it; perhaps that would make our discussions clearer and more effective.

Mr WILLIAMS (MacKillop) (12:29): The last contribution was interesting, but I stand here and speak unashamedly on behalf of the hospitals in my electorate, and the comments that I make will refer to hospitals across regional South Australia rather than in the metropolitan area. I think one of the problems that we are facing with this change to the governance of our hospitals is that

the government has failed to recognise the difference between hospitals and their role in delivering health services in country areas and in metropolitan Adelaide, because there is a huge difference.

Hospitals and boards in country communities play a role that has no equivalent in metropolitan Adelaide. I will give examples as I go through my contribution, pointing out the difference between what occurs in country communities and in metropolitan Adelaide. A lot of this difference is because of the nature of the politics in the two distinct locations. Politics in country towns dictate that certain things happen that are probably irrelevant in metropolitan Adelaide, because the major hospitals in metropolitan Adelaide, especially the major teaching hospitals, are not specific to a particular electorate. So, there is not the political imperative in the same sense as one finds in country towns.

I guess the political imperative with regard to health in metropolitan Adelaide is to supply a world-class health system that has major teaching hospitals and hospitals that provide a large range of services, which we never expect to have in country towns. We never expect to have open heart surgery, kidney transplants and those sorts of operations performed outside of metropolitan Adelaide. We do expect—and I believe we have a right to expect—obstetric services to be delivered as far and as wide as possible.

In a contribution to the house in, I think, the last sitting week, I commented on the drought in the Eyre Peninsula region and spoke about the Cleve hospital, which has not only lost its GP, but which also has no obstetric or postnatal services. So, young women who are forced to travel from that community to Port Lincoln or Whyalla, for example, to deliver their baby cannot even go back to their local hospital to spend the next few days in their home town. That imposes a great burden on country communities, because their loved ones—their family—who are obviously working in the local community (in that instance, at Cleve), have a long way to travel.

We continually hear about work/life balance, paternity leave, and all those sorts of things, and how important it is for a father to be involved in the birthing process, and so on, from day one and to support the mother. It is almost impossible for a young family, in a place such as Cleve, to enjoy that experience in their life together; they are torn apart by the tyranny of distance, because we fail to deliver the services that we should be delivering in places such as Cleve. I guess that is where one of the imperatives comes from, when I talk about the political imperative, to ensure that, throughout the history of the state, we develop health services in our country communities.

The other important thing is that GP services in country communities depend very heavily upon the local hospital. I suggest that, when the local hospital has been downgraded to the point where it does not provide minor surgical procedures, that community will have difficulty in attracting and retaining GPs. In hospitals that have minor surgical procedures (or even significant surgical procedures) carried out by visiting surgeons, it is relatively easy to attract and maintain GPs—and I cite my own electorate. The communities of Millicent and Naracoorte traditionally have not had great difficulty in attracting GPs. I think about 12 GPs operate out of the Millicent medical clinic.

A large number of them undertake significant work in the local hospital, either on their own in obstetrics, minor surgery and anaesthetics, or assisting visiting surgeons. The work that is done in the hospital underpins the local medical clinic, and therefore it underpins the whole delivery of medical services in that community. That is the model we should be endeavouring to ensure we have across regional South Australia.

Unfortunately, with a centralised system, it is always easy to win the argument that you deliver the services from a central point, particularly the significant services; that is, the services that have any amount of risk or cost associated with them. I acknowledge that you can always deliver those services more cost effectively and minimise the risk from a central point. However, that comes at a great cost, as I pointed out in relation to the family at Cleve who have to receive their obstetrics at a distant point, say, Whyalla or Port Lincoln. The cost is shifted from the taxpayer and the health system to the individual family or the person receiving the service.

That is what is happening here. We are transferring the cost away from the Department for Health to the individual families. That only impacts in country South Australia. It does not occur in metropolitan South Australia; it will not occur and it is not an issue in metropolitan South Australia, because these changes will make very little difference there. My argument is that, as a result, not only will we see a downgrading of the services currently delivered in a significant number of country hospitals—some of them might be centralised to the four regional centres that the minister has identified: Mount Gambier, Berri, Whyalla and Port Lincoln—

The Hon. J.D. Hill interjecting:

Mr WILLIAMS: And I believe an upgrade at Ceduna, too. I do not have a problem with that. I have had much experience with the conflicting interests of a regional hospital (in this case Mount Gambier) and the sub-regional hospitals in my electorate, say, Millicent and Naracoorte in particular. I have had much experience with the sort of things that happen. The hospital at Mount Gambier believes that it should be all things to all people and will do whatever it can, irrespective of the impact on the sub-regional hospitals and their ability to continue to deliver their service.

They say that that is not important: the important thing is to have a good base hospital in a place such as Mount Gambier. I would argue that, in this instance, that is not necessarily delivering the best service to the community of the South-East. The reality is that, if people living at, say, Naracoorte (which is about an hour's drive from Mount Gambier) need a significant procedure which cannot be delivered in their local hospital, by and large, they would choose to come to Adelaide rather than go to Mount Gambier.

Members would ask: why do they do that? The reality is that families are very important when people are receiving medical services, and people in Naracoorte would be more likely to have family in Adelaide than in Mount Gambier; therefore, the support that they need when they are receiving their medical service is more than likely to be available in Adelaide. I receive a continual stream of complaints and inquiries through my office about families living in my electorate who have to come to Adelaide for their services.

Some people have family members in Adelaide and have access to living arrangements and therefore their husband, wife, loved one, children or the person supporting the patient can stay in Adelaide for the time—and obviously some of these procedures involve weeks of treatment—and that support is incredibly important. By and large, people in my electorate would not necessarily receive that support in Mount Gambier. This is an argument I have been having for a long time. The hospital in Mount Gambier—notwithstanding that it is a very good hospital which delivers a good range of services—is not the ideal delivery point for my constituents. That is a fact.

Another thing I want to say about country hospitals, as I was alluding to earlier, is that the country communities themselves throughout the history of the development of our health system saw that they had to help themselves. The reality was that distance largely meant that, for them to try to defray the costs that I was referring to that are pushed back to the individual families, they needed the service to be delivered within their local community. So, country communities got together and raised the money to build their hospitals.

They raised the money to support bringing GPs to their hospitals. They put together boards to manage those hospitals and, by and large, I would argue that those boards have done a very good job. When you add in the point that they have made the connection between the delivery of our health services and the community, they have done an excellent job and a job which will fail to be done under these new governance arrangements.

I will give an example. At the hospital at Bordertown some 10 to 12 years ago, a local GP, who had a large range of skills, decided to leave the town. A lot of issues are behind this story, and I will not go into all of those. When he left the town, he left the hospital bereft of a lot of its ability to deliver the services that it had been delivering. Basically, it meant that the whole health system in Bordertown was at the point of collapse. The Liberal government of the day—and I think it was a little tardy in doing it—intervened and put a new board in place with considerable support and a charter to rebuild the health system from the ground up, which it did in a fantastic way.

I remember an article which I think was on the front page of *The Advertiser* some months ago about how our health system in South Australia does not receive enough support and does not get enough money coming out of the private health sector to support our public hospitals and our health system in general.

The Hon. J.D. Hill: We're trying to get more.

Mr WILLIAMS: From memory, minister—and you may correct me—I think you were aiming at about 4 or 5 per cent of the total.

The Hon. J.D. Hill: I can't remember. It might have been 10 per cent.

Mr WILLIAMS: Anyhow, it might have been 10 per cent; I accept that.

The Hon. J.D. Hill: We wanted more.

Mr WILLIAMS: Yes, you wanted to double it, and I think it was commendable. It is an argument that I have been making, minister, in my electorate in regard to the Mount Gambier hospital for a number of years.

One of the things that have been achieved at the Bordertown hospital through this process of the community really getting behind their hospital and knowing how close they came to losing everything is that 32 per cent of the total budget of that hospital is generated from private patients. I would say to you, minister, that you have been saying that we need to run our hospitals with professionals and that it is time to push the amateurs aside. I would argue that the amateurs who have been running the Bordertown hospital have done a commendable job, and I would argue that they have probably done a better job than quite a number of your professionals.

Minister, it is not unique to Bordertown. I give the example of Bordertown because it is a fascinating example and case study, and I can tell you that both the Naracoorte and Millicent hospitals have a record not dissimilar. The board has understood that, to maintain the sort of services that the community wants and should aspire to have, it has to get those dollars out of the private sector. They have done funny little things. If I go into the Millicent hospital—

The Hon. J.D. Hill interjecting:

Mr WILLIAMS: No; they do funny little things, minister, which I do not believe you can do in your major teaching hospitals. If I went into the Millicent hospital, said that I would come in as a private patient and asked about the advantages, they would say, 'We'll put you in a private room.' I would say, 'That's very nice.' The reality is that, if I went into the Millicent hospital as a public patient, I would probably be in a room on my own anyway. I would say, 'Why should I come in?' and they would say, 'We'll give you a newspaper in the morning and a glass of wine or a stubby of beer with your dinner at night. The furnishings in a small number of rooms in the hospital are of a superior quality. You'll enjoy that. You'll get the TV without having to pay an extra few dollars a day for it.' It is a very small cost to the hospital to offer those little incentives, but it brings in a huge amount of income. They are the sorts of things we can do—and can do quite readily—in country hospitals, and I would suggest that it happens right across country health.

The Hon. J.D. Hill interjecting:

Mr WILLIAMS: The minister says that we can do it in the city. I would love to see it happen in the city. As I have said, within a bee's whisker of a third of the income of the Bordertown Hospital comes from private patients, and it is those sorts of things that have caused that to happen. If we could achieve half of that in our metropolitan hospitals, we would go a long way towards solving our health cost problems. But, minister, the reason this can be achieved in country hospitals is that there is a huge connection between the hospital and the community, and that connection, I would argue, is built through having a board that is responsible to its community.

Another thing that happens in country health, in a lot of our country hospitals—and it was a deliberate ploy of the previous government—is to have aged care facilities built on the same campus as our hospitals. This is to bulk up the services to defray some of the common costs and to ensure, again, that we retain GPs in country towns. Also, in country communities the local government body is quite happy to put a special rate onto their communities to put into establishing the bricks and mortar of those aged care facilities, and that has happened in a number of areas in my electorate. It has happened in Naracoorte, Penola and Millicent, and it has probably happened in a couple of other areas that do not come to mind right now. I do not see that happening in metropolitan Adelaide; I do not see the connection between local councils and health in metropolitan Adelaide. However, it happens in country South Australia.

So, there is a whole range of differences between country health and the system we have in metropolitan Adelaide. I have seen no evidence to suggest that by centralising the governance of our hospitals we will improve the system or improve the delivery of service, especially in regional South Australia. I see a mountain of evidence to say the contrary is indeed the reality, that is, as we centralise the governance, as we take the power away from the local communities, we will form a disconnect between the communities and their hospitals.

Another small point I make is that, as the local member, I have enjoyed fantastic access to the hospitals in my electorate. I question whether a minister—I am not necessarily talking about this minister—will enjoy me having the same access in the future. Through that access, I have been able to get a lot things over the years for various hospitals—and the renal dialysis unit in the Millicent Hospital is one that comes to mind—through being able to have access via the board. Once it is managed centrally, I fear that local members may well lose that access and lose the

ability to have the influence we have enjoyed on behalf of our communities in the past. I do not support the measures that are before us today. I think they will be the death knell for services in country South Australia and will make it incredibly difficult to attract and retain GPs in many country communities. I think it is a bad measure.

Time expired.

The Hon. R.B. SUCH (Fisher) (12:49): I trust this new initiative will work. What I want to see happen is a system that is dedicated to the wellbeing of the patients, and that might seem a very basic thing to say. There is a danger—and I think it has existed for a long time—that the health system is often run for the benefit of doctors. The health system, to some extent, has been run for the benefit of the people who work in it: for doctors and, in particular, specialists; to a lesser extent, nurses and other professionals; and the support staff. It is very important in our health system that the role of caring for the patient be absolutely number one in regard to priority. It might seem a fundamental and basic thing but if one is not careful with bureaucracies they become self-serving and self-justifying. I believe we see that in education and other areas as well. I hope, with this new structure, that we do not end up with an overly bureaucratic system where the patient is forgotten. The patient should be at the top of the list.

Overall, our health system in South Australia is quite good. There will never be a perfect system which will satisfy all the demands that people put upon it. Expectations rise and people want prompt treatment, but their expectations are often unrealistic. The medical profession has to engage in a lot of detective work. It is not infallible or foolproof in the way it conducts investigations. There is always going to be the human element but, overall, I think we should be proud that, in South Australia, we have a very good health system.

I have experienced both private and public and I have found that the public system, in terms of the standard of medical care, is excellent. It does not necessarily have all the frills, the fancy glass of wine and those sort of things, but the standard of care, in my experience, has been fantastic. From time to time we hear negative stories about our health system but, overall, it is a very good system.

What I would like to see—and I know this is not the prime purpose of this bill—is more emphasis on keeping people out of hospital; not those who should be there, but greater emphasis on preventative health measures and education. I think, for a lot of people in the country—and I will be talking about this tomorrow in parliament if time permits—and particularly for rural men (who have been the big losers in regard to preventative health programs), it is important that, whether you are male or female in the country, you get adequate information and education about health issues. What the system needs to do is to focus more and more on preventative health, early screening and health checks so that people can take measures to ensure that they are relatively healthy. Once again, that is not foolproof. In our society we have a huge looming medical and, ultimately, hospital problem in terms of care and cost because we are not collectively doing enough to maintain issues and to focus on preventative health.

The administration of the health system needs to be kept simple so that there is direct accountability, wherever possible, and the fewer layers of bureaucracy there are, the better. The people actually delivering front-line services should have ready access to the people at the top, and the people at the top should be required to spend time at the front line (if they are appropriately qualified) so that they do not lose touch when dealing with front-line issues.

The approach then should be the old and famous one of KIS (keep it simple). I am not too sure that this model is going to do that. Staff should be allowed to perform and given responsibility, not hampered and restricted. Too much management is often focused on control of staff rather than allowing them to perform. If staff do not perform then one has to deal with it, but they should be allowed to get on with the job.

In our hospital system at the moment we probably have excessive accountability. Obviously, we need some accountability. I notice that, in hospitals, a lot of the professional staff spend more time attending to paperwork than they do to patients. Obviously, we need some paperwork, but it is not as important as the patient. If one visits any hospital, public or private, one will see a lot of the professional staff spending time filling out bits of paper rather than spending time with the patient. To me, that indicates that maybe the system is a bit out of whack in terms of accountability. There are so many people out there who want to sue for any trivial reason that the bureaucracy goes out of its way to protect staff to the point where accountability becomes an albatross around the neck of the staff.

In regard to training our staff, clearly we need more medical professionals. We now have a lot of women who work part time as doctors. If you go into a doctor's surgery at five o'clock, you will see old blokes like me, because the women have gone home to look after the kids. I do not have a problem with that but, if we are going to have that, we need to train more men and women as doctors. If we are going to have a system where female doctors want to spend time with their family—which is good—let us train more people so that we do not have a situation where we are left with grey-haired doctors after 4 or 5 o'clock.

We need to have high standards in regard to people coming in from overseas. I understand that the Nurses Board is now insisting on assessing all overseas trained nurses, because the training of a few who have come into the system is under question. I have heard that sometimes local nurses can barely understand some of these people who have come in from overseas. It is not good enough if professional staff members cannot communicate clearly and precisely with each other in a hospital situation.

There is also a cultural issue. For example, the Australian sense of humour can be found a bit disconcerting. One of my constituents, who had a leg removed, said to the medical staff that it was fantastic that he had his leg removed. He meant that he was pleased that his leg had come off because it saved his life, but the foreign-trained professional thought he was a nutcase and put him down for psychiatric referral. He did not understand that he was looking at it with a dry sense of humour: 'Thank God I've got my leg off, because it saved my life.' They thought he was a bit of a lunatic.

So, we need to make sure that we have adequately trained staff and that they can speak English. I know someone who has been involved in a training program for overseas trained nurses. That person is under pressure to approve them as being competent in English, otherwise the company training them in English will not get its money. In conclusion, I support this measure and trust that it will deliver even better services for those in South Australia who need care in our hospital system.

Debate adjourned on motion of Mr Venning.

[Sitting suspended from 13:00 to 14:00]

SANTOS

The Hon. M.D. RANN (Ramsay—Premier, Minister for Economic Development, Minister for Social Inclusion, Minister for the Arts, Minister for Sustainability and Climate Change) (14:01): I seek leave to make a ministerial statement.

Leave granted.

The Hon. M.D. RANN: Later today I will be introducing to the house historic legislation for the removal of the 28 year old Santos 15 per cent shareholder cap. This is important legislation that will allow Santos to grow strongly. It will also ensure that South Australia will benefit from a good share of that growth as well as from a healthy social dividend for education and community development, amongst other things. Further detail will be provided when I introduce the bill.

Everyone is aware that the opposition leader has not declared his support for this historic legislation. We know that he described the review into the shareholder cap as Santos would be 'taken over and fall prey to global equity markets' and various other dire consequences, but at the end of his media statement he said, ' We are open to the measure.' This is a test of leadership for the opposition leader. South Australian Liberal commonwealth ministers Nick Minchin and Alexander Downer have supported the removal of the cap with the very protections we have negotiated with the company. These protections are set down in the company's deed of undertaking to the state.

On the day of the announcement that the South Australian government would move to lift the shareholder cap, Howard government finance minister Nick Minchin had this to say:

> I commend the state government and congratulate Santos on being set free from this constraint on the company.

So, I call upon the opposition and all members of the Legislative Council to support this vital legislation. It would also be a show of support for the future growth and development of South Australia's valuable resources industry, which continues to loom large in our state's future economic success.

I have an announcement to make today. Hillgrove Copper has today signalled to the Australian Stock Exchange its plans to redevelop the 1970s era Kanmantoo copper-gold mine. This new mining operation is expected to initially involve an investment of $100 million and the creation of 400 jobs in the development stage and 200 permanent jobs following the resumption of mining. The mine is located between Callington and Kanmantoo, south-east of Adelaide—an area that would welcome jobs and investment growth. I repeat: $100 million, the creation of 400 jobs in the development stage, plus 200 permanent jobs following the resumption of mining.

Mr Williams: All in the electorate of Kavel.

The Hon. M.D. RANN: Yes—all in the electorate of Kavel. I hope that we have the support of the member for Kavel. Do we have that support? Good.

Mr Williams interjecting:

The Hon. M.D. RANN: Apparently, the former premier, Dean Brown, is chairman of the board.

The Hon. P.F. Conlon: He does a good job, that bloke.

The Hon. M.D. RANN: He does a very good job. I am told that Hillgrove has been investigating the copper mining potential around Kanmantoo for several years. This development application follows detailed consultation with all relevant government agencies, the community, the District Council of Mount Barker, and other major stakeholders. I understand that formal community consultation on this new mining proposal will begin tomorrow and close on 7 December this year. It is terrific to be able to welcome the opening of another mine in South Australia.

An honourable member interjecting:

The Hon. M.D. RANN: Sure.

LEGISLATIVE COUNCIL VACANCY

The Hon. M.D. RANN (Ramsay—Premier, Minister for Economic Development, Minister for Social Inclusion, Minister for the Arts, Minister for Sustainability and Climate Change) (14:05): I seek leave to make a ministerial statement.

Leave granted.

The Hon. M.D. RANN: Yesterday I informed the house that the government will act in accordance with its legal advice in relation to filling the casual vacancy caused by the decision of Mr Nick Xenophon to prematurely quit the Legislative Council. This is a very detailed constitutional statement, as you would expect. I will turn to the legal advice that the government has received in a moment. In essence, it states that to nominate an eligible candidate to fill the vacancy, the No Pokies campaign must establish, amongst other things, that it is a political party, that it endorsed Mr Xenophon as a candidate for the 2006 election, that it publicly recognised that endorsement, and, importantly, that Mr Xenophon represented himself as the endorsed candidate of the campaign.

I informed the house yesterday that I had not received a letter from Mr Xenophon or the No Pokies campaign, or the mooted replacement, anti-land tax campaigner, Mr John Darley, about the replacement. Following my statement yesterday I received a letter from Mr Xenophon originating from his legal practice. He repeats his public statement that Mr Darley is his preferred replacement. If by that letter Mr Xenophon purports to satisfy the requirements of the Constitution Act then he has completely failed. As a practising lawyer he should know better. Certainly, his public statements immediately following the March 2006 election suggest that he knows more than he is now prepared to acknowledge about the constitutionality of the approach that he is suggesting.

On Monday 20 March 2006, two days after the election, when asked who would fill the casual vacancy if something should happen to his running mate Ann Bressington, Nick Xenophon said this on Radio 891:

> It's a very interesting constitutional point...it's unprecedented so I don't know what the answer is. It's being looked into. Because I am not a political party it raises all sorts of issues as to what will happen. Hopefully nothing will happen to Ann in the next eight years and nothing to me.

In that exchange Mr Xenophon disclosed the complexity of this constitutional issue and, in particular, the relevance of party status in the selection of a replacement. Mr Xenophon makes no mention of that matter in his letter to me yesterday. Nor does he purport to act with the authority of any party or the No Pokies campaign itself. As I have indicated, an eligible nomination can only be

accepted by the joint sitting of the houses if Mr Xenophon has publicly represented himself as the endorsed candidate of the No Pokies campaign operating as a political party.

Satisfying this requirement may prove difficult to reconcile with Mr Xenophon's public mantra that he is in fact an Independent. For example, on election night in March 2006, in relation to the election of Ms Bressington and the issue of political parties, he said that his party room meetings would be when he was shaving in front of the mirror. He confirmed that view on ABC Radio on Monday 20 March 2006 when he told ABC listeners that that would not change 'because Ann Bressington ran on my ticket but we are Independents'.

Certainly, that view was persuasive with Ms Bressington. She told *The Weekend Australian* on 25 March 2006 that Mr Xenophon had asked her and anti-tax lobbyist John Darley to join him on the ticket simply so that the Xenophon name would appear above the line on the voting card. Ms Bressington also told *The Advertiser* on 20 March 2006 that the two would remain independent. She went on to say, 'Nick is so anti-party politics.' In the same article Mr Xenophon himself stressed that he would remain independent regardless of the number of seats he won, and said:

> I am never going to change from an Independent. I am never going to be a minister, and I will never join any party.

A widely circulated political pamphlet distributed by Mr Xenophon for the 2006 election was personally authorised by him, not by a political party. In it he refers to himself as an Independent; there is no acknowledgement that he is endorsed by the No Pokies campaign acting as a political party. Election advertisements are, likewise, authorised personally by Mr Xenophon care of his legal practice address. I will table a copy of the pamphlet and advertisement for the information of honourable members, as well as the letter I have written to Mr Xenophon today.

Campaign donations are sought for a campaign, again in his own name. It would appear that Mr Xenophon wants to have his cake and eat it too. When he considers that there is an electoral advantage to assert his independence he does so at every opportunity; now, when he has decided that he has outgrown our parliament and wants to appoint his successor, he pretends to have some authority to nominate his preferred candidate to fill the next six and more years in the Legislative Council.

It is clear from his previous public statement that Mr Xenophon, a lawyer, knows that the nomination must come from a political party. The parliament and the public have a right to know whether Mr Xenophon is making this nomination as a representative of a political party or, somehow, as an Independent. If so, where is the evidence to satisfy the requirements of the constitution? If so, what does this say about his so-called independent campaign for the Senate? To date I have not been approached by any person or any organisation that demonstrates the right to nominate an eligible candidate to fill the casual vacancy. Obviously, it will be preferable to resolve this issue before the joint sitting of the houses rather than at the sitting itself. The government does not want to see the situation descend into either a constitutional crisis or a fiasco, or give opportunistic politicians the forum for political stunts.

I am advised that the nomination and selection of the replacement is justiciable. That is, it can be challenged in the Supreme Court of South Australia and could, indeed, go all the way to the High Court of Australia—and I am sure we would see the Bar Association and other groups wanting to enter as amicus curiae. Therefore, it is imperative that the filling of that casual vacancy be done properly and in accordance with the law so as to avoid a legal challenge which would only serve to undermine the integrity of the Legislative Council—God forbid.

I have written to Mr Xenophon inviting him to place before me any relevant material, including whether he is acting on behalf of a political party, so that I may give my full consideration to whether his nomination falls within section 13(5) of the Constitution Act. I await a responsible and properly presented approach with anticipation, and a commitment to act in accordance with the constitution, the law and relevant conventions. We will do the right thing, we will obey the Constitution of South Australia, we will obey the law, and we will obey all the precedent conventions.

Ms Chapman interjecting:

The SPEAKER: Order!

The Hon. M.D. RANN: I now turn to the constitutional—

Members interjecting:

The SPEAKER: Order!

The Hon. M.D. RANN: I think it is very important for the member opposite, given that we both have a shared history in the law, to listen to the relevant constitutional points. I turn now to the constitutional requirements for the filling of a casual vacancy in the council. Section 13(1) of the Constitution Act makes clear that the person to be chosen to fill a casual vacancy in the Legislative Council is to be selected by an assembly, that is, a joint sitting of the members of both houses of parliament. So, we decide collectively. It will therefore be necessary to conduct an assembly to select the replacement for Mr Xenophon. That assembly must be conducted in accordance with section 13(4). Section 13(4)(a) provides that the assembly shall meet at a time and a place fixed by proclamation. Thus, the Governor will determine the time of the assembly.

I am advised that the assembly should be convened as soon as reasonably practicable having regard to all relevant considerations. In other words, the assembly should not be unduly delayed nor need it be unduly rushed. It may be delayed if some good reason exists but not for an excessive period. In practice, that means that the time will be determined by cabinet and Executive Council. As I have indicated, it is my intention to recommend to the Governor a date prior to the federal election. I think we all want to see this wrapped up properly, done decently and observing the law and the constitution before the federal election.

That, of course, will be subject to resolution of the issue of who is eligible to be nominated. We do not want to see this being dragged through the courts, all the way to the High Court, with various parties claiming, 'No, it's our candidate'; 'No, it's our member, not yours.' Any question before the assembly is to be decided by a majority of the votes cast by the members actually present at the meeting. Each member present at the assembly, except the person presiding, has one deliberative vote. The presiding member has a casting vote.

Section 13(5) requires that where the member who has resigned was at the time of his or her election 'publicly recognised by a particular political party as being an endorsed candidate of that party and publicly represented himself or herself to be such a candidate', the person chosen by the assembly to fill the vacancy shall, unless there is no member of that party available to be chosen, be a member of that party nominated by that party to occupy the vacancy. That is what we have always done, and that is what we should do. I am firmly advised that before section 13(5) can govern the process, the relevant political party—rather than Mr Xenophon personally—must nominate Mr Darley (or another of its members) as his replacement.

I am also advised that before making a decision to support a candidate nominated by that party, the government should satisfy itself that there is sufficient evidence that the nomination is within section 13(5), that is:

(a) whether at the time of the 2006 election the No Pokies Campaign Inc. (or some other relevant group) was a political party albeit not registered as such on the basis that it had amongst its objects the promotion of the election of candidates endorsed by it;

(b) alternatively, whether at the time of the 2006 election the No Pokies Campaign (or some other relevant group) was a political party albeit not registered as such on the basis that one of its activities was to promote the election of candidates endorsed by it;

(c) if the answer to either (a) or (b) is yes, whether Mr Xenophon was the endorsed candidate of the campaign (or some other relevant group) for the 2006 election;

(d) whether the campaign (or the other relevant group) publicly recognised that fact;

(e) whether Mr Xenophon publicly represented himself as the endorsed candidate of the campaign (or the other relevant group) at the 2006 election. He should be specifically asked to reconcile any such claim with his frequent use of the label 'Independent'; and

(f) whether the person now nominated by the campaign (or the other relevant group), whether Mr Darley or someone else is currently a member of the campaign (or relevant group).

So, the message to Mr Xenophon is: please let the parliament know whether or not you are an Independent or a member of a political party. If he is a member of a political party, that party has a right to nominate a successor. However, apparently in a series of statements, Mr Xenophon has

ruled out the fact that he is a member of a political party and claims that he is an Independent. Now that he wants to nominate a successor, he is saying something different.

I am advised that Mr Xenophon was not nominated by a registered political party under section 53 of the Electoral Act 1985. I have also been advised that the No Pokies Campaign is not a registered political party under part 6 of the Electoral Act. For that reason, Mr Xenophon had applied under section 58 of the Electoral Act to be grouped together with other candidates on the ballot paper. The effect of section 58 is to permit independent candidates to group together so as to obtain the benefit of above the line voting. Section 13(5) of the Constitution Act does not refer to registered political parties; it simply refers to a particular political party. I am advised that the term 'political party' is defined in section 4 of the Electoral Act to mean:

> An organisation of which an object of activity is the promotion of the election to the House of Assembly or the Legislative Council of candidates endorsed by it.

I am advised that the section 4 definition accurately reflects the meaning intended in the Constitution Act. Adoption of the same meaning also enables the Electoral Act and the Constitution Act to operate as a coherent legislative package. Moreover, the definition also reflects the ordinary meaning of the term 'political party'.

On that point, I leave members with Nick Xenophon's own words on Radio FiveAA on 20 March 2006, two days after he was re-elected for his second eight-year term. Mr Xenophon said:

> We are not a party. I have never been a party. I am an Independent.

I now table a pamphlet and electoral advertisement for the 2006 election authorised by Mr Xenophon in his personal capacity.

NORTHERN EXPRESSWAY

The Hon. P.F. CONLON (Elder—Minister for Transport, Minister for Infrastructure, Minister for Energy) (14:22): I seek leave to make a ministerial statement.

Leave granted.

The Hon. P.F. CONLON: Yesterday the shadow spokesman for transport suggested in this house—

Dr McFetridge interjecting:

The Hon. P.F. CONLON: Please, live it up: you will enjoy this. He suggested in this house that the government was hiding further cost blow-outs to the construction of the Northern Expressway by purchasing land which was originally part of the Northern Expressway project as part of the Gawler River Flood Mitigation Scheme, and that affected residents have told the opposition that they now fear they will be paid only a fraction of their real estate land value as it is being acquired as part of the Gawler River Flood Mitigation Scheme, not as part of the Northern Expressway project. Those were the allegations. Advice from the Deputy—

Mr Williams interjecting:

The Hon. P.F. CONLON: I think you should stay out of this one, Mitch.

An honourable member interjecting:

The Hon. P.F. CONLON: You're right, I agree with you. He's got form.

The SPEAKER: Order!

The Hon. P.F. CONLON: Mr Speaker, advice from the Deputy Chief Executive of the Department for Transport, Energy and Infrastructure has confirmed that those suggestions were completely false. No land is being acquired for the Northern Expressway project by the Gawler River Floodplain Management Authority, or any other project. Indeed, as members will see from the ministerial statement, it is extremely difficult to see how it could be. The Northern Expressway project is funding all land acquisitions necessary to construct a road and associated interchanges, including any land that needs to be acquired to construct the required structures and diversion channels associated with the crossing of the Gawler River.

Dr McFetridge interjecting:

The Hon. P.F. CONLON: I think it's time you kept quiet, mate.

The SPEAKER: Order!

The Hon. P.F. CONLON: Of course, he did say he would apologise if he was wrong, but I am sure that is not going to occur. All acquisitions for the Northern Expressway will be consistent with the Land Acquisition Act, which requires fair compensation to be paid.

The reason I am absolutely confident about all of that is that the Gawler Flood Mitigation Scheme is administered not by the state government but by the Gawler River Floodplain Management Authority. The authority advises that it does not propose to acquire any land along the Gawler River, for any purpose. The authority does intend to secure some easements (and, if the member for Morphett needs some assistance, I can explain the difference to him later) to enable construction of a levy and channel cleaning works to be undertaken along the river.

The Gawler River Floodplain Management Authority consists of representatives of the six councils responsible for the catchment. Not a single state government person is on it and has authority over it. Indeed, it is in fact chaired by a former state leader of the Liberal Party.

The Hon. M.J. Atkinson: And a vet!

The Hon. P.F. CONLON: And a man who used to be a vet, I understand, just like the member for Morphett used to be a vet.

The member for Morphett, if he will not apologise to this house, should apologise to the members of the authority for his allegations. He should consider why, indeed, those local councils would want to spend their funds buying land for the state government. Above all, if he does find some councils who want to buy the state government some free land could he please refer them to me.

LEGISLATIVE REVIEW COMMITTEE

Mrs GERAGHTY (Torrens) (14:25): I bring up the report of the ninth committee.

Report received.

VISITORS

The SPEAKER: I draw to honourable members' attention the presence in the chamber today of students from Pembroke School, who are guests of the member for Hartley.

QUESTION TIME

INDEPENDENT COMMISSION AGAINST CORRUPTION

Mr HAMILTON-SMITH (Waite—Leader of the Opposition) (14:27): My question is to the Premier. Does he agree with statements made today by Labor Premier Morris Iemma on the need for state governments to have independent commissions against corruption? Premier Iemma stated today, and I quote—

Members interjecting:

The SPEAKER: Order!

Mr HAMILTON-SMITH: He stated:

Corruption thrives in the dark—

Members interjecting:

The SPEAKER: Order!

Mr HAMILTON-SMITH: They don't want to hear it, do they, Mr Speaker. They do not want to hear it. He is the only Labor premier who doesn't want an ICAC.

Members interjecting:

The SPEAKER: Order! Members will not interject. The Leader of the Opposition.

Mr HAMILTON-SMITH: Premier Iemma stated—

The Hon. M.J. Atkinson interjecting:

The SPEAKER: Order! I warn the Attorney.

Members interjecting:

The SPEAKER: Order!

Mr HAMILTON-SMITH: All calm? Very good.

Members interjecting:

The SPEAKER: Order! The Leader of the Opposition.

Mr HAMILTON-SMITH: Premier Iemma stated:

Corruption thrives in the dark, and it resists the tools of conventional policing. Any jurisdiction which doesn't have an ICAC type body is in my view just crazy. If you don't have one you have either discovered a secret of human nature that has eluded the rest of us or, as is more likely to be the case, you're just kidding yourself.

Members interjecting:

The SPEAKER: Order! The Attorney-General.

The Hon. M.J. ATKINSON (Croydon—Attorney-General, Minister for Justice, Minister for Multicultural Affairs) (14:29): We have better than an ICAC. We have the police Anti-Corruption Branch—

Members interjecting:

The SPEAKER: Order!

The Hon. M.J. ATKINSON: We have whistleblower legislation. We have the Ombudsman, a very good Ombudsman too. We have the Auditor-General. Mr Speaker, South Australia is better served by those agencies than it is by the $30 million construct that the Leader of the Opposition wants. Here is someone from New South Wales who wrote for *The Advertiser* on the question of an ICAC. He had experience of it from New South Wales where he was the chief executive of the Liverpool council, and he wrote:

...'If you want to destroy someone, report them to ICAC'...the organisation I headed was investigated three times. Each time it was cleared of any wrongdoing, but not before enormous damage was sustained by the council and its workers. The New South Wales ICAC Commissioner recently admitted that of the 2,500 complaints of corrupt conduct ICAC receives each year, only 50 warrant serious investigation. A mere five or six lead to full-blown inquiries.

Ms Chapman interjecting:

The SPEAKER: Order!

The Hon. M.J. ATKINSON: Those can be conveniently handled in South Australia by the police Anti-Corruption Branch, the Ombudsman, the Auditor-General—

Mr Pisoni interjecting:

The Hon. M.J. ATKINSON: For the information of the member for Unley, we are talking about Mr Brian Carr, CEO of Light Regional Council, who has been a CEO in local government for 26 years.

Members interjecting:

The SPEAKER: Order!

The Hon. M.J. ATKINSON: He went on to say:

In the highly charged political climate of New South Wales, there are two main groups who have become adept at exploiting the ICAC system. The first group comprises those who want to exert inappropriate pressure on government officials. To do this, they use the threat of an ICAC investigation in an improper way. This approach is designed to paralyse elected officials with fear and render them incapable of making hard decisions.

He continued:

One high-profile New South Wales lawyer, seeking to manipulate local government decisions, would regularly bully elected members by threatening them that if they acted contrary to his professional advice, their behaviour could be seen as 'ICAC-able'...The second group is made up—

—the Leader of the Opposition, who marched into police headquarters with information that was subsequently proved to be of no value whatsoever—

—of political opponents and those with an axe to grind. For personal or political reasons—

Mr Hamilton-Smith interjecting:

The Hon. M.J. ATKINSON: No, the member for Waite ought to listen to this, because he will see himself in this—

—they wish to maliciously damage the reputation of those in public office. As former CEO of Liverpool Council, one of New South Wales' largest, I saw many disgruntled parties—

Ms Chapman interjecting:

The SPEAKER: Order!

The Hon. M.J. ATKINSON: The quote continues:

community groups, mayoral aspirants, political candidates, developers and companies who'd lost out on tenders—all misuse ICAC in this way. For them, ICAC was the perfect vehicle to vent their spleen, leak their spurious allegations to the media and publicly injure the elected official they held a grudge against.

Gee, does anyone recognise that picture?

The Hon. P.F. Conlon: It does sound familiar, doesn't it?

The Hon. M.J. ATKINSON: It does sound a bit familiar. Mr Brian Carr went on:

Is this really the kind of unchecked anti-corruption system we want for South Australia? In my view, it merely paves the way for a more sinister form of corruption to flourish.

DEFENCE INDUSTRY

Ms PORTOLESI (Hartley) (14:33): My question is to the Premier. Can he inform the house of more good news for South Australia on the defence industry front?

The Hon. M.D. RANN (Ramsay—Premier, Minister for Economic Development, Minister for Social Inclusion, Minister for the Arts, Minister for Sustainability and Climate Change) (14:33): I was very pleased to attend the Land Warfare Conference, which was held at our Convention Centre today, with the Deputy Premier. It was the second major defence conference and exhibition to be held in the last few months. I thank the honourable member for her question. It is a question that I am delighted to answer, because today has brought news that South Australia has again been recognised as the undisputed hub of Australia's high-tech and high skill defence industries. Today's announcement by the Prime Minister that the commonwealth will support the establishment of Carnegie Mellon's Software Engineering Institute in Adelaide comes after about three years of intense lobbying by me, the Deputy Premier and others within the state government.

This good news follows many meetings involving the state government and, certainly, my own visits on a couple of occasions to Carnegie Mellon in Pittsburgh and here in Adelaide, as well as vigorous negotiations between South Australia and the Defence Materiel Organisation. I also went to Canberra to meet with the Prime Minister and the federal education minister, and also with the defence minister and the foreign minister.

I am pleased to announce today that South Australia will invest up to $4.5 million in the Software Engineering Institute here in South Australia and that the commonwealth has committed a further $20 million to this important project. We are talking about another $25 million of investment in the highest of high technology in terms of software engineering for the defence industry, and I am delighted that it builds upon the investment that we have made in bringing Carnegie Mellon to Adelaide, the first overseas university ever to establish in Australian history. I am sure that members opposite who have criticised Carnegie Mellon will be delighted that our funding of Carnegie Mellon is now being matched by the commonwealth government.

As home to Carnegie Mellon University and critical defence major projects, including the largest defence project in Australia's history in the air warfare destroyers, Adelaide was the logical choice for location of the Software Engineering Institute. In addition, key top class defence firms are investing strongly in their futures here in South Australia, including companies such as Australian Submarine Corporation, BAE Systems, SAAB, Raytheon, Tenix, General Dynamics and many others.

Our campus of the Defence Science and Technology Organisation, together with the air warfare destroyers systems centre, currently employing about 300 high-skilled technical and systems people, are just two things that place South Australia in the national vanguard of defence technologies. Again, this has been confirmed by the news that the Software Engineering Institute, which is number one in the United States, is setting up here in Adelaide.

Having won more than $12 billion in defence contracts in the past two to three years, we are favoured with major opportunities, but with those opportunities come challenges and meeting those challenges is what the Software Engineering Institute is all about. In the United States, the Software Engineering Institute operates as part of the Carnegie Mellon University in Pittsburgh,

with major funding from the US Department of Defence, the Department of Homeland Security, NASA and key defence companies.

In America it employs more than 500 people and has a budget of over $US100 million. It is a world leader in software engineering, helping to reduce technical risk in major defence projects. It is these complex software integration systems that allow modern defence forces to work. With SEI here in Adelaide, we will be placed in the forefront of defence software engineering in the Asia Pacific. Because SEI is held in such high regard in the United States and internationally, its presence in our state will help local firms seeking work in larger offshore markets.

Adelaide today plays host to the Land Warfare Conference. We visited the exhibits this morning and we were simply amazed by the level of participation, with 1,600 delegates and about 600 defence companies taking part. But most of all, it is great to see the Carnegie Mellon decision being endorsed by the federal government and by the federal opposition, and Carnegie Mellon will continue to grow here, adding to our defence push.

SHARED SERVICES

Mr HAMILTON-SMITH (Waite—Leader of the Opposition) (14:38): My question is to the Premier. Exactly how many Public Service positions does his government intend to relocate from regional South Australia to be centralised in the CBD under his government's shared services arrangements approved by cabinet on 15 October? From which regions will the positions be taken?

The Hon. M.J. WRIGHT (Lee—Minister for Industrial Relations, Minister for Finance, Minister for Government Enterprises, Minister for Recreation, Sport and Racing) (14:39): The shared services initiative is an important government initiative. It was announced by the Treasurer in the 2006-07 budget and it is something that from 2009-10 will deliver $60 million in savings. We are talking about back-of-office government corporate services and functions and, in regard to the member's question, I think that approximately 250 will be in scope from the regional areas.

SCHOOLS, WATER AND ENERGY CONSUMPTION

Mr PICCOLO (Light) (14:39): My question is to the Minister for Education and Children's Services. How are school communities working with the state government to reduce their water and energy consumption?

The Hon. J.D. LOMAX-SMITH (Adelaide—Minister for Education and Children's Services, Minister for Tourism, Minister for the City of Adelaide) (14:39): I am quite confident that no-one in this place would deny the need to conserve both energy and water resources in our current environment, both drought wise and in terms of carbon footprints. It is true that, whilst every part of our community has a responsibility to conserve these resources, schools cannot be outside these issues. South Australia has, of course, a very large percentage of our energy produced by wind and solar power, but we still have much to do in order to make our energy footprint smaller and conserve water.

I am very pleased to inform the house that South Australian schools have reduced their water use over the last few years, with 602 state schools having slashed their use from 5.06 million kilolitres in 2000-01 to 3.8 million kilolitres in 2005-06. This is a 25 per cent reduction over a five-year period which, for those of you who cannot imagine the scale of this water, is equivalent to 1,200 Olympic sized swimming pools saved over five years. Schools and preschools have been working hard to reduce their impact on the environment, and from 2008 all schools, district offices and state office consumption of water must reduce by 10 per cent, and energy by 25 per cent, based on the targets in the South Australian State Strategic Plan. I am pleased to inform the house that already almost half of individual schools have met their water targets, and a large number of schools have met their energy targets as well.

We will continue to work with schools to help them achieve these targets by introducing a range of measures and continuing throughout the next few years to reach these goals. We are releasing 'green kits' with tips on saving energy and water within all schools in term 4. We are having energy audits in a number of schools to help them assess where and why they use energy and to come up with practical solutions to reduce their consumption. In addition, $1 million of annual Green School grants were issued in June and will continue to be issued each year to help schools become greener; and 624 grants have been awarded over the past five years. In addition, we are continuing our Solar Schools program, with 112 schools already signed up to this initiative.

Reducing water and energy use not only helps the environment but also frees up extra funds to be reinvested in our children's education. I am extraordinarily impressed by some of the projects being run through our schooling system to impact on this reduction in energy and water usage. I name particularly two schools that have had an extraordinary success in this area. The Pines Primary School has reduced its water consumption by 40 per cent, and it purchases stormwater stored in an underground aquifer, a system developed through the Salisbury Council. In addition, Gawler High School (in the member's electorate) has had a massive reduction of 63 per cent in its water use by replacing its manual irrigation system with an automated system and installing five 50,000-litre tanks to capture and reuse stormwater run-off. There are many different initiatives around the state, and each of these has the added advantage of not just taking us further towards sustainability but also acting as pilots and great indicators for children to learn about sustainability and take those measures home to their families.

SHARED SERVICES

Mr GRIFFITHS (Goyder) (14:43): My question is to the Premier. What will be the impact upon regional South Australia flowing from plans to cut 1,000 people from the Public Service through the shared services reform process, revealed by the Public Service Association yesterday? Did the government conduct a regional impact assessment before making its decision? On 19 October, the Public Service Association stated that the PSA still has concerns about the impact in regional communities and that there will be an adverse impact on regional employment, with flow-on effects felt in the community.

The Hon. M.J. WRIGHT (Lee—Minister for Industrial Relations, Minister for Finance, Minister for Government Enterprises, Minister for Recreation, Sport and Racing) (14:44): In regard to the latter part of the member's question, we did conduct a regional impact assessment statement.

Members interjecting:

The SPEAKER: Order!

The Hon. M.J. WRIGHT: With respect to the first part of the question, we should put it in context. We are talking about approximately 2,300 full-time equivalents who will be in scope, of which, as I said earlier, approximately 250 are in regional areas. As I said earlier, this is an important government initiative about back office savings. We do not expect it to have an impact on front line services in regional areas.

ORGANISED CRIME

Mr KENYON (Newland) (14:45): My question is to the Attorney-General.

Mr Williams interjecting:

The SPEAKER: Order! The member for MacKillop will come to order!

Mr KENYON: Can the Attorney-General inform the house about the visit to South Australia by Professor James A. Finckenauer, a world renowned sociologist and criminologist?

The Hon. M.J. ATKINSON (Croydon—Attorney-General, Minister for Justice, Minister for Multicultural Affairs) (14:46): The Rann government takes the fight against organised crime most seriously. We understand the risk that it poses to our state, indeed, our nation. Many argue that, on the international stage, the threat posed by organised crime is no less than the threat posed by terrorism. Organised crime has many facets. Locally, the focus is on crimes committed by outlaw motorcycle gangs and crimes of drug trafficking and distribution. It emphasises the need to study anti-organised crime measures overseas.

The South Australian government's work to create new laws targeting outlaw motorcycle gangs includes research that is necessarily broad. I am pleased to tell the house that one of the foremost international authorities on organised crime is visiting South Australia, and I have invited him to speak to government officials on the challenge of combating organised crime and outlaw motorcycle gangs. Professor James Finckenauer comes from Princeton, New Jersey. He gained a masters degree in sociology and criminology from New York University and, later, his doctorate from the Centre for Human Relations at that university. He has had a distinguished academic career of over 40 years devoted almost entirely into the study of the causes and prevention of crime, as well as working with police and other law enforcement agencies in training and planning.

In 1998 he became director of the International Centre of the National Institute of Justice, which is the research arm of the US Department of Justice, a position he held until 2002. I had the

opportunity to meet officers of that international centre earlier this year to discuss a broad range of law reforms, including juvenile justice reforms. Professor Finckenauer is the co-author of six books as well as many articles and reports. His latest book, *Mafia and Organised Crime: A Beginner's Guide,* was published earlier this year, and it provides an insight into the mafia as a group that has the capacity to destabilise on a global scale.

Professor Finckenauer is in Adelaide as a guest of Flinders University. I welcome the opportunity for the state government to seek out his views and advice on the challenges we face in South Australia. His visit comes at the very time when the state government is preparing its own bikie legislation, and I am glad that we are able to draw on his international expertise to inform our reforms. I look forward to meeting him this afternoon. The government has already begun to roll out reforms that target criminal motorcycle gang activity in licensed premises and in hydroponics, and I expect to introduce further legislation later this year. The government intends to be vigilant and consult widely. I thank the member for Newland for his interest in stamping out bikie-related crime.

SHARED SERVICES

Mr HAMILTON-SMITH (Waite—Leader of the Opposition) (14:49): My question is to the Premier. How many of the 4,000 positions identified by the Public Service Association as in scope, or the 2,300 positions identified in scope by the minister moment ago, across 56 government agencies does the government plan to declare surplus to requirements? The PSA media release dated 19 October has revealed that:

> Services to be transitioned in the first quarter of 2008 include payroll, accounts receivable and accounts payable. Positions will be transferred to Adelaide including those in regional areas. People not electing to transfer will be surplus to requirements.

The Hon. M.J. WRIGHT (Lee—Minister for Industrial Relations, Minister for Finance, Minister for Government Enterprises, Minister for Recreation, Sport and Racing) (14:51): This is a very important initiative and I do not know why the leader would carry on about it. I referred to 2,300 full-time equivalents that are in scope. This equates to roughly 4,000 positions. We will work through this very carefully because, as I have already said, it is an important government initiative, and we will make sure we get it right. Most other jurisdictions around Australia have already embarked upon shared services, as have other countries around the world. What we will be about is making sure we deliver these services more efficiently, and we will work carefully with people in the regions and also with people in metropolitan Adelaide as we move forward. With regard to the first phase of our shared services (which the member refers to in his question), we are looking at human resources, payroll, accounts payable and accounts receivable, and we are looking at about late February next year.

FAIRNESS TEST

The Hon. L. STEVENS (Little Para) (14:53): Is the Minister for Industrial Relations. aware of employers being given approval to slash South Australian workers' pay and conditions under the Howard government's Fairness Test?

The Hon. M.J. WRIGHT (Lee—Minister for Industrial Relations, Minister for Finance, Minister for Government Enterprises, Minister for Recreation, Sport and Racing) (14:53): I am very aware of that, and I am sure that members opposite will want to hear about it as well. The Howard government's Workplace Authority has delivered clear evidence that workers' pay and conditions can still be slashed under WorkChoices. The Howard government's Workplace Authority has said that under the Howard government's Fairness Test slashing workers' pay and conditions is fair.

I am advised that a South Australian employer formally asked the Workplace Authority whether its proposed workplace agreement passed the Fairness Test. The proposed agreement cut overtime penalties, slashed loadings for weekend work, abolished paid breaks, abolished annual leave loading, and increased ordinary working hours. I understand that in exchange for that there was to be a supposed $50 a week increase in the base rate but, when the slashing of workers' entitlements is added up, many workers would be $70 worse off—many other workers would be even more worse off. One of the workers affected has said publicly that last year he earned $51,000 but the proposed agreement would see him lose $15,000 a year. So, under the Howard government's Fairness Test $70 a week less pay for longer hours is fair. On 5 September this year the federal Minister for Workplace Relations said:

Employees have more protections in place than ever before, ensuring that penalty rates, overtime and other protected conditions cannot just be taken away without fair compensation. The Labor Party and unions continue to scare people and lie about penalty rates. They continue to criticise the Fairness Test.

The Howard government has spent tens of millions of taxpayer dollars peddling poisonous propaganda to try to deceive Australians. The evidence is all here for everyone to see: the Howard government's so-called Fairness Test says slashing workers' pay and conditions is fair. What is clearly shown is that WorkChoices means working longer for less—even with the so-called Fairness Test.

Members interjecting:

The SPEAKER: Order!

SHARED SERVICES

Mr GRIFFITHS (Goyder) (14:54): My question is to the Treasurer. Is the Treasurer now the minister responsible to the parliament for all matters linked to shared services? The Public Service Association has revealed details of a briefing with Under Treasurer Jim Wright that a new organisation called Shared Services SA will be established to carry out the whole-of-government administrative functions within the Department of Treasury and Finance, which reports to the Treasurer.

The Hon. K.O. FOLEY (Port Adelaide—Deputy Premier, Treasurer, Minister for Industry and Trade, Minister for Federal/State Relations) (14:55): What a boring question!

Members interjecting:

The Hon. K.O. FOLEY: Well, it was announced in the budget. Last week we were getting criticised for not delivering the shared services savings, and today members opposite are suggesting that we are being too harsh; that we are cutting too deep; that we are being too efficient. The Liberal Party walks both sides of the fence. If I put my hands over my eyes, I would see a bunch of old socialists sitting over there, not a modern reformers party, like us.

An honourable member interjecting:

The Hon. K.O. FOLEY: We have only young ones over here! A big streak of red goes through the benches on the other side! The Minister for Finance is responsible for shared services. The Under Treasurer reports to the Minister for Finance on matters relating to shared services. As Treasurer, obviously I have overall responsibility for budget integrity, but the matter is an aligned responsibility of the Minister for Finance. It was actually outlined in the budget and has been known since the budget was brought down. You must read the budget papers, and you must listen to what is said at budget time. It is not a difficult concept. I accept that the opposition wants to walk both sides of the fence, but in this case it cannot say one thing one week and the opposite the next.

MARINE SCIENCE INFRASTRUCTURE

Ms FOX (Bright) (14:57): My question is to the Minister for Science and Information Economy. What support is the government providing to assist South Australia's marine science industries to plan better for a prosperous and sustainable future?

The Hon. P. CAICA (Colton—Minister for Employment, Training and Further Education, Minister for Science and Information Economy, Minister for Youth, Minister for Gambling) (14:57): I thank the member for Bright for her question and acknowledge her active interest in matters of science. As I informed the house last month, the South Australian government is a key investor in the National Collaborative Research Infrastructure Strategy (NCRIS), which helps our research institutions to retain and attract scientific expertise through the establishment and sharing of leading-edge science infrastructure. I am pleased to announce that, under NCRIS, the state and commonwealth governments will contribute more than $5 million to establish in our state a key node of the integrated marine observing system, the Southern Australian Integrated Marine Observing System (SAIMOS).

I can advise the house that SAIMOS will support research on many of the critical marine issues facing Australia, including climate change and the sustainability of ecosystems. I know that all members, including our very loud backbench, are extremely interested in this project. The South Australian node is expected to be launched early next June and will include two separate state-of-the-art, high frequency radar systems—one located at Cape Borda on Kangaroo Island and the other at Cape Wiles on Eyre Peninsula.

I am told that a further system is being considered for the Bonney coast between Robe and Portland. The state government has provided $1.4 million for the installation of the infrastructure, with Flinders University having contributed $500,000. The purchase of this vital infrastructure will enable us to better understand the marine ecosystems in the southern region, as well as helping to underpin the sustainable expansion of our important seafood industry, an industry that I know every member of this house supports.

South Australia stands to benefit enormously through this initiative. The SAIMOS facility will enhance our potential to be a leading location for research and marine science fields, such as marine biology, physical oceanography and meteorology. SAIMOS will also help our state to attract and retain the best scientists and postgraduate students, and it will provide flow-on benefits for emergency services through improved indications of adverse weather and sea conditions.

SAIMOS will provide real-time monitoring conditions, such as ocean currents, temperatures and wind speeds, and will provide valuable information on fish stock availability and early warning weather prediction. SAIMOS will also assist the development of our ecotourism industries, such as deep sea diving, and will support increased oil and gas exploration in South Australian waters by assisting the processes for environmental impact analysis.

Mr Kenyon interjecting:

The Hon. P. CAICA: I knew that would attract the interest of the member for Newland. Access to year-round maps of ocean waves and currents will also deliver very substantial savings in fuel and labour costs by optimising voyage routes for the emergency services and fishing sectors. The South Australian facility will build on our state's expanding research and development capability in marine sciences and enhance our international reputation as a leading centre for marine research and development expertise. SAIMOS also builds on the state government's existing investment of $13.7 million in Marine Innovation SA and the SARDI Aquatic Sciences Centre and is further evidence of this government's commitment to science and research in South Australia.

SHARED SERVICES

Mr HAMILTON-SMITH (Waite—Leader of the Opposition) (15:01): My question is to the Treasurer. If he is ruling out the WA model for shared services reform using new computer programs to standardise systems, simplify and integrate finance, procurement, HR and payroll processes, how does he intend to achieve the $130 million worth of savings in the 2006-07 budget?

An honourable member interjecting:

Mr HAMILTON-SMITH: Well, who is responsible? Is it you, or him?

The SPEAKER: Order!

Mr HAMILTON-SMITH: Who is ultimately responsible?

The SPEAKER: Order!

Mr HAMILTON-SMITH: With your leave, sir, I will explain. The Western Australian Auditor-General, in a special report in June this year, has confirmed that a similar program of shared services reform in that state is in serious financial trouble. His report states that the project is behind schedule and over budget and that 'there are lessons to be learned about managing by a committee'.

The Hon. M.J. WRIGHT (Lee—Minister for Industrial Relations, Minister for Finance, Minister for Government Enterprises, Minister for Recreation, Sport and Racing) (15:02): I am delighted to take that question, as silly as it is. We are doing it uniquely the South Australian way.

Members interjecting:

The SPEAKER: Order!

The Hon. M.J. WRIGHT: We have learnt from other jurisdictions and, as a result, we will do it better than have other jurisdictions. The member refers to Western Australia. Yes, there have been some clear mistakes made in Western Australia. Treasury officials have been to Western Australia and spoken to people there, and looked at other jurisdictions as well. The savings that the member refers to are: in 2007-08, $25 million, which comes from ICT, which has been the

responsibility of the Minister for Infrastructure (in fact, I think it might be a bit above $25 million); in 2008-09, $45 million; in 2009-10 $60 million; and $60 million in each year after that.

SHARED SERVICES

Mr HAMILTON-SMITH (Waite—Leader of the Opposition) (15:02): I have a supplementary question. Given the answer to that question and earlier questions—

An honourable member interjecting:

The SPEAKER: Order!

Mr HAMILTON-SMITH: —I ask my question to the Treasurer or the Premier, whoever would like to answer. Who, ultimately, is responsible for the success or failure of the shared services program? Which minister is responsible to the parliament for its success or failure? Is it the Treasurer, is it the minister for administrative services, or is it the Minister for Finance? Is it all of those, or who is it?

Members interjecting:

The SPEAKER: Order!

The Hon. M.D. RANN (Ramsay—Premier, Minister for Economic Development, Minister for Social Inclusion, Minister for the Arts, Minister for Sustainability and Climate Change) (15:03): Cabinet is responsible, and the Minister for Finance has personal responsibility for the project, reporting to cabinet. The cabinet is responsible. I know that the member was a minister for a only very short period—about six weeks, I think—but, essentially, what happens is that there is a cabinet, which also forms as Executive Council with the minister, and there is cabinet responsibility: but there is portfolio responsibility with the relevant minister, which is the Minister for Finance. I would have thought that was easily understood.

GAMBLING, PROBLEM

Mr O'BRIEN (Napier) (15:04): My question is to the Minister for Families and Communities. How is the state government improving services to problem gamblers?

The Hon. J.W. WEATHERILL (Cheltenham—Minister for Families and Communities, Minister for Aboriginal Affairs and Reconciliation, Minister for Housing, Minister for Ageing, Minister for Disability, Minister Assisting the Premier in Cabinet Business and Public Sector Management) (15:04): Last Friday I launched the statewide gambling therapy service, made possible with an annual funding of $1.34 million from the Gamblers Rehabilitation Fund. This service is a statewide expansion of the Flinders problem gambling intensive service, a service that has proven to be extremely successful, with something like an 85 per cent success rate for those who have completed the course.

The service is in the process of now being rolled out to eight regional areas, those being Port Lincoln, Ceduna, Whyalla, Port Augusta, Port Pirie, the Riverland, Murray Bridge and Mount Gambier. At the same time that I launched the problem gambling state-wide service I also launched the Problem Gambling Services Action Plan, and this is a plan which will guide the government's work in delivering problem gambling services. It is true to say that we have now grown our offering in relation to gambling services from a miserable $900,000, that I think the previous government used to supply to the Gamblers Rehabilitation Fund, to now something in excess of $5.5 million. There is now a capacity, for the first time, to really provide a service system, and so we have sought to do that with a set of priorities.

The five priorities are, first, a unified service system across South Australia. We will be able to respond quickly, use agreed assessments, share referral protocols and offer treatment plans tailored for each client, and service providers will work together to ensure that problem gamblers receive the service that best fits their needs.

Secondly, we will involve consumers in the development of the services and in evaluating them. We need to know what works and, in particular, to encourage people with problem gambling to get help. For instance, we have consumer spokespeople such as Elsie Cairns, who was at the launch, who told us so powerfully of her story of struggling to find a service that helped her, before coming across the Flinders Program. One of the important elements of the Flinders Program is that it is carefully evaluated and we are able with some confidence to look at longitudinal studies which point to the success of that program.

Third, we will be evaluating problem gambling services to identify the effective programs and interventions so that we can be confident in decision making as to future services. We have really gone beyond just providing funding to some charities and expecting them to do good works. We really now need to rigorously analyse these services to make sure that they are actually making a difference, and we know that the Flinders Program in which we have invested heavily is having those successes.

Fourth, we aim to develop a specific treatment and support service to address the needs of particular communities, in particular Aboriginal people, people from culturally and linguistically diverse communities, and also young people. It is not the case that every group in our society is easily going to be engaged with some of the mainstream services.

Fifth, we want to target early intervention and prevention activities. Early intervention is critical in limiting the damage that problem gambling can wreak on families and communities. We also know that problem gambling also presents itself at the same time as other issues, such as depression, anxiety and drug and alcohol problems, and so connecting with those other service systems is crucial. The Problem Gambling Services Action Plan is an important part of ensuring that services which are successful in providing positive outcomes for problem gamblers are promoted, and this plan is available through the Office for Problem Gambling within the Department for Families and Communities.

SHARED SERVICES SA

Mr GRIFFITHS (Goyder) (15:08): My question is to the Minister for Finance. How many additional senior executive positions will be created in the Department of Treasury and Finance to accommodate the new Shared Services SA agency?

The Hon. M.J. WRIGHT (Lee—Minister for Industrial Relations, Minister for Finance, Minister for Government Enterprises, Minister for Recreation, Sport and Racing) (15:08): I will get that detail for the member. I do not carry that information in my head, but—

Members interjecting:

The Hon. M.J. WRIGHT: I am more than happy to get that detail and will come back to the honourable member.

FLOODING

Mrs GERAGHTY (Torrens) (15:09): Can the Minister for State/Local Government Relations advise the house what the state government is doing to assist those council areas affected by yesterday's storm?

The Hon. J.M. RANKINE (Wright—Minister for State/Local Government Relations, Minister for the Status of Women, Minister for Volunteers, Minister for Consumer Affairs, Minister Assisting in Early Childhood Development) (15:09): I thank the member for Torrens for her question; it is one the member for Goyder should have been asking me. In the aftermath of yesterday's storms I am aware of several of our northern communities that have sustained damage to important council infrastructure. In fact, my colleague in another place, the Minister for Emergency Services, today travelled to Kadina to meet with members of the local community affected by yesterday's flash flooding. I am advised that the minister also met with the emergency services workers responsible for dealing with the impacts of the flood and managing the clean-up efforts, and I understand that they are doing a magnificent job.

Again, the government has taken the initiative to make contact with country councils primarily affected by these quite significant and somewhat unexpected downpours that occurred yesterday. It is ironic that, in this year of drought, we have now had not only one but at least two significant storm damage events in South Australia. Members will remember the terrible storms that struck earlier this year in January and February. When those storms occurred, we swiftly put in place mechanisms to assist those councils most affected by the floods. At that time, discussions resulted in eight of the most severely affected councils making applications to the Local Government Disaster Fund. Funds totalling $4.4 million were made available to assist eight of the councils to repair vital infrastructure for their communities. As I said, yesterday we again saw several of these very same councils experiencing floods.

I have today made contact with the Northern Areas and Peterborough councils to offer immediate financial assistance if they require it, and we are also in the process of contacting a range of other councils. A similar practice is likely to be adopted with respect to the Local

Government Disaster Fund, which was quite successfully used for the floods earlier this year. We will assist in the assessment of the damage in each of the council areas prior to making application to the fund. Once the full extent of the damage is known, the overall assessment will take into account any immediate assistance provided at this time. Councils are forwarding details of the damage that has been sustained as we speak. A fuller assessment will be known into next week.

GLENSIDE HOSPITAL REDEVELOPMENT

The SPEAKER: The Deputy Leader of the Opposition.

Ms CHAPMAN (Bragg—Deputy Leader of the Opposition) (15:12): Excellent, thank you, sir. Thank you for the opportunity for a question. My question is to the Treasurer. Is the Glenside Hospital redevelopment that has been announced by the government conditional upon the sale of nearly half its land?

Last night, officers from the Department of Health were welcomed to my electorate to give a public meeting and a briefing on the redevelopment. At that meeting, in response to questions, the officers said the following. First, 'the government does not have any money for health'. In response to precincts 3, 4 and 5 (the commercial, retail and private housing development sell-off portions) they said, 'The property will be sold,' and they later said, 'These precincts are not negotiable.'

The Hon. K.O. FOLEY (Port Adelaide—Deputy Premier, Treasurer, Minister for Industry and Trade, Minister for Federal/State Relations) (15:13): And the deputy leader's point is?

Ms Chapman: Question: is it conditional?

The Hon. K.O. FOLEY: I will get an exact—

Ms Chapman: No sale, no development, no hospital.

The SPEAKER: Order!

The Hon. K.O. FOLEY: I will get this confirmed, but the normal order of events with such a project as this is that I assume that the forward estimates will hold all the expense side of the exercise, that is, that the government would appropriate funding for the expense side of the Glenside redevelopment, and further into the forward estimates would be the receipts from land sales. That is how we fund these projects. We do not say, 'Here is 60 per cent of the funding for the project and the other 40 per cent is coming from the sale of land, so we will not'—

Mr Pisoni interjecting:

The Hon. K.O. FOLEY: Sorry?

Mr Pisoni interjecting:

The SPEAKER: Order! The member for Unley will come to order!

The Hon. K.O. FOLEY: The Soviet Socialist Republic lives on in the Liberals opposite. Honestly! I will obtain an exact answer for the deputy leader, but I am not quite sure what the point was, to be honest.

QUEEN ELIZABETH HOSPITAL

Ms CHAPMAN (Bragg—Deputy Leader of the Opposition) (15:14): Can the Minister for Health confirm that, as a result of recent media attention, the Department of Health is now providing funding for the replacement of out-of-date ultrasound equipment at the Queen Elizabeth Hospital so that it can maintain its accreditation as a training centre for radiologists?

The Hon. J.D. HILL (Kaurna—Minister for Health, Minister for the Southern Suburbs, Minister Assisting the Premier in the Arts) (15:15): I am happy to get some information for the member about that detailed question. Of course, all of our hospitals are assessed regularly by the various colleges that manage or look after particular parts of training, and I dare say that the radiology department at the QEH goes through that process as well.

We need to replace equipment from time to time. I think I recall in relation to the radiology department that a team of experts from the college came and checked out the radiology department and said that they would be recommending that it be reaccredited as a training institution. They also indicated that a piece of equipment was coming to the end of its life and would have to be replaced in 12 months or so, and, from memory, the hospital said, 'Yes, we will

replace that equipment.' That is the way the system works. It is a good system. I do not see the problem.

WORKCOVER CORPORATION

Mr WILLIAMS (MacKillop) (15:15): My question is to the Minister for Industrial Relations. When can South Australian businesses expect to be able to compete with interstate businesses on a level playing field? Businesses in New South Wales have been given a $110 million tax break today after their workers compensation levies were reduced by a further 5 per cent. The reduction follows the New South Wales WorkCover scheme increasing its surplus to $812 million. That compares to South Australia's scheme having the worst return to work rates in the country, a $149 million loss last financial year and an unfunded liability of a whopping $843 million.

The Hon. M.J. WRIGHT (Lee—Minister for Industrial Relations, Minister for Finance, Minister for Government Enterprises, Minister for Recreation, Sport and Racing) (15:16): I have already announced to the house that we are undertaking a review of workers compensation. That is due to report to the government on 30 November. We look forward to the findings of that report. Amongst other things, Mr Clayton is looking at other jurisdictions. The member referred to New South Wales. Victoria also in recent years has done very well in reducing its unfunded liability. It needs to be remembered that both New South Wales and Victoria, although doing well now, have come from high levels of unfunded liability. I think I said when I announced the review that we look forward to the opportunity of having—

Members interjecting:

The SPEAKER: Order!

The Hon. M.J. WRIGHT: We look forward to the opportunity of having a competitive—

Mr Williams interjecting:

The SPEAKER: Order! I warn the member for MacKillop. The member for MacKillop is warned.

The Hon. M.J. WRIGHT: —environment which will allow an independent board to bring down the average levy rate but, of course, it will be their decision unlike what happened under the former Liberal government.

WORKCOVER CORPORATION

Mr WILLIAMS (MacKillop) (15:18): My question is to the Minister for Industrial Relations. Has the financial position of WorkCover deteriorated even further in recent weeks? Does the minister agree with WorkCover's Chief Executive Officer that the organisation faces a deteriorating financial position and that its failure to reduce the rate at which employees return to work has come at great social cost? Page 8 of WorkCover's 2006-07 annual report states:

> South Australia had the lowest return to work rate of all jurisdictions at 78 per cent—well below the national average. At six months after a work-related injury, the proportion of South Australians still receiving income maintenance payments was more than double the Australian average. 'Ineffective return to work for injured workers that remain dependent on compensation for long periods of time comes not only at significant economic cost but also at great social cost' said WorkCover CEO, Julia Davison.

Ms Davison is also quoted in the report as saying:

> Without rapid and significant improvement in return to work rates, leading to an improvement in the number of injured workers returning to work, the funding position of the Scheme will further deteriorate and South Australian businesses will continue to face unacceptably high WorkCover levies.

The Hon. M.J. WRIGHT (Lee—Minister for Industrial Relations, Minister for Finance, Minister for Government Enterprises, Minister for Recreation, Sport and Racing) (15:19): The government takes note of the actuarial advice, which occurs twice a year; the member is fully aware of that. I am not sure whether he was asking me about Mr Carter or Ms Davison, so I will answer that they are both doing a good job and that the government has every confidence in the work being undertaken by the chairman, the board and the chief executive officer.

In regard to return to work, it is no secret—and has not been for a decade or more—that, in relation to return to work, we are not doing well enough in South Australia. That is why we are having a review.

EYRE PENINSULA WATER SUPPLY

Mrs PENFOLD (Flinders) (15:20): Thank you, Mr Speaker.

Members interjecting:

The SPEAKER: Order! The member for Flinders.

Mrs PENFOLD: My question is to the minister for water insecurity. On 25 September, the minister, in response to my question regarding the poor quality of water and pipe calcification being experienced on Upper Eyre Peninsula, and costing people thousands of dollars, said:

I will be seeking advice from SA Water on what it is doing, and I will bring back to the house and to the member a detailed explanation as to the actions that SA Water is undertaking as a consequence of those issues regarding the blockage of pipes.

I have not yet heard from the minister. However, SA Water—

The Hon. K.A. MAYWALD: I rise on a point of order, Mr Speaker .

Mrs PENFOLD: —at the closed consultation meetings at Streaky Bay—

The SPEAKER: Order!

The Hon. K.A. MAYWALD: I missed the question. Will the member repeat the question?

Members interjecting:

The SPEAKER: Order! Members on my right will come to order. I ask the member for Flinders to repeat the question.

Members interjecting:

The SPEAKER: Order! Members on my right will come to order.

Mrs PENFOLD: If it was costing you thousands of dollars, you would scream. On 25 September, the minister, in response to my question regarding the poor quality of water and pipe calcification being experienced on Upper Eyre Peninsula, and costing people thousands of dollars, said:

I will be seeking advice from SA Water on what it is doing, and I will bring back to the house and to the member a detailed explanation as to the actions that SA Water is undertaking as a consequence of those issues regarding the blockage of pipes.

I have not—

The Hon. P.L. WHITE: On a point of order—

Mrs PENFOLD: —yet heard from the minister.

The SPEAKER: Order! The member for Taylor has a point of order.

The Hon. P.L. WHITE: I do not believe that there was a question. It sounded like a statement, and the member is now going on to give an explanation. I do not believe that there was a question.

The SPEAKER: Order! If the member for Flinders comes to the table, I will assist her with her question.

Mrs PENFOLD: Mr Speaker, I just say that I would like an answer to my question I asked previously.

Members interjecting:

The SPEAKER: Order! The member for Flinders will take her seat. I could not actually hear a question being asked. There was what appeared to be a restatement of an answer the minister had given, but not a question. If the member for Flinders comes to the table, I can look at it. In the meantime, I call the member for Morphett.

Mrs PENFOLD: I will rephrase it, if you like, Mr Speaker.

The SPEAKER: The member for Morphett.

SOUTH ROAD UPGRADE

Dr McFETRIDGE (Morphett) (15:23): Thank you, Mr Speaker.

Members interjecting:

The SPEAKER: Order!

Dr McFETRIDGE: My question is to the Minister for Transport. Has the $300 million South Road/Port Road/Grange Road underpass project been scrapped and replaced by a $28 million road widening project? The 2006-07 budget papers show that $28 million is to be spent on the reconstruction and upgrade of South Road, between Grange Road and Torrens Road, to allow South Road traffic to continue uninterrupted past the Grange Road-Manton Street intersection, the Port Road intersection and the Outer Harbor corridor.

In evidence given to the Budget and Finance Committee on 8 October 2007, Rod Hook stated that the $28 million is being used for property acquisition. At the same meeting, Mr Hallion stated that, 'It is a road widening project.' When referring to the Port Road underpass project, Mr Hook, 'We are unlikely to progress much further on any design works, concept design work or engineering design work.'

The Hon. P.F. CONLON (Elder—Minister for Transport, Minister for Infrastructure, Minister for Energy) (15:24): The question (although the explanation did not bear any great relationship to it) was: have we abandoned the South Road/Grange Road underpass work? No, definitely not. I cannot imagine what would lead you to that conclusion. In fact, I would go so far as to say that, if the opposition spokesperson had paid any attention to what was going on in the federal election, he would have found that not only have we committed to those future works but, as a result of a campaign that we ran with the major lobby groups in South Australia—the freight council, the RAA, SARTA, the Committee for Adelaide Roads—we have a commitment from the federal Liberal government and the federal Labor opposition to become our partners in fixing the north-south corridor. Both have referred to committing a billion dollars with us for the project. I have to say, those are not the circumstances when you stop doing something.

This was one of the most successful joint lobbying campaigns ever undertaken. It was done even with the begrudging support of the Leader of the Opposition and, believe me, it was very begrudged. But, the truth is that we are now in a position where we will have a very significant partner in those works. So, far from it being the case that we have abandoned them, I would have thought that we should be congratulated on that achievement, for tackling a problem that your government, of course, never went near because it was much too difficult. I got an interesting email the other day about the tram project. It said, 'Thank God, it wasn't built by the Liberal government; it would have gone one way in the morning in a different way in the evening.' It was very good.

An honourable member interjecting:

The Hon. P.F. CONLON: The interjection, 'If we had a Treasurer that could manage a budget'—with six surpluses in a row against nine deficits in a row. Six surpluses against nine deficits, and they want to compare budgets! The truth is that, not only are we committed to the north-south corridor, there are also processes of road widening in it. The member for Morphett's question was as notoriously difficult to understand as they always are. I will try to discern what his true meaning was, but there are undoubtedly roadworks in the north-south corridor. We will have a big partner in the commonwealth, and there are road widening works on South Road as well, some of which I know have the enthusiastic support of the member for Croydon, who is the local member. I will try to discern a meaning from the member's question and bring some detail back for you.

GRIEVANCE DEBATE

GLENSIDE HOSPITAL REDEVELOPMENT

Ms CHAPMAN (Bragg—Deputy Leader of the Opposition) (15:28): Recently, the government announced a $100 million redevelopment of the psychiatric hospital facility at the Glenside campus of the Royal Adelaide Hospital, formerly a hospital which stood independently since 1870 in this state, having previously been the Parkside psychiatric hospital. It has a proud record of delivery of service to South Australia for people with mental illnesses, and it has served the community statewide for some 140 years. The redevelopment, or promise to rebuild a contemporary psychiatric facility for a South Australia's mental health patients, was welcomed.

However, the proposal, which has been announced, is that, in addition to building a new psychiatric hospital, there will be a significant reduction in bed capacity in the hospital based on the claim that some services are being transferred to other facilities. It has also been announced that the government will rent out the heritage area, which is currently on the site, some of which is vacant and some of which undertakes psychiatric administration services. Nearly 50 per cent of this 30 hectare site will be sold for private, commercial, retail and private housing projects. Interestingly, the announcement included a significant area of hectares fronting Fullarton Road, which is being

offered as a first option to the Frewville Shopping Centre owners, which are neighbours to the facility, only divided by a heritage wall. Services are provided for mental health, as I said, all across South Australia, not only available to metropolitan residents, but it is the only facility available to country residents. So, it plays a very significant role.

It has announced that it proposes to remove the aged patients (who will be relocated at various places) but will add a facility for drug and alcohol services after the sale and consolidation of three other sites in metropolitan Adelaide. It will privatise the assessment process (that is going off for someone else to do) and bulldoze an undisclosed number of trees on the site. We have had assurances from the Premier that he is committed to trees, that he loves trees, but, of the 299 trees on this site (165 of which are significant), we have had no indication of the number that will be removed or damaged or, in some way, be the subject of relocation; neither have we had an undertaking from the government that it will not remove any trees until there has been full consultation with the community.

Well, the consultation process has started (of a sort). There have been two public meetings in the last couple of weeks and, not surprisingly, the local community has a lot of questions regarding what will happen to their trees, regarding the design and density of the proposed housing precinct, the security that will be available with the introduction of drug and alcohol patients, and access they may have to the public area. They have questions regarding what will happen with schools and local community groups who use the oval, which will be covered up by a shopping centre, and what will happen with the traffic and roads to be opened in and out of the site, which is currently accessible only through residential facilities for aged persons, and the like. These are all legitimate questions for which they are seeking answers.

The Minister for Mental Health and Substance Abuse has promised a consultation period and Commissioner Cappo has advised the government, in his report, of his support for this concept. He says that it is important to open the site and bring in the wider community. I do not see anywhere in his report where it says that, for the mental health of South Australia, we need another supermarket in Glenside when, at the other end of the suburb, there is one of the biggest supermarkets, cafe and retail shopping facilities in the state—in fact, I think the supermarket at the Burnside shopping centre actually has the biggest turnover in South Australia. Nevertheless, he says that it is important.

I do not know where he has been for the last 10 or 20 years when we have taken down the ha-ha walls and members of the public have been using these facilities. What is absolutely unconscionable is the announcement by the government that it will proceed with this development by ministerial PAR, and cut out and silence the voice of Burnside.

Time expired.

RETAIL SERVICE

Mrs GERAGHTY (Torrens) (15:33): A constituent recently came into my office to express concerns over the failure of a new split system airconditioner that she had purchased from a prominent cash-and-carry retailer. It failed to work correctly. The unit was installed and the installation double-checked by the installer but, unfortunately, the airconditioning unit did not work properly; it would come on for a few minutes and then turn off and would not restart for two hours or more.

My constituent complained to the cash-and-carry retailer, who then referred her to the manufacturer's service number. She was put in contact with the company's service technician, who came out to look at the unit. The service technician replaced the thermostat but all to no avail. He then suggested that the unit's logic unit may be faulty, but was not sure where he would go to get one.

After more than a month of trying to resolve this issue herself, the constituent came into my office and one of my staff spoke to the retailer, who referred us to the regional sales manager for the manufacturer. He then referred us to the national service manager for the manufacturer and, in doing so, suggested that the national service manager should be told that the unit be replaced. This we did, and the national service manager said he would investigate the matter.

A representative then rang us back to say that the inside unit of the airconditioner would be replaced. Although he did suggest that the problem may well be the location of the indoor unit, the manufacturer was prepared to replace the indoor unit to see whether this would fix the problem. We have taken some photographs of the airconditioning unit to check its positioning, and whilst I am no expert on this matter, it seems to me that there is no obvious problem with its location.

Hopefully the replacement of the inside unit should see the problem resolved. My office then spoke to my constituent and advised her of all this. She told us that the service technician had called her to say that the inside unit would be replaced.

She told us that the new unit would be installed within days; and this was some two weeks ago. Unfortunately for her the saga continues. Despite the commitments given, she still awaits the replacement of the inside unit. These unfortunate events have left a 78 year old pensioner very distressed, and I have to say that I am quite angry. My office contacted the manufacturer last Friday and was told that the wrong component for the split airconditioning unit had been sent to Adelaide.

The outside unit rather than the inside unit had been sent. We were assured that an inside unit would be despatched that day. Subsequently, my constituent received a call on Monday that the inside unit had arrived in Adelaide this week. Thinking that her problems were starting to be addressed, she was feeling somewhat relieved, but, alas, no-one made sure that the service technician was available to install the unit immediately. Again, she has been let down. My office contacted the local sales manager for the airconditioning manufacturer to point out how farcical the service provided to my constituent had been.

The local sales manager has given my office a commitment to resolve the issue as soon as possible, but I await with some trepidation for this to be done. As of this afternoon, I understand that the manufacturer cannot contact its sole repairer. The question is: what do I think needs to be done? Certainly we need to reinforce with the public that both the retailer and the manufacturer of goods sold to the general public have a responsibility to sell goods in good, working condition and in accordance with the specifications that both the retailer and the manufacturer said they would be, that is, if you want a product to undertake a certain function, you make that clear to the retailer and it recommends a product to meet that need.

The retailer has a legal obligation to ensure that the product does in fact meet that need. I would say to anyone purchasing from a retailer—particularly a large one—that they ask about the service that will be provided to support the item they are buying. In this case, while the item might have been cheaper, the problem is that there is no support—certainly not to my constituent. Everyone has had the run around. My office has had the run around. Certainly we will again phone them later this week and, if they have not done the right thing by my constituent, I will feel somewhat obliged to name them.

Time expired.

TRAMLINE EXTENSION

Dr McFETRIDGE (Morphett) (15:38): I would like to talk about our new trams, again. It is not quite a weekly update, but I will keep giving updates as long as they are required. It is bouquets and brickbats today. First, the bouquets. It is an undisputed fact that the new trams have been very popular. Thousands of people have been on the new trams. Can I just say, 'I told you so.' I have always had that belief, and I have said in this place for four years that light rail is the answer to modern public transport in Adelaide. The only problem is getting off and on the trams, as well as trying to get a seat at times. The new trams have excellent brakes, and I can vouch for that.

They have a couple of different sorts of brakes. They have electric brakes and a magnetic brake. I know this because, last Friday morning after leaving this place, I was not quite thrown to the ground but certainly I had to hang onto some of the poles. In fact, I was late for a meeting with the Premier at Brighton High School because of this. A stupid fellow stepped out in front of the tram on King William Street and the whole tram came to an absolute stop on a dime, and that was because of the new trams' modern brakes—electric and magnetic brakes. Fortunately, no-one was hurt. The crew was changed. The driver had to go because he was very shaken up by that idiot's actions.

It was a near miss. I hope that people do get used to the fact that trams are there. They are very quiet and sometimes difficult to hear, particularly with the other background noise. I hope that people do not step out in front of them because someone could get severely injured. I will give a big plaudit to the staff—the conductors, drivers, and also the assistants who have been helping out at the tram stops both down in my electorate in Morphett and in Adelaide, because they have been doing a terrific job. They have been very helpful and have been giving a lot of advice and assistance to regular users, visitors to town and also those who are just there for a bit of a sticky beak, for want of a better description. I hope people continue to use the tram as a regular form of public transport. I have used it just about every day since the extension has been opened.

However, it does have some issues. First, we paid over $5 million for each of these trams, yet they still go to Victoria Square: you cannot change the destination sign on the tram to City West. We can do it with buses and the old trams—they only went to Victoria Square and Glenelg, so you could wind it down—but we have $5 million worth of tram and we cannot change that. That begs the question: didn't we plan to extend the tram line anywhere else? Didn't we plan to extend the tram line beyond Victoria Square at any stage whatsoever? Maybe that was not the case, and I can understand only from Glenelg to Victoria Square, but you would think that on a $5 million tram you would be able to program not only the destination indicators on either end of it but also inside the tram.

Talking about inside the tram, the announcements still say that the next stop is stop 19 at Brighton Road, and then we go down to stop 21 at Moseley Square. Stop 21 at Moseley Square is now stop 17, and it goes all the way back to South Terrace when we change to South Terrace, City South and so forth. So, next time we buy some trams, can we make sure we can program them?

I was very concerned yesterday when the tram I was on ran a red light. I understand the red T means stop. I have been told by other people that trams are running red lights, and I understand this is so they can maintain schedules. I know that tram drivers are doing their absolute best to drive as safely as possible, but I hope they are not being forced to do anything they should not do.

I want to talk about the tram shelters. The day before yesterday (Monday) it was raining when I came to parliament. The tram stopped at the tram stop but only two of the doors were under the shelter: the third door was out in the rain. I have not actually stepped out and measured the length between the tram doors and the tram shelter, but I hope that was a consideration and that they actually cover all three doors when they stop.

The other problem I had was this morning I caught the quarter past 10 tram from Glenelg into town. Instead of getting here at seven minutes to 11, it got here at 1 minute past 11, so I was late for parliament. If we cannot run them on time, let us look at the programming and the schedules and do something about it so that people are attracted to a reliable and safe public transport system—not only the trams, but also the trains and buses. They do need to interconnect, because people have appointments they need to keep.

WATKINS, Mr J.

Ms BEDFORD (Florey) (15:43): On 17 October, South Australia learned of the passing of one of its most influential adopted sons. Although I knew Jack Watkins, I did not know him as well as many so, on their behalf, it would be an honour to place on record a tribute to someone who all of us privileged to know him would wholeheartedly agree was a great man.

I say 'adopted son' because Jack Watkins was born in Manchester, England 10 years before World War II ended. During the family eulogy I learnt that Jack was a twin at birth, and that he remembered hiding in caves during the bombing, watching the glow of war in the sky. He and his family lived in a cave when their home was destroyed and eventually moved into a vacant house where, in years to come, he began his own family. Jack married his sweetheart, Cathy—or Cath, as most of us knew her—in 1955, and they had two sons, Bill and Paul. In 1966 Jack and Cath and their sons left their family and friends to emigrate to Australia on board a ship called the *Fairsea*. During the six week crossing the young family enjoyed shipboard life and the sights of new worlds.

They disembarked in Adelaide to start their new life and, after 18 months living in the Pennington hostel, they rented for a few years until they had enough to buy a block of land in the north-eastern suburbs where I first met them, because it was there where they built their home in Ridgehaven and where Jack eventually passed away. We all hope that Jack is now with his beloved Cath, who passed away in 1993. What helped him greatly in the years without Cath was his family, and particularly through Bill and his daughter-in-law, Carlye, his beloved grandchildren Christie, Brent and Ebony, whom he adored. Cath's death was a great blow for Jack and he struggled for years with her loss and in many ways never recovered. They were very close and loved each other dearly.

Through her working life I had met and known Cath a little through her participation and work in the ALP. Like Jack she was proud of the party and they both knew that the ALP, founded by workers in their struggle for fair wages and conditions, was the means to a better and more just society. I respected her as much as Jack, knowing that she too was always as good as her word, never wavering from her beliefs and undertakings, honest, true and caring.

During his life Jack cared not for himself but, rather, for his family and others. Proud of his working heritage, Jack worked in mines from the age of 13 surrounded by the poisons and harsh working conditions that he fought for the rest of his life. He learnt the lessons of exploitation, no doubt the hard way, and Alan Harris, obviously a close friend and collaborator, gave a personal and very moving account of life with Jack, which we all knew could sometimes be hair-raising. Alan recounted adventures with Jack. One I had had was a night out with Jack on a ladder, putting up election posters. After a few hours we realised that Jack's keys were missing and we spent the rest of the night scouring grass and gravel looking for the keys—which as far as I know are still missing.

Alan also had tales of being on picket lines with Jack and evening expeditions to uncover unsafe work practices and locations harbouring asbestos, that silent killer used by greedy companies to make a profit in such a deadly manner. It was Jack's work raising awareness about the dangers of asbestos and the struggle for compensation and justice for those afflicted by the sinister and terrible effects of exposure to it that is legendary, and earned him the soubriquet 'Asbestos Jack'. He was fearless in his pursuit of its detection and safe removal. He will always be remembered for his dedication and determined contribution to the eradication of this lethal substance.

In this pursuit, Alan recounted the uncanny way Jack had of getting information, invariably accurate and detailed information, that many concerned had hoped would never see the light of day. He also told the story of the day that Jack convinced the then doubting members of parliament of the dangers of asbestos. They soon believed, as a fine layer of dust floated down from the public gallery.

A proud unionist, Jack made sure that when he started in the Plumbers, and eventually through to the BLF, that he never forgot his working class heritage. He also made sure that every worker he ever encountered knew that labour was the valuable means by which all industry functioned and prospered. He always did his best to make sure that there was truly a fair go for all, and up to his death maintained the struggle for workers' rights.

He was particularly angry and upset about the current situation workers face, and was passionate that everyone in the Labor Movement double their efforts to take the message to today's workers about the situation they may face or may already be facing through the legislation known as WorkChoices, which Jack felt was no choice at all. Today we farewelled Jack at a service led by Mr Ian Wood and directed by Kaylene of White Lady Funerals, both of whom have assisted me with information for this contribution. Jack's legendary status within the ranks of the Labour Movement was reinforced by the number of trade unions represented at the service. To the strains of 'Hit the Road, Jack', and with apologies to those I did not see in the overflowing gathering at Centennial Park's Heysen Chapel, secretaries and members of many unions, the CFMEU, the AWU, the NUW, the AEU, the CEPU, the CPSU, the ASU, SA Unions and RUMA (the Retired Union Members Association) all paid their respects.

Also present were past and today's members of state and federal parliament and representatives from local government, in particular Johanna McLuskey from the City of Port Adelaide Enfield, who during her time as mayor of that city oversaw the development and opening of the Jack Watkins Park at Kilburn in honour of his work for that community. Many other of his community connections were also present, and I know Jim Doyle and a good number of other comrades were not able to be there. They were there, though, Jack, in spirit. Jack will be greatly missed. Vale comrade.

Time expired.

MOUNT LOFTY RANGES WATER CATCHMENT

Mr GOLDSWORTHY (Kavel) (15:49): I rise in the house this afternoon to speak on a particularly serious issue in relation to the water resources in the Mount Lofty Ranges region and, in particular, issues that have come to the fore in my specific electorate. This relates to the prescription process that the government is currently undertaking concerning the Western Mount Lofty Ranges water catchment area. The government has a bit of form in relation to this particular issue, in terms of the initial process that was undertaken in making the decision to prescribe the region and in relation to the community consultation process at the outset. I have highlighted this issue in the house previously, as has the member for Heysen, concerning the actual consultation that the government supposedly undertook. The community consultation process was really a communication of decisions that had already been made. However, we have moved past that stage in the process, and we have reached the point where the water allocation plan has to be formulated.

As a preliminary step in the water allocation plan process, a committee has been established to look at this aspect and will consult through the NRM board. More recently, a letter has been sent to key stakeholders—people involved in the issue: farmers, primary producers and affected parties. A letter and an information pack has been distributed to all those different people and organisations, and a series of public meetings are being held. Some were held last week, I understand, in the Fleurieu region (of which the member for Finniss would be aware). A meeting was held at Gumeracha last week, which I attended, and also at Hahndorf last night. I understand that two or three more meetings are to be held.

One only had to attend the meeting at the Gumeracha Town Hall last Thursday evening to gauge the level of concern that this part of the process is causing. The hall was packed to the rafters. I estimate that 300 plus people would have attended the meeting, which is an obvious indication of the level of quite significant concern that the local people have in relation to this issue. As the meeting proceeded, workshops were formed in relation to some key specific issues. It was all very well managed by the chairman of the local NRM board.

However, the quite specific point is that, if the government, the departments and the NRM board do not get this right—if they do not get the water allocation plans to all the individual primary producers in the Adelaide Hills—there is a real risk of destroying that region as one of the prime agricultural and horticultural districts of the state. I have spoken about this issue previously. The Adelaide Hills is a highly productive agricultural and horticultural district in South Australia. If the government, the bureaucracy and the people associated with making these decisions get it wrong, there is an enormous potential to destroy the Adelaide Hills region as we know it.

What makes the Adelaide Hills so attractive, not only to the people who farm and live there but also those who visit on a regular basis, is the open space. The only way in which we will maintain open space in the Hills district is to have viable farming operations, and these operations rely fundamentally on the satisfactory supply of water. If their water is cut off or a mistake is made in the water allocation plan it will destroy these people and their livelihoods, and it will also destroy the very environment of the Adelaide Hills which we all enjoy. That is the risk that the government and the bureaucracy take if they make a mistake with respect to this water allocation plan.

The 350 people who attended the meeting at Gumeracha and all the other people who have attended previous meetings, and those who will attend meetings in the future, share those same concerns. If one looks at a map of the affected area, one will see that it runs from the northern part of the Adelaide Hills right down through the Hills region into the Fleurieu. I know that the member for Schubert takes in the northern part of the Hills, and the member for Heysen and the member for Finniss also share my concerns.

Time expired.

WITH ONE VOICE

Ms SIMMONS (Morialta) (15:55): I was very privileged last week to launch a new book called *With One Voice* written by two dear friends: school teacher extraordinaire, Campbell Whalley, and Pappa Reg Dodd, elder of the Arabunna people in the Far North of this state.

The book is a story of reconciliation, not one of rhetoric or policy but a reflection of a 'just do it' program between two schools which commenced in October 1995. Campbell Whalley, a former game warden in Africa and a geography teacher at Pembroke School with a bent for practical escapes from the classroom, took 20 students to the Far North of the state. They called in at the Arabunna Aboriginal Cultural Centre and Reg welcomed the group, striking up a lasting friendship with Campbell.

Campbell had a vision that great things could come from the trust and friendship that the two men developed. Driven only by hope and mutual respect for each other and each other's cultures, Reg and Campbell worked collaboratively to move hundreds of young South Australians from their two schools to build a new understanding and new processes that allowed for everyone to walk together and create better tomorrows.

Although aimed at the schoolchildren, many families from both ends of the state were included in the practical delivery of this active reconciliation program which has to be one of the true success stories in reconciliation in South Australia. We were one of those lucky families, my daughter Katie being one of the original focus group followed closely by her brother Matt. This connection between two unlikely schools worked because Reg and Campbell allowed an easy and unforced relationship between students in both communities to unfold.

All the adults took a back seat but still provided support if it was needed. The primary focus was for the students to work and play well together and allow true understanding and sincere friendships to evolve naturally. The adults remained mindful that all the activities needed to be purposeful and allow students to learn about their communities, personal lives and aspirations, even their hopes and fears.

It was also imperative for the Marree students to develop an understanding of the world at large, the world unfamiliar to them that existed beyond Marree through the eyes and hearts of their Pembroke friends. Equally important was for the Pembroke students to appreciate issues involved with living in an isolated Outback community, especially if you had an indigenous heritage. Amazingly, the obvious differences generally did not pose any difficulties and students remained open and aware, assisting each other's journey into the unknown. Incidental learning seemed as important and as meaningful as any that was structured and planned.

On retirement from Pembroke, Campbell Whalley has been teaching at Marree and he has expanded the original reconciliation program to take in Dr Jane Goodall's (one of our thinkers in residence) Roots and Shoots program. Campbell and Jane had known each other back in Tanzania many years ago and reconnected during her visit to Adelaide in 2006. Roots and Shoots builds on this early work and ensures the creation of a better world for all living things. It is about making positive change happen.

Campbell Whalley has now turned 70. He says that he is retiring again. There are many families throughout our state who will be forever indebted to him for changing our lives. He is one of life's optimists. He believes that hope and peace are values we can teach our children even in this materialistic world. He shows children how to dream and then how to make dreams come true. I recommend *With One Voice* to the house and I thank Reg Dodd and Campbell Whalley for all they have done for reconciliation in this state over the past 12 years.

STANDING ORDERS SUSPENSION

The Hon. P.F. CONLON (Elder—Minister for Transport, Minister for Infrastructure, Minister for Energy) (15:59): I move:

That standing orders be so far suspended as to enable me to introduce a bill without notice.

The ACTING SPEAKER (Mr Koutsantonis): I have counted the house and, as an absolute majority of the whole number of members of the house is not present, ring the bells.

An absolute majority of the whole number of members being present:

Motion carried.

SANTOS LIMITED (DEED OF UNDERTAKING) BILL

The Hon. P.F. CONLON (Elder—Minister for Transport, Minister for Infrastructure, Minister for Energy) (16:01): Obtained leave and introduced a bill for an act to give effect to a deed of undertaking made by Santos Limited in favour of the Premier, for and on behalf of the Crown, in right of the state of South Australia; to repeal the Santos Limited Shareholdings Act 1989; and for other purposes. Read a first time.

The Hon. P.F. CONLON (Elder—Minister for Transport, Minister for Infrastructure, Minister for Energy) (16:01): I move:

That this bill be now read a second time.

A 15 per cent shareholding restriction was placed on Santos Limited in 1979 to prevent a hostile takeover of Santos by Alan Bond. The basis for this original legislation was to secure the state's gas supplies in the Cooper Basin. Significant developments have occurred in energy markets since the introduction of the 1979 act. The Cooper Basin is now a mature asset, and the state is now no longer totally reliant on the Cooper Basin for its energy supplies, with competing gas supplies now available from Victoria, through the SEAGas pipeline, and from Queensland, through the gas hub at Moomba. The 1979 act was replaced in 1989 with the Santos Limited (Regulation of Shareholdings) Act 1989, which applies while Santos Limited produces petroleum in South Australia.

Santos has matured significantly as a company since that time. It is now a global gas producer, with projects throughout Australia and overseas. The Cooper Basin, while accounting for around 80 per cent of Santos's South Australian based staff, now accounts for only 23 per cent of Santos production and 17 per cent of its reserves. Santos has substantially increased its corporate

presence in South Australia over the years. This has been a commercial decision by the company, as there are no restrictions in existing legislation which require Santos to maintain its head office in South Australia. Earlier this year, Santos Limited requested that a formal review be undertaken into the act on the basis that it believed that the shareholding restriction was limiting its ability to grow.

A review was undertaken with the assistance of the Economic Development Board, and consideration was given to the original intent of the legislation, the impact of the cap on the future growth of Santos, potential risks from the removal of the cap, energy security issues and regional development implications. The review recommended the removal of the cap on the basis that the original basis for the introduction of the legislation in 1979 was no longer valid.

The government has consistently stated that it would consider the removal of the share cap only if the state could be assured that it was in the interests of the people of South Australia. As members would be aware, Santos is an outstanding corporate citizen in South Australia, investing millions in oil and gas exploration and production each year, employing well over 1,000 people, and providing substantial corporate sponsorship. To reinforce Santos's ongoing commitment to the state, it has provided a deed of undertaking in relation to its ongoing corporate presence in South Australia. The deed of undertaking offered by Santos provides three fundamental commitments. These include:

- guarantees that effectively 90 per cent of the current South Australia-based roles stay here, which includes all the roles at our major South Australian operational sites. This equates currently to approximately 1,700 jobs in South Australia;
- a Social Responsibility and Community Benefits fund of some $60 million over 10 years to be applied to a range of sponsorships, including support for the Royal Institution, indigenous programs and educational scholarships; and
- these commitments are supported by a $100 million legally enforceable compensation mechanism should there be a significant reduction in corporate presence.

The shareholder cap will be removed 12 months after assent has been given to the passage of this bill. This is at the request of Santos, which sought a period of orderly transition.

I today table a copy of the deed of undertaking to the Premier for and on behalf of the Crown in right of the state of South Australia. This is a good outcome for South Australia and for Santos, which ensures a continued strong corporate presence by Santos to South Australia and provides the company with the flexibility to grow and pursue new opportunities. I commend the bill to members. I seek leave to insert into *Hansard* the explanation of clauses without reading them.

Leave granted.

Explanation of Clauses

1—Short title

This clause is formal.

2—Commencement

The commencement of the measure is to operate in a manner consistent with clause 1 of the Deed. In particular, the Bill provides for the removal of the Share Cap to be effective 12 months from the date on which it receives assent as an Act. The removal will be effected by the repeal of the Santos Limited (Regulation of Shareholdings) Act 1989.

3—Interpretation

This clause provides for a definition of the Deed, being the Deed of Undertaking made by Santos Limited (ACN 007 550 923) in favour of the Premier for and on behalf of the Crown in right of the State of South Australia, as tabled in the House of Assembly.

4—Ratification and effect of Deed

The Bill provides for the Deed to be ratified and approved by the Parliament. The measure will also expressly provide that the Deed will have full force and effect and will ensure that it is binding and enforceable by virtue of the enactment of this law. The Deed will be enforceable by the Premier acting for and on behalf of the Crown in right of the State.

5—Effect of Act

This clause will ensure that the enactment of this measure does not in itself give rise to a termination of the Deed under clause 3.2(a)(2) of the Deed.

6—Evidence

This is an evidentiary provision.

7—Repeal

This clause provides for the repeal of the Santos Limited (Regulation of Shareholdings) Act 1989, subject to the operation of clause 2.

Debate adjourned on motion of Dr McFetridge.

STATUTES AMENDMENT (PROHIBITION OF HUMAN CLONING FOR REPRODUCTION AND REGULATION OF RESEARCH INVOLVING HUMAN EMBRYOS) BILL

The Hon. J.D. HILL (Kaurna—Minister for Health, Minister for the Southern Suburbs, Minister Assisting the Premier in the Arts) (16:07): Obtained leave and introduced a bill for an act to amend the Prohibition of Human Cloning Act 2003 and the Research Involving Human Embryos Act 2003. Read a first time.

The Hon. J.D. HILL (Kaurna—Minister for Health, Minister for the Southern Suburbs, Minister Assisting the Premier in the Arts) (16:07): I move:

That this bill be now read a second time.

I seek leave to have the second reading explanation inserted in *Hansard* without my reading it.

Leave granted.

Parliament is being asked to consider amendments to the South Australian Prohibition of Human Cloning Act 2003 and Research Involving Human Embryos Act 2003 to bring these Acts into line with the equivalent recently amended Commonwealth Acts. The amendments to both Acts are contained in a single Bill, the Statutes Amendment (Prohibition of Human Cloning for Reproduction and Regulation of Research Involving Human Embryos) Bill 2007, and it is proposed that they be considered in a cognate debate.

Human cloning and embryo research legislation has been subject to a conscience vote in every jurisdiction, including in the South Australian Parliament, when the Bills for these Acts were first debated in 2003. This Bill raises important moral and ethical questions that require deep consideration, and I note that both major parties have accorded their members a conscience vote on the amendments to the South Australian laws.

The national scheme and recent changes

The Commonwealth Acts were passed in 2002, and the South Australian Parliament passed equivalent legislation in 2003. The original Commonwealth legislation prohibited the creation of embryos for research, allowed research using embryos donated to research by couples who had completed their infertility treatment, but restricted what could be done with such embryos; the current South Australian laws are consistent with this original model.

The Commonwealth legislation, together with equivalent legislation in all States and Territories and the National Health and Medical Research Council Embryo Research Licensing Committee, creates a national legislative scheme for prohibiting human cloning and regulating embryo research. This national scheme regulates the use of human embryos that are excess to fertility treatment and hybrid embryos, but not animal embryos nor human embryonic stem cells. The Commonwealth amendments extended the national scheme to also regulate embryos created by means other than fertilisation and human eggs used for such processes. In South Australia, clinical reproductive medicine practice is separately regulated by the Reproductive Technology (Clinical Practices) Act 1988.

The national scheme needs to be responsive to developments in technology and shifts in community attitudes and standards. For that reason, the Commonwealth Prohibition of Human Cloning Act and the Research Involving Human Embryos Act included requirements for a 3 year review. The Review, chaired by the late John Lockhart AO QC, was conducted in 2005 and held consultations around the country. South Australian experts, academics and community representatives contributed to the inquiry.

On the basis of their consultations and background research, including into community attitudes to embryo research, the Lockhart Review made 54 wide ranging recommendations. The Review proposed changes to legislation to extend embryo research to allow the creation of embryos for research, but recommended that the prohibition on the creation of embryos by fertilisation for any purpose other than assisted reproductive medicine procedures be retained. They also recommended that certain research procedures be permitted on embryos created through laboratory techniques, but not on embryos created by the fertilisation of an egg by a sperm. Most of the recommendations aimed to streamline current processes for embryo research licensing and to strengthen oversight.

The recommendations of the Lockhart Review were referred to the Australian Parliament and the Council of Australian Governments in December 2005. Some recommendations required changes to legislation while others related to national policies and procedures. A Private Member's Bill tabled by Senator the Hon Kay Patterson reflected almost all the Lockhart Review's recommendations for legislative changes and was passed by the Australian Parliament on 12 December 2006. The Commonwealth amendments were promulgated on 12 June 2007.

Human reproductive cloning remains prohibited in Australia. The Commonwealth amendments retained limitations on research and training using embryos created by fertilisation, but now permit the creation of embryos for research by means other than fertilisation whilst prohibiting the implantation or development of any embryo created in a laboratory for more than 14 days.

Corresponding Act status

The Commonwealth legislation makes provision for the Minister for Health and Ageing to declare a State or Territory Act corresponding for the purposes of the national scheme. State and Territory laws rely on the NHMRC Licensing Committee established under the Commonwealth legislation to licence embryo research. Only a corresponding State law can effectively confer regulatory powers and functions on the NHMRC Embryo Licensing Committee.

When the Commonwealth amendments came into force on 12 June 2007 the Parliamentary Secretary to the Minister for Health and Ageing advised that he had revoked the previous declaration. The South Australian Research Involving Human Embryos Act 2003 then ceased to be a 'corresponding Act', so the NHMRC Embryo Licensing Committee can no longer exercise functions under the State Act. If the Act is amended, South Australia will need to ask the Minister for Health and Ageing to determine whether the State Act is corresponding and make a new declaration. This Bill has been drafted to amend South Australian laws to make them substantially the same as equivalent interstate laws (where amendments have already been made). It is expected the amended legislation would be regarded as corresponding with the amended Commonwealth laws.

At the meeting of the Council of Australian Governments in April 2007, the Premier of South Australia, together with his colleagues from all Australian jurisdictions, signed an Agreement that commits all State and Territory leaders to use their best endeavours to introduce corresponding legislation into their legislatures by 12 June 2008 and for all parties to maintain nationally consistent arrangements over time.

State and Territory governments are considering the relevant Commonwealth amendments and their implications for local laws. The Victorian, New South Wales and Queensland Parliaments have amended their equivalent legislation, and Tasmania and Western Australia have tabled amendment Bills. This Parliament now has an opportunity to consider changes to these challenging but important laws.

Coverage of Commonwealth and State laws

Why do we need both State and Commonwealth legislation? Commonwealth legislative powers are not wide enough to cover all agencies and individuals in South Australia that might possibly undertake reproductive technology activities or human embryo research. In summary, the Commonwealth laws cover Australian Government authorities, constitutional corporations, and trade and commerce. The Commonwealth laws do not cover South Australian Government agencies, non trading corporations nor individuals operating outside a trading corporation; these are covered only by the South Australian Acts.

The South Australian and national laws are currently different; embryos can be created under Commonwealth laws that would be unlawful under State law. As Members would know, the section 109 of the Australian Constitution provides that when a law of a State is inconsistent with a

law of the Commonwealth, the latter shall prevail, and the former shall, to the extent of the inconsistency, be invalid. Since 12 June this year, South Australian researchers regulated under the Commonwealth Acts have been able to apply for a licence under the Commonwealth legislation to conduct research that is currently not permitted by State legislation. The corresponding Act declaration has been revoked, so researchers covered only by South Australian Acts are currently not permitted to seek a licence from the NHMRC Licensing Committee.

All current South Australian human reproductive medicine and embryo research and training activity is being conducted within either a corporation (Repromed laboratories) or a university (the University of Adelaide Medical School laboratories). It is thought to be unlikely that future research or training proposals will emanate from facilities that are not a university, a research institute or a corporation. There is, however, some legal uncertainty about whether our universities are constitutional corporations and are therefore facilities covered by the Commonwealth legislation.

To date, no South Australian researchers have sought a licence to conduct human embryo research, but have focussed their efforts on either animal embryos or human embryonic stem cell lines developed elsewhere which do not require a licence. However research teams are planning to apply for such research licences in the near future, and since embryonic stem cell research is often conducted as part of national collaborations, legal clarity and national consistency is important.

If Parliament does not pass this Amendment Bill, then researchers will still be able to apply for a licence to conduct research that is legal under the Commonwealth Acts provided they are clearly operating within a corporation. However the capacity of researchers operating within the university environment to contribute to national research collaborations may be compromised if their legal status remains uncertain.

Amending the South Australian Prohibition on Human Cloning Act and the Research Involving Human Embryos Act to ensure consistency with the equivalent Commonwealth Acts will ensure that, wherever they conduct their work, all South Australian researchers will be covered by substantially identical legislation, providing regulatory consistency where the legal coverage of Commonwealth and State laws is considered uncertain.

Summary of the proposed amendments

The proposed amendments mirror the changes to the Commonwealth laws and apply them to the South Australian Prohibition on Human Cloning Act and the Research Involving Human Embryos Act. The Bill retains a prohibition against human reproductive cloning, which is universally unacceptable, and a strict licensing, monitoring and compliance regime. Not all the Commonwealth amendments need to be reflected in the South Australian Acts as some relate only to the activities of the NHMRC Embryo Licensing Committee established under the Commonwealth legislation.

The Bill amends each Act to include a new definition of an embryo that changes the point of identification from the commencement of fertilisation (which is impracticable to ascertain) to its completion (which is detectable microscopically). The Bill extends the scope to regulate the creation, development and use of all embryos, not just excess ART embryos, and to regulate the use of donated eggs (oocytes).

The amendments differentiate between embryos created by fertilisation of an egg by a sperm for the purpose of creating a baby, and embryos created by technical manipulation of cells and DNA for research and potential therapies. For clarity I will refer to embryos created by fertilisation as reproductive embryos and embryos created by technical manipulation as research embryos.

Creating reproductive embryos for research purposes remains prohibited; they can only be created for the purpose of establishing a pregnancy but couples undergoing infertility treatment will still be able to donate their excess embryos to research.

Strict legislated criteria must be met before a licence will be issued to create research embryos; implanting embryos not created through fertilisation is prohibited.

Neither reproductive embryos nor research embryos will be able to be developed for more than 14 days in a laboratory; this is the point at which the rudimentary nervous system—the 'primitive streak'—first appears.

The amendments required to the SA Prohibition of Human Cloning Act 2003 to ensure it corresponds with the amended Commonwealth Act include:

- changing the name to reflect that it is reproductive cloning that will be prohibited; and
- increasing penalties for breaching prohibitions to 15 years; and
- reclassifying prohibited practices into those completely prohibited and those prohibited unless authorised by a licence.

In general, prohibitions on using reproductive embryos for research will be retained. The 'embryo parents' decide whether to donate their excess embryos to research and the type of research to which they are prepared to donate them, and can set binding conditions on researchers when they consent to their use.

Creating a chimera by adding components of an animal cell to a human embryo and implanting any type of human embryo in an animal will remain completely prohibited. Creating embryos with genetic material from more than two persons or from precursor cells will remain completely prohibited for reproductive embryos, but permitted for research embryos under licence.

Creating hybrid embryos by combining human and animal cells will remain completely prohibited, with the single exception of a diagnostic test for sperm quality which will be permitted only under licence in reproductive medicine clinics. A licence will be permissible for using animal eggs to test the fertilisation capacity of sperm, but embryo development will only be permitted in this case until a detectable change indicates a result, which is the first cell division on day 2.

The amendments required to the SA Research Involving Human Embryos Act 2003 to ensure it corresponds with the amended Commonwealth Act include:

- extending criteria for licences issued for research and training to include the use of embryos not created by fertilisation; and
- clarifying what constitutes proper consent by donors and embryos unsuitable for implantation.

Somatic cell nuclear transfer and other research techniques

The Bill will legalise the creation of embryos under a licence by a range of laboratory techniques now allowed under the amended Commonwealth Acts.

These will include:

- somatic cell nuclear transfer or SCNT, where the nucleus of a human egg is replaced by the nucleus of a somatic cell (a cell from a human body) and the resultant cell is stimulated to develop for 5 to 7 days to blastocyst stage when embryonic stem cells can be removed; and
- parthenogenesis, where a human embryo could potentially be formed by stimulating a human egg to undergo spontaneous activation; such embryos may have the capacity for limited development.

SCNT was used to create ‘Dolly’ the sheep, but since development past 14 days and implantation of such embryos will be prohibited, SCNT in humans will only be licensed to derive embryonic stem cells or for laboratory research, not to produce babies.

Embryonic stem cell research seeks to generate patient matched stem cells for research to enable development of specific cellular therapies with the potential to overcome problems such as tissue rejection, so this process is sometimes called 'therapeutic cloning'. SCNT will also allow the development of embryonic stem cells containing specific disease genes, which may assist better understanding of the causes of disease and identification of drugs and treatments.

Excess ART embryos are not suitable for this type of research because stem cells derived from ART embryos would not be a genetic 'match' to the patients for whom potential cellular therapies were being developed or would not carry the disease in question. However, maintaining and improving the quality and safety of infertility treatment and procedures and minimising the risks to children born of assisted reproductive medicine relies upon excess reproductive embryos generously donated by parents to research and training.

Protections

The Research Involving Human Embryos Act 2003 will retain its stringent licensing and reporting requirements. Before the NHMRC Embryo Licensing Committee issues a licence for research, diagnostic testing or training, very strict criteria must be met, including:

- research ethics approval from the local Human Research Ethics Committee; and
- restricting the number of embryos to that likely to be necessary for the project; and
- the likelihood of significant advance in knowledge, treatment technologies or other applications from the proposed project; and
- evidence of proper informed consent by those donating cells or embryos and their partners; and
- accounting for every embryo licensed and abiding by conditions set by donors; and
- transparent reporting requirements.

The Bill does not change any of these criteria, but strengthens and extends the consent provisions to include all donors whose genetic material is incorporated in the cells used, and their spouses if the embryo is a reproductive embryo.

The Commonwealth Amendment Bill extended the monitoring, oversight and search provisions for NHMRC inspectors. However, the amendments required to State laws are minimal because the South Australian provisions are already more comprehensive than those in other jurisdictions' legislation.

NHMRC Guidelines

Researchers and clinicians are required under Commonwealth and State law to abide by guidelines issued by the NHMRC. The NHMRC has produced criteria to define embryos unsuitable for implantation, and recently revised and released their National Statement and their Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research, which are referenced in the South Australian Research Involving Human Embryos Act 2003.

A clause was added during the Act's passage in 2003 requiring that any NHMRC guideline or policy referenced in the legislation be tabled in Parliament within 3 sitting days from changes taking effect and referred to the Parliamentary Social Development Committee, both initially and each time it is changed. This requirement is unique to South Australia.

The NHMRC reviews and revises its guidelines routinely every 5 years and South Australia keenly engages in its national consultations. The Social Development Committee considered revised NHMRC Ethical Guidelines in 2005, and will consider further revisions to both the NHMRC Ethical Guidelines and the National Statement in 2007. The Social Development Committee cannot in fact change nationally agreed guidelines issued under the Commonwealth NHMRC Act.

The Bill retains the requirement for relevant new or revised NHMRC guidelines to be tabled in Parliament and referred to the Social Development Committee, but extends the time period from 3 to 6 sitting days (which is the usual period in South Australian legislation) from commencement of their operation to allow final printed copies to be procured for tabling in the Parliament.

National consistency and transparency

This is an area of rapid change, not only in research capability but also in community attitudes and standards. Governments and Parliaments have a responsibility to encourage high quality and ethically sound scientific research and medical practice. Society generally needs to be assured that research that uses embryos is strictly regulated under a coherent national scheme. South Australia hosts a recognised centre of excellence for infertility research at the University of Adelaide, and scientists and researchers are seeking the surety of nationally consistent regulation and licensing so the public can be confident that they operate according to nationally endorsed legal and ethical standards, with strict oversight and monitoring and transparent accountability requirements.

This Bill will ensure that further advances in this field are made within a responsible regulatory framework with strong oversight and protections and transparent public reporting. The Commonwealth Acts provide for a further review in 3 years, allowing for continuing Parliamentary oversight into the future.

An explanatory guide with more detailed explanations and fact sheets for the public have been prepared and are available on the Department of Health website.

I commend the Bill to the House.

Explanation of Clauses

Part 1—Preliminary

1—Short title

2—Commencement

3—Amendment provisions

These clauses are formal.

Part 2—Amendment of Prohibition of Human Cloning Act 2003

4—Amendment of long title

5—Amendment of section 1—Short title

These clauses amend the long and short titles of the Act to reflect the fact that the Act, as amended by this measure, will no longer prohibit the creation of human embryos for research purposes.

6—Amendment of section 3—Interpretation

This clause amends section 3 of the Act to replace the existing definition of human embryo with a new definition developed by the NHMRC. It also clarifies that 'human embryo' refers to a living embryo only and does not include a human embryonic stem cell line or a hybrid embryo, and that a reference to a human oocyte is the same as a reference to a human egg.

7—Substitution of Part 2

This clause substitutes Part 2 of the Act. The new Part contains 2 Divisions. Division 1 deals with practices that are completely prohibited and Division 2 deals with practices that are prohibited without a licence issued by the NHMRC Licensing Committee.

Part 2—Prohibited practices

Division 1—Practices that are completely prohibited

5—Offence—placing a human embryo clone in the human body or the body of an animal

This section makes it an offence for a person to place a human embryo clone in the body of a human or in the body of an animal. The effect of this provision is to ban human cloning for the purposes of reproduction. The maximum penalty is imprisonment for 15 years.

6—No defence that human embryo clone could not survive

This section provides that it is no defence that the human embryo clone did not or could not survive.

7—Offence—creating a human embryo for a purpose other than achieving pregnancy in a woman

This section makes it an offence for a person to create a human embryo by fertilisation of a human egg by a human sperm outside the body of a woman, unless the person's intention in creating the embryo is to attempt to achieve pregnancy in a particular woman. The maximum penalty is imprisonment for 15 years.

8—Offence—creating or developing a human embryo by fertilisation that contains genetic material provided by more than 2 persons

This section makes it an offence for a person to create or develop a human embryo by fertilisation of a human egg by a human sperm outside the body of a woman if the embryo contains genetic material provided by more than 2 persons. The maximum penalty is imprisonment for 15 years.

9—Offence—developing a human embryo outside the body of a woman for more than 14 days

This section makes it an offence for a person to develop a human embryo outside the body of a woman for more than 14 days, excluding any time that the embryo's development is suspended. The maximum penalty is imprisonment for 15 years.

10—Offence—heritable alterations to genome

This section makes it an offence for a person to intentionally alter the genome of a human cell in such a way that the alteration is inheritable by descendants of the human whose cell was altered. The maximum penalty is imprisonment for 15 years.

11—Offence—collecting a viable human embryo from the body of a woman

This section makes it an offence for a person to remove a human embryo from the body of a woman, intending to collect a viable human embryo. The maximum penalty is imprisonment for 15 years.

12—Offence—creating a chimeric embryo

This section makes it an offence for a person to intentionally create a chimeric embryo. The maximum penalty is imprisonment for 15 years. A chimeric embryo is a human embryo into which a cell of an animal, or any component part of a cell of an animal, has been introduced. It includes anything else that is declared by the regulations to be a chimeric embryo.

13—Offence—developing a hybrid embryo

This section makes it an offence for a person to intentionally develop a hybrid embryo for a period of more than 14 days, excluding any period when development is suspended. The maximum penalty is imprisonment for 15 years.

14—Offence—placing of an embryo

This section makes it an offence for a person to intentionally place a human embryo in the body of an animal, or in a part of a human body other than a woman's reproductive tract. It also makes it an offence to intentionally place an animal embryo in the body of a human for any period of gestation. The maximum penalty is imprisonment for 15 years.

15—Offence—importing, exporting or placing a prohibited embryo

This section makes it an offence for a person to intentionally import an embryo into South Australia knowing that, or reckless as to whether, the embryo is a prohibited embryo. It makes it an offence for a person to intentionally export an embryo from South Australia knowing that, or reckless as to whether, the embryo is a prohibited embryo. The section also makes it an offence for a person to intentionally place an embryo in the body of a woman knowing that, or reckless as to whether, the embryo is a prohibited embryo. The maximum penalty is 15 years.

A prohibited embryo is—

(a) a human embryo created by a process other than the fertilisation of a human egg by human sperm; or

(b) a human embryo created outside the body of a woman, unless the intention of the person who created the embryo was to attempt to achieve pregnancy in a particular woman; or

(c) a human embryo created using human egg and human sperm and containing genetic material provided by more than 2 persons; or

(d) human embryo that has been developing outside the body of a woman for a period of more than 14 days, excluding any period throughout which development is suspended; or

(e) a human embryo created using precursor cells taken from a human embryo or a human fetus; or

(f) a human embryo that contains a human cell whose genome has been altered in such a way that the alteration is heritable by human descendants of the human whose cell was altered; or

(g) a human embryo that was removed from the body of a woman by a person intending to collect a viable human embryo; or

(h) a chimeric embryo or a hybrid embryo.

16—Offence—commercial trading in human eggs, human sperm or human embryos

This section makes it an offence for a person to intentionally give or offer valuable consideration to another person for the supply of a human egg, human sperm or a human embryo, or to intentionally receive, or offer to receive, valuable consideration from another person for the supply of a human egg, human sperm or a human embryo. The maximum penalty is imprisonment for 15 years. However, valuable consideration does not include the payment of reasonable expenses incurred by the person in connection with the supply.

Division 2—Practices that are prohibited unless authorised by a licence

17—Offence—creating a human embryo other than by fertilisation, or developing such an embryo

This section makes it an offence for a person to intentionally create a human embryo by a process other than fertilisation of a human egg by a human sperm, or to develop a human embryo so created, if the creation or development of the embryo by that person is not authorised by a licence. The maximum penalty is imprisonment for 10 years.

18—Offence—creating or developing a human embryo containing genetic material provided by more than 2 persons

This section makes it an offence for a person to intentionally create or develop a human embryo by a process other than fertilisation of a human egg by a human sperm, if the human embryo contains genetic material provided by more than 2 persons and the creation or development of the embryo by that person is not authorised by a licence. The maximum penalty is imprisonment for 10 years.

19—Offence—using precursor cells from a human embryo or a human fetus to create a human embryo, or developing such an embryo

This section makes it an offence for a person to use precursor cells taken from a human embryo or fetus, intending to create a human embryo, or to intentionally develop an embryo so created, if the person does so without being authorised by a licence, and knows or is reckless as to the fact that the person is acting without a licence. The maximum penalty is imprisonment for 10 years.

19A—Offence—creating a hybrid embryo

This section makes it an offence for a person to intentionally create or develop a hybrid embryo. The maximum penalty is imprisonment for 10 years. A person does not commit an offence if the creation or development of the embryo by the person is authorised by a licence.

Part 3—Amendment of Research Involving Human Embryos Act 2003

8—Amendment of section 3—Interpretation

This clause amends section 3 of the Act to replace the existing definition of human embryo with a new definition developed by the NHMRC. It inserts definitions of hybrid embryo, unsuitable for implantation and use, and substitutes the definitions of proper consent and responsible person. It clarifies that 'human embryo' refers to a living embryo only and does not include a human embryonic stem cell line or a hybrid embryo, and that a reference to a human oocyte is the same as a reference to a human egg.

9—Substitution of heading to Part 2

This clause substitutes the heading to Part 2 of the Act.

Part 2—Regulation of the use of excess ART embryos, other embryos and human eggs

10—Insertion of sections 5A and 5B

This clause inserts 2 new sections into the Act.

5A—Offence—use of other embryos

This section makes it an offence for a person to intentionally use an embryo if the embryo is—

(a) a human embryo created by a process other than the fertilisation of a human egg by a human sperm; or

(b) a human embryo created by a process other than the fertilisation of a human egg by a human sperm that contains genetic material provided by more than 2 persons; or

(c) a human embryo created using precursor cells taken from a human embryo or a human fetus; or

(d) a hybrid embryo,

and the use is not authorised by a licence. The maximum penalty is imprisonment for 5 years.

5B—Offence—certain activities involving use of human eggs

This section makes it an offence for a person to undertake research or training involving the fertilisation of a human egg by a human sperm up to, but not including, the first mitotic division, outside the body of a woman for the purposes of research or training in ART if the person is not authorised by a licence to undertake the research or training. The maximum penalty is imprisonment for 5 years.

11—Amendment of section 6—Offence—use of embryo that is not an excess ART embryo

This clause amends section 6 of the Act to make it an offence for a person to intentionally use, outside the body of a woman, a human embryo created by fertilisation of a human egg by a human sperm if it is not an excess ART embryo and the use is not for a purpose related to the assisted reproductive technology treatment of a woman carried out by an accredited ART centre under a South Australian clinical practice licence, and the person knows or is reckless as to that fact.

12—Insertion of section 7A

This clause inserts a new provision.

7A—Person not liable for conduct purportedly authorised

This section makes it clear that a person is not criminally responsible for an offence against the Act in respect of particular conduct if—

(a) the conduct by the person is purportedly authorised by a provision of a licence; and

(b) the licence or the provision is invalid, whether because of a technical defect or irregularity or for any other reason; and

(c) the person did not know, and could not reasonably be expected to have known, of the invalidity of the licence or the provision.

13—Amendment of section 10—Person may apply for licence

This clause amends section 10 of the Act to expand the classes of activities for which a licence may be sought. Currently only the use of excess ART embryos may be licensed. Under the proposed changes a person will be able to apply to the NHMRC Licensing Committee for a licence authorising 1 or more of the following:

(a) use of excess ART embryos;

(b) creation of human embryos other than by fertilisation of a human egg by a human sperm, and use of such embryos;

(c) creation of human embryos other than by fertilisation of a human egg by a human sperm that contain genetic material provided by more than 2 persons, and use of such embryos;

(d) creation of human embryos using precursor cells from a human embryo or a human fetus, and use of such embryos;

(e) research and training involving the fertilisation of a human egg by a human sperm up to, but not including, the first mitotic division, outside the body of a woman for the purposes of research or training in ART;

(f) creation of hybrid embryos by the fertilisation of an animal egg by a human sperm, and use of such embryos up to, but not including, the first mitotic division, if—

(i) the creation or use is for the purposes of testing sperm quality; and

(ii) the creation or use will occur in an accredited ART centre.

The section makes it clear that (a), (b), (c) and (d) do not permit the NHMRC Licensing Committee to authorise any use of an excess ART embryo or other embryo that would result in the development of the embryo for a period of more than 14 days, excluding any period when development is suspended.

14—Amendment of section 11—Determination of application by Committee

15—Amendment of section 14—Licence is subject to conditions

The amendments made to sections 11 and 14 of the Act by these clauses are consequential on the amendments to section 10. It ensures that the provisions relating to the determination of applications for licences and the imposition of licence conditions apply in relation to licences authorising activities relating to human eggs and embryos other than excess ART embryos.

16—Amendment of section 16—Suspension or revocation of licence

This clause amends section 16 of the Act to alter the reference to legislation the title of which is amended by this measure.

17—Amendment of section 19—NHMRC Committee to make certain information publicly available

This clause amends section 19 of the Act to require the NHMRC Licensing Committee to include in its licence database the number of ART embryos or human eggs authorised to be used under a licence, and the number of other embryos authorised to be created or used under a licence.

18—Amendment of section 21—Interpretation

This clause amends section 19 of the Act to enable the holder of a licence to apply for a review of a decision to modify NHMRC guidelines in respect of the licence. The relevant guidelines are those issued by the CEO of the NHMRC under Commonwealth legislation and prescribed by regulations under the Commonwealth Research Involving Human Embryos Act 2002 for the purposes of the definition of 'proper consent' in that Act.

19—Amendment of section 22—Review of decisions

The amendment made to section 22 of the Act by this clause is consequential on the insertion of section 14(8) in the Act.

20—Amendment of section 23—Powers of inspectors

This clause amends section 23 of the Act so that if, during a search of premises, an inspector believes on reasonable grounds that there is at the premises, a human egg or embryo other than a human embryo that may afford evidence of the commission of an offence against the Act, the inspector may secure the egg or embryo pending the obtaining of a warrant to seize it.

21—Amendment of section 30—NHMRC guidelines

This clause amends section 30 of the Act so that alterations to NHMRC guidelines are required to be tabled in Parliament within 6 sitting days of taking effect under the Act.

Part 4—Transitional provision

22—Transitional provision

This clause provides that if an application for a licence under section 10 of the Research Involving Human Embryos Act 2003 made before the commencement of this clause has not been determined at the commencement of this clause, the application is to be determined as if it had been made after that commencement.

Debate adjourned on motion of Dr McFetridge.

HEALTH CARE BILL

Adjourned debate on second reading (resumed on motion).

(Continued from page 1315.)

Mr VENNING (Schubert) (16:09): I rise to contribute to the debate on the government's Health Care Bill. The bill proposes to reform the governance and administration structures of South Australia's health care system. Really, it is not so much about health care; it is more about health administration change. The bill's proposal to abolish existing hospital boards in country areas and replace them with health advisory councils, hereafter known as HACS (that is a rather ironical way of putting it), will spell the beginning of the end of the many country hospitals. This proposed wind-down of country health would rate as one of the most important issues that I have dealt with in my many years here, and is of serious concern to me, because these hospitals are the lifeblood of our communities, particularly the more isolated, smaller communities.

I have made many speeches in this house over the years in support of our hospitals, especially our country hospitals. In the last six to eight weeks I have vamped up my comments in

support of the status quo. For the record, I have five hospitals in my area (Angaston, Tanunda, Mannum, Mount Pleasant and Gumeracha) with three boards operating. I have had experiences serving on a hospital board. I served on the Crystal Brook Hospital Board for approximately six years as the council's representative. I know how the community supports its hospital, and Crystal Brook is just fantastic.

The government reduced the eight regional hospital boards across the state early in its term of office, and I supported that. It was a level of bureaucracy that we did not need to have—and it really was. Why then, minister, are we putting it back in this instance? Having local hospital boards replaced by health advisory councils, which would report directly to the state government and minister, will be disastrous for this state's health system. This bill will only result in a centralised, massive bureaucratic mess and will not provide better service for patients and communities. Mr Deputy Speaker, you can be assured of a poorer performance and it will cost more—much more. Why are we doing this is the question. Is this legislation necessary? Why change something that has worked so well for so long and means so much to so many people?

The most important thing in regard to health care is that the services offered are delivered in ways which best help local people. They know who they are. What better way to achieve this than by having in place local hospital boards which have some real authority and can make decisions about what happens in a given hospital? This issue is one on which the government and the opposition are poles apart, and that is for philosophical and basic reasons. If management decisions are made closer to the people being affected by them, ultimately, a better quality of decision making will result. The Minister for Health said last year in a ministerial statement:

> These new governance changes will streamline decision-making and ensure that we have an integrated health system for the future and give a strong voice to community members and clinicians.

This is what is happening now under the current system. Why change it? Why change the structural arrangements of our health system when it is already delivering the goals outlined by the minister? The government claims that this bill will result in a more unified health system for South Australia through the integration and coordination of services. Rubbish, I say. This is a long-term plot spanning over 20 years, as the shadow minister very capably put in this house yesterday, for health bureaucrats to increase their control of the health system—a long-term goal. They have always wanted to control it; they never have, and here is their big opportunity.

I have to say that those two words: 'integration' and 'coordination' set off alarm bells in my head. It sounds like a lot of political palaver for what we really know the government wants to happen. It seems that this government's real plan is to slowly dismantle country hospitals by limiting the services they offer, take away the control and input that locals have via the removal of their hospital boards, and, therefore, force rural residents to travel to the city to obtain adequate health care and relevant services. Ever since Don Dunstan's electoral reform, country people have been losing out on the provision of government services. Equity—

The Hon. J.D. Hill interjecting:

Mr VENNING: The minister said 'democracy is a bugger'; they are his words, sir, not mine. There is fairness and equity. I believe governments have obligations to serve all communities. If you could only do it on the one-vote/one value policy, there would be a lot of people out there who would not get any services at all. The government has the responsibility to offer minimum services to people, and they are not even getting that.

This bill is yet another kick in the guts to country people, and highlights the citycentric approach of Labor. I am somewhat concerned that there has not been more public reaction or uproar about this legislation and what it will do. I have attempted to beat this up via public comment and press releases in my local media, but it seems that many of the stakeholders have given up and accepted the inevitable. I spoke to a doctor who is well known to me, and I was not happy with his response. He said 'What's the use?' And he was a person who should have known better, and I am very concerned about that. I am not prepared to give up.

Under the draft bill, country communities will continue to have a voice through a local health advisory council. However, their influence on real decision making will be limited and the real responsibility will be transferred to the Department of Health. Under the current Health Act a minister cannot easily sack or remove a local hospital board; under this new act the minister can, very easily. Is this just a halfway house to total oblivion? How many of our country hospitals will this affect? The Blyth hospital is totally gone; it was a wonderful facility but Labor shut it, and I wonder

what will happen after all this. I was a member at the time Labor shut Blyth; it was an excellent facility but, boom, it was shut—and I have never forgotten that.

I have not given up, and I will not. This is a most important issue; it will go before the other place—and I hope the government will appoint the Hon. Nick Xenophon's replacement before it gets there. Or is that part of the plot? The upper house can prove its worth here and represent the important, oppressed minorities in South Australia.

The state Labor government says this bill has come about due to the rising cost of health care, and that the increasing demand for and complexity of health services inevitably mean that communities will have a relatively less central role in maintaining and controlling their assets, but can still have a role in the planning of appropriate services. Part 4 of the bill deals with Health Advisory Councils (HAC) and the Country Health Community Assets Authority. Clause 18(2) of division 2—Functions and Powers—provides that:

> ...a HAC must, in the performance of its functions, take into account the strategic objectives (including any health care plan or plans) that have been set or adopted within the government's health portfolios.

In other words, you will do as you are told. It also provides that:

> Subject to this act, a HAC has the power to do anything necessary, expedient or incidental to performing its functions.

So now, to meet rising costs, we are to have these new health advisory councils (the HACs) which, at the end of the day, will be nothing more than councils who are directly responsible to the minister—in other words, the minister's HACs. Do rural communities not know their needs better than some bureaucratic outsider? Of course they do. In a letter I received from the Minister for Health he stated that, 'Overwhelmingly, country hospital boards and communities support the local retention of hospital assets.' Well minister, you got that right.

This can hardly be considered surprising. Of course country hospitals and communities support the local retention of assets. It is their people, their auxiliaries, who have worked hard over the years to raise funds to provide assets for their local hospitals; why should they relinquish control? In most cases they built them, gave the land for them, and have helped in their governance ever since—and some of them are over 100 years old. The way it is currently is that the community has ownership of the hospital and therefore they support it personally and financially. Many people make a bequest to 'their' hospital or donate money, and most hospitals have local auxiliaries that raise money for 'their' hospital. All this would be lost if you take away local management; local ownership will be gone. The minister is silent; I presume he agrees with me. If local hospital boards cease to exist—

The Hon. J.D. HILL: I rise on a point of order. The member for Schubert is accusing me of having a particular opinion because I did not interject upon him. I think that is disorderly and it is also dishonest.

Mr VENNING: I withdraw—

The ACTING SPEAKER (Mr Koutsantonis): Order, member for Schubert! You cannot infer opinions other than your own.

Mr VENNING: I apologise to the minister; it is just that he was silent and I was a bit provocative in what I said. I hope he will pick that up in his reply. It is about whether the auxiliaries will survive when you take that individual ownership away. If local hospital boards cease to exist then the locals will no longer have a say in how hospital funds, that they have helped raise, are spent. Surely the state government can understand that this would cause a lot of money that flows into hospitals to dry up, especially as the hospital loses its identity.

The form of health care system proposed by the Rann state government will simply result in the minister running all hospitals, including those in the country, from his office in Adelaide. This will ensure that the decision-making process is taken further away from where the service delivery is, inhibiting the growth and development of local hospital services. This bill seeks to do nothing more than deliver ultimate and total control of our health service to the minister and the government—the bureaucracy. The local health service would gradually be perceived as just another government service impeding any community involvement.

What is happening at the moment is that even very minor decisions have to be referred to the director's or minister's office. Such decisions or problems get logged there and never dealt with; as a result the issue remains unresolved, staff morale decreases and a bad situation gets worse. The result of this is that South Australians have the longest elective surgery waiting list ever

recorded in the history of this state, the worst emergency response times in the whole country, and the lowest elective surgery and mental health funding per capita in Australia. If this is the Rann state government's idea of a healthy hospital system I have to say that South Australians deserve better.

Under the scheme proposed by the Rann Labor government, the performance of health services at regional and local levels will not be published; it will be kept secret from South Australians. The new health care bill states that 'the aim is to provide a prosperous, environmentally-rich and culturally stimulating state which offers its citizens every opportunity to live well and succeed.' By centralising health care services and management the government is achieving exactly the opposite. Each area is different, and that is why a local approach is the best way to treat these issues. This will all come to a halt under the new system—another questionable brainwave of the Rann government.

I see local involvement as a real positive; when you keep management local you get the best value for your dollar. There has been much criticism of the Rann state government, saying that direct funding hospitals via community hospital boards will add another level of political bureaucracy to the current health system. This is just plain nonsense. Local hospital boards are already in place and have been for a long time. Minister Hill says that South Australia must 'have a strong health system that can take responsibility of delivery of health service to all the people in the country, not rely on the goodwill of local volunteer boards'. How ungrateful! Keeping hospital management local has proved over the last 80 years to be the most efficient and community friendly system. It is clear that the bureaucrats want greater control, but boards comprised of volunteers are there for the benefit of their local hospital, their local communities, and do not have any other motive.

For the health minister to say that it would be adding another level of bureaucracy to the health system is absolute garbage—and, worse, to say that it will create inefficiencies is grossly hypocritical. We do not need to be reminded of his latest attempt at creating an efficient system, namely, the NRM review, the principle of which I supported. However, burgeoning government bureaucracy has killed it. I know that the minister had every good intention, but now what we see is a system totally out of control with the bureaucracy taking it over and killing it. In regard to the health care service, the Minister for Health said:

> ...one of the things that people have said to me is that there is far too much bureaucracy.

Well, one has to ask: who is running this state's health system and who has put this bureaucracy in place? None other than his government. I cannot accept this backward step, which again depicts that this government is interested in maintaining only large regional hospitals—similar to its direction on education in smaller schools. The current hospital board system can deliver and has been for decades. Bureaucracies, empire building, increased costs of service and over-servicing is what will result if the current boards are dismantled. If management is local and funded externally, by either the state or federal governments, I am totally confident that all taxpayers will get better value for money and people in country communities will get a better standard of health care.

Bringing an end to the local management of hospitals runs counter to the Rann state government's stated desire to encourage local community involvement through the proposed health system. I do not believe that the Rann Labor government's plan for health advisory councils will ever be a suitable replacement for local hospital boards, which are made up of locals, not boffins in Adelaide attempting to micromanage the whole state health care system. This plan is just another example of this government's incompetence and ineffectiveness in managing this state's health care system. It is government ideology overshadowing commonsense. The fact that the country health budget for this financial year has been cut by over $35 million is one of several concerns and even more reason why we should resist the hijacking of our country hospitals. With cuts like this already made to country health services, what will happen if the minister and government gain absolute authority?

The pool of budget allocations for country health is proof of the minister's contempt for health services outside Adelaide. The last thing country people need now in this time of drought is any concern over the future of their local hospital. I pay the highest tribute to the various local hospital boards across South Australia. Their work ought to be rewarded, not wiped out. I will never compromise on my position to fully support individual hospital boards made up of members of the local community. I ask: what happens to the land, the real estate? I know that the government is moot on this matter and has locked it up in various areas, but I am still very concerned because this real estate belongs to the community. The land is usually donated by local people and money

is put in by local people, so it really belongs there and it should always be guaranteed to stay there. I give my full support to the federal government's proposal of retaining local management of country hospitals by maintaining the boards currently in place and not implementing boards of city hospitals currently managed by bureaucrats.

And what about the Barossa Hospital? I mention that because we are still waiting for something to happen. For all the years of pushing, the priority is unknown. It is an absolute disgrace. I believe that the federal government has a good opportunity to fund this hospital because the state government never will. If it is able to do it in Tasmania the federal government should be able to do it here. The only way to achieve that result for the Barossa Hospital is to have it externally funded. This Labor government at the last state election said that no hospital board would go—sacked, or anything else. Remember that, minister? Well, what is this? Where is the truth and the commitment? The love and care given by my constituents to country hospitals is appreciated. The level of service given in often antiquated facilities is just fantastic. It is now time for us to stand up and be counted and to support our families and our communities.

I put on the record my desire to support all country hospitals and to keep the management local, to encourage local funding, to promote community ownership of the hospital and to recognise the performance and service delivery, not condemn it forever. This is a prime example of a government which does not understand, which is not close to the subject and which is dumping on people legislation they really do not want. In terms of some of the legislation coming through here, over the years I have been in this place I have often thought, 'Well, why are we doing this?' If it is not broken, why fix it? Are people asking for this legislation? Who is asking for this? I will tell you who: the minister's department. The bureaucrats want this. They do not want these boards in country areas to have any power at all. How dare they have any say at all! After all, they do raise the money and, over the years, their record has generally been pretty good—not always, but generally pretty good.

I am sure that a minister with clout and respect could always go out—and this minister has visited my hospital—and talk about the problems he may see, and I have no problem with that. I am very concerned. This bill has been coming for sometime. I thank the minister for the public consultation period, which I think is straight and honest. I appreciate that. As I say, he is still one of my favourite ministers. There are not many over there anymore. He has certainly blotted his copybook on the NRM, but it was not him. He gave a commitment to me, but he was moved on. That is always the thing: you bring something in with a good minister and then the minister is moved on. You get a dud minister and you end up with a real problem, as we have got with NRM; and we could have it with this when the minister moves to high office in a year or two. I urge the house to support all South Australian hospitals and oppose this bill.

Ms BREUER (Giles) (16:30): Country South Australia has a vast diversity of geography and cultures. Approximately 429,000 residents live in 1,200 cities, towns and hamlets across an area of 983,000 square kilometres, and I point out that about 500,000 of those square kilometres are in my electorate. In response to the Generational Health Review, the government identified governance reform as a priority to improve the management and operation of the health system. The doom and gloom coming from members opposite is quite incredible. I have been listening to some of their arguments and discussions, and I am amazed at what they are coming up with. In May 2006 a country health conference, attended by 260 delegates made up of regional and local board members, hospital staff and other stakeholders, spent two days discussing the best way to govern the public health services in South Australia.

The general view reached by the delegates was that if Country Health is to work as a fully integrated service system, changes would have to be made to local governance arrangements. This was decided at that conference. You cannot write off 260 delegates at a conference. There has been significant support from the country for the proposed changes in the bill, and again I say that I am not sure where members opposite are getting their message, but I certainly am not hearing what they are hearing.

For the country region many important functions of the existing boards will be maintained—we will not lose that—and delivered through the Country Health SA board and the local health advisory councils. The health advisory councils will continue to undertake an advocacy role on behalf of their communities, so we will not lose that. Also, they will be able to provide advice on planning and service issues in their local area to the minister and also to Country Health SA and the chief executive of the Department of Health. So, I do not see what the problem is. That will not be changing.

The members of the health advisory committees will be drawn predominantly from the local community to ensure that the voice of the community is well represented on that health advisory committee. We will not be losing that local touch that we have in country areas. For many years it has been a status symbol in country regions to be on the hospital board. People like to say they are on the hospital board. If they are running for local council it suits them to say they are on the local hospital board or they have served on the local hospital board. It can be a status symbol for them.

Mr Pengilly interjecting:

Ms BREUER: Also, very often those local hospital boards over the years have been stacked by various governments to make sure that they are favourable to the current government—

Mr Pengilly interjecting:

Ms BREUER: —and I know that Labor and Liberal governments have done that.

Mr Pengilly interjecting:

The ACTING SPEAKER: The member for Finniss is warned. The member for Giles.

Ms BREUER: Thank you for your protection, sir. They are being very rude. The Country Health SA board will continue to provide advice to Country Health SA and to the chief executive and the minister. The bill does not change the arrangements for commonwealth funded aged care facilities and accommodation bonds, and the retention amounts and interest will continue to apply to the benefit of that facility. So any warnings about aged care facilities in hospitals is not true.

Historically, governments at the local level grew out of a traditional community participation model, with members volunteering their time to fundraise and support their local hospitals, and there have been some wonderful examples of that over the years. I know in my own city of Whyalla this has been the case for many years, and they have done a wonderful job over the years. However, over time, the governance responsibilities of local health boards have substantially changed and the issues that require determination have increased in complexity, and this has resulted in concern about the responsibilities that have been placed on those local health boards.

To make country health services safer, more accountable and sustainable in the long term, there is little doubt that the health services must operate as part of a modern, integrated system, one that is large enough to provide common mandated quality and safety standards, consistent policies and corporate systems, and sector-wide career opportunities for those people working in the hospitals. It is no longer a little world; it is a big world now. There is a global picture. We want better health outcomes for country residents in line with the recommendations of the Generational Health Review. We need a new system, and the new Health Care Bill establishes the legislative foundation on which to build the new system of health care.

We heard a number of issues cited by members opposite. There are a number of examples of boards spending beyond their budgets without approval. Issues with financial management have occurred over the years. With the dissolution of the seven regional boards and the establishment of Country Health SA, processes have been implemented to assist with the management of financial issues. I served on the aged care board many years ago, and there were many issues dealing with finance, and I know that the hospital board had considerably more. I would not like to be dealing with those issues in our current times. There have been examples of boards approving staff positions and filling them without the funds available and where boards have not complied with commonwealth legislation in their use and management of funds held in trust.

I am sure most of these incidents have not been deliberate. It has been through ignorance and not understanding, and beyond the scope of their capabilities. There are two examples where bequests have not been used consistent with their terms, and one led to a successful challenge and the loss of a bequest worth nearly $750,000. Another situation required the health unit to seek Supreme Court approval for changes to the way the funds are used. In both instances, the Department of Health has had to intervene after the event to resolve the matter. These financial issues are beyond the capabilities of people to manage nowadays on those hospital boards—you are talking about volunteers giving up their time.

In terms of clinical issues, there is a variable approach across Country Health sites in relation to clinical governance and safety and quality matters, and an example of this was the breakdown of the colonoscopy cleaning and disinfection practices at the Riverland regional hospital which potentially could have resulted in cross-infection to other patients. Patients were required to be tested and retested for any cross-contamination, and it no doubt caused them considerable

worry. There were many reports at the time in the newspapers. It would be very frightening for people in situations such as this. The minister had to instruct the board to cooperate with the review into the procedures of cleaning and disinfection of clinical equipment by the Communicable Disease Control Branch of the Department of Health.

There are also concerns with the management of medico-legal risks, because some boards have little or no involvement or comprehension of their roles in this area. One example particularly was close to my electorate at the Wudinna health service. In 2005 the board of the Mid-West Health service, which has responsibility for the running of the Wudinna hospital, commissioned a clinical review regarding a number of allegations which centred around difficulties between nursing staff and the general practitioner at the time, Dr Du Toitt, who was then resident in the area.

An independent review heard from individuals who raised many issues in relation to performance, behaviour management, clinical assessment and treatment. The review team found a lack of appropriate and sound leadership and management practices over a number of years and recommended corporate governance training for board members, annual board performance development plans and performance reviews for all executive and management staff. The review found that the medical and nursing care did not meet contemporary standards at that time, although the situation was not serious enough to place lives at risk—but this was a serious issue. Of course, there was some hostility after that—and the member for Flinders was quite vocal about some of this—but it was an incident which highlighted that the board was not the able to handle the situation.

We have also had issues with procurement processes in hospitals. The most notable was the failed contract negotiations with Gawler obstetricians, which resulted in a breakdown of relations between the doctors and the health service. Protracted negotiations with the two private specialists saw the board making decisions which were outside their delegations. A review was undertaken by the Department of Health which found:

- a lack of clearly defined processes for negotiation;
- the GHS board did not know that, due to the value of the contract, a tender should have been undertaken or a tender waiver sought;
- the board allowed the GHS chief executive to withdraw from the contract negotiations;
- the deputy chair of the board subsequently took a more 'hands on' role in the contract negotiation process, which is normally considered outside the role of a board member; and
- recommendations of the review included a centralisation of contract negotiations process. The new Health Care Bill will allow greater authority in this area.

Delays in pursuing a tender for medical imaging services at one hospital resulted in an extension of the existing provider's contract without due processes, leading to the intervention by Country Health SA to ensure the continuation of an essential service.

The recruitment and retention of staff is a major issue for our country hospitals. There are many examples of difficulties associated with GP recruitment and negotiating contracts in country locations. I know that, in my own town of Whyalla, with its population base, we should have approximately 22 GPs and I think we have 14. The Whyalla hospital has been negotiating for well over two years now to get a local resident physician but has not been able to pursue it. This is a major issue for country hospitals. Difficulties in recruiting and retaining medical staff in country locations is not unique to South Australia. Some examples on the public record include the South African specialist who was recruited from New Zealand, arrived at the Mount Gambier hospital, changed his mind and returned to New Zealand on the next available flight.

A very sad case was that of Dr Singh who was recruited to Wudinna from India and who left within a week. That was particularly sad. I read an article written by Dr Singh. He was frightened; he was terrified; he did not know where he was. His family was frightened. He had come from a major city in India which had millions of people and arrived in Wudinna (which has a population of between 300 and 500 people) and thought that he was on the edge of the earth. He could not cope and no support services were provided to help him. A director of nursing hired by the Lameroo community fled before a welcoming party was held. An ongoing issue for us in country hospitals is being able to keep people.

Another thing that has happened in our country hospitals has been the lack of quorums. Increasingly boards have found it difficult to achieve the constitutionally required number of

participants for board meetings and annual general meetings. I think this is a reflection of the amount of input and work that is required from them and perhaps that feeling of being overwhelmed when some board members realise how much control and responsibility they have. For example, in 2005-06, eight country health services failed to achieve a quorum for their AGM, which is the most important meeting for the year. These included services such as the Barossa, Ceduna, Millicent and Penola health services.

I believe that this new bill will provide a service for us in the country that we have not seen before. I am very happy that Whyalla will be one of the four centres of excellence for country health, because I believe that we do serve a large hinterland and we will be able to serve those people well. I am very pleased about this.

Before I sit down, I pay tribute to my local hospital, the Whyalla hospital, and the work that goes on there. Before my mother passed away with cancer last year, she spent a considerable time in the hospital I have to say that the care she received at the Whyalla hospital was outstanding. The nurses were very supportive to us as a family, as well as to my mother. The medical services were excellent. Again, we had a situation where, because of doctor shortages, we saw a number of doctors attend my mother. I was able to experience first hand the issues with doctor shortages and a high turnover of doctors.

We will have some major problems in future years in country hospitals. Many of our country hospitals no longer provide obstetric services and that is generally because we are unable to get obstetricians and anaesthetists in country communities. I would hope that we can continue to maintain some of these services in country areas, but I am quite fearful that, over the next few years, we may find that all country women will have to come to Adelaide to have their babies because of health professional shortages in those areas.

I look forward to the new structure. I certainly support this bill. It will be a wonderful thing for country people and I believe that, despite what the opposition says, there is not a lot of opposition. Most people are sensible and see that this is the way to go. It will provide better services for us in the future and I congratulate the minister on his foresight.

Mr PENGILLY (Finniss) (16:44): I also rise to make some points regarding the government's Health Care Bill, which I oppose. Quite frankly, after some time in this place, you start to wonder why on earth they do some of these ridiculous things and, in this particular case, I could not agree more with my colleagues on this side of the house. Unfortunately, the member for Giles says that she has not heard too many complaints. I suggest that she drives around the country and chats to people. In particular, I would like to place on the record in due course my regard and respect for the efforts of the boards of the two hospitals in my electorate, the Kangaroo Island general hospital (now known as the Kangaroo Island Health Service) and the South Coast District Hospital at Victor Harbor.

I picked up on the comments made by the member for Giles, with respect to the fact that some board members saw this as an opportunity to gain social status in the community. Let me tell the member for Giles that, in the 16 years I have spent on health boards, at both unit and regional level, I never encountered people going on the boards or into local government so that they could become status symbols. The fact of the matter is that they went onto those units and put their hands up for regional boards to provide service to the community in the best spirits of the volunteer ethic. I think that is an absolute slap in the face for those people across South Australia.

Mr Goldsworthy: It's an insult.

Mr PENGILLY: It is quite insulting and rude, as my friend, the member for Kavel, said. I would also like to express my thanks and appreciation to the former minister for health, the Hon. Lea Stevens; the member for Little Para. As regional chair, I had a lot to do with Lea Stevens, and I thought that she had a firm grip of reality: she was not in cuckoo land, where we are now. The fact of the matter is that minister Stevens (as she was at the time) recognised that the Menadue report really did not add up and was not in the best long-term interests of South Australians and, in particular, South Australian country health.

Former minister Stevens actually listened to what the regional chairs had to say. She took us into her confidence and she had enough trust in us to be able to talk to us about the problems surrounding country health in South Australia and take it on board. I have deep respect for Lea Stevens. She listened, she observed and she took note. There was no hint of arrogance about her, which was terrific. So, I place on the record my appreciation of the efforts of the member for Little Para during her term as the minister for health. Obviously, she was under a good deal of pressure

with respect to a number of issues, but that is always the case whether someone is the minister for health or the minister for whatever; it goes with the job.

I was involved in health when the Menadue report was being prepared. Members of the communities with which I was involved at the time put forth their thoughts freely. Mr Menadue ultimately produced his report, which was basically put to one side, the Hon. Lea Stevens was put to one side, and we now have the Menadue report.

I would also like to mention what a great performer Mr Jim Birch was when he was CEO of the health department. Jim Birch had come through the country health system; he had been there for many years. He was very fair and equitable, and he also did not have any arrogance about him; he would listen to people. I think it was a sad day when Jim eventually gave up and moved on to other fields. I saw him in Goolwa just recently, and he looked about 15 years younger, and a much happier man. So, CEOs of government departments may well take that on board.

Ms Breuer interjecting:

Mr PENGILLY: Thanks for your help, member for Giles. I am not going too badly. I would like to talk about the two hospitals in my electorate. I will first talk about the South Coast District Hospital, which is at the core of health service provision on the south coast. I would particularly like to recognise the efforts of the chairman of the private board, Mr Kevin Howard, and the chairman of the public board, Mr Brenton Hutchison. Both are deeply committed to the South Coast community and, indeed, are widely respected in the community, and they are wringing their hands over what is now proposed with respect to that health service—and, likewise, board members who have been there many years, who have been phenomenal on that board and have put in sterling service.

One person whom I would like to mention in particular is Mr Adrian Lush of Inman Valley. Mr Lush served on the board for a long time (along with many others, of course), and he always had a profound interest in what was going on and a profound understanding of the health needs of the south coast. I now want to talk about Kangaroo Island general hospital, of which I am very much aware, having been born there, along with the member for Bragg.

Ms Chapman interjecting:

Mr PENGILLY: It does not seem that long ago since we were born there; but we were born there.

Mr Pederick: Just like yesterday!

Mr PENGILLY: Yes, just like yesterday.

An honourable member interjecting:

Mr PENGILLY: I hear what the minister is saying, but I have a feeling that the member for Bragg might have been born before me. I am not sure. The Kangaroo Island General Hospital has a proud record of service to the island community and, indeed, as has been mentioned by other members, is very much at the core of that community's interests and funding.

Ms Chapman interjecting:

Mr PENGILLY: Dr Mary McHugh? No, she did not deliver me—Bunty Burnell, I think. The current Chairman of the Kangaroo Island board, Mark Warren, at the annual general meeting a couple of weeks ago, spoke of his concern about the unknown nature with respect to where the hospital and the health service were going under these proposed new arrangements. I restrained myself from making any utterances, knowing that I would have plenty of opportunities to do so in this place.

They really do not know what is going on. Health units around South Australia have invariably had problems from time to time. I think it is most unfair to blame the boards for those problems because, as I have discovered during my term as regional chair, in particular, quite often the mistakes are made at the administrative level and are only brought to the board's attention when it has to go and clean up the mess, which is most unfortunate—that is not to say that that happens with all of them. It is just a fact of life that all our instrumentalities are run by people, and people invariably make mistakes. Sometimes they do not have the correct training and they get in deeper than they should and, unfortunately, just cannot cope with what is going on.

I feel that I should mention one person who was on the Kangaroo Island board who is now deceased: Mr Don Brown. He was the chairman of the Kangaroo Island hospital board for 17 years and provided sterling service. The hospital went through a great period of change while he was

there. So, I acknowledge the late Mr Don Brown. I attended innumerable functions with him and, in fact, I succeeded him as chairman of that hospital in the early 1990s. I worked with some fantastic people who were on the board at the time. I worked with a few who probably struggled to understand what it was all about, but I think that is part of the learning process that people who get onto local health boards have encountered. Indeed, that happens when you get into local government. You find that when you get into these things if you do not have a grip on what is going on, you are on a steep learning curve and it is hard to pick it up for some people.

I turn to the business of hospital auxiliaries and the sterling work that they have done. I have a great fear that these auxiliaries are going to wring their hands in despair and disappear because for years, as I think the member for Schubert inferred a while ago, people have regarded these units in country towns as their own. The auxiliaries and the community rally around to work and to raise money in order to put more facilities and more equipment into the hospitals. I can see that disappearing because I do not think they will have any inspiration whatsoever to continue doing that. I think that the government has made a fundamental catastrophic blunder in doing this.

These health advisory councils (HACs) are going to be creatures of the minister and the minister will put on who he likes. He may well say that they come through from the communities but we all know what happens when ministers go to appoint boards or councils: they put on people who are ethnically clean, so to speak—

The Hon. J.D. Hill interjecting:

Mr PENGILLY: That's all right, minister; you can have your turn again in a minute to wind up. I do not agree that these HACs are going to be much at all. They are socialism gone crazy. Advisory councils are a good way of saying that people can stand up there and have input and that they will be totally ignored. I thank the volunteers on the auxiliaries for their work and for what they are doing now. I hope that they will continue and I hope that the communities will still rally around. In due course, I do not think they will.

I would like to mention briefly the regions that were dissolved. In my case, our region was phenomenally successful, and I know that some of the regions were not. But the region I was chairman of for a number of years—namely the Hills Mallee Southern Regional Health Service—was outstandingly successful and I attribute much of that to the administrators that we had at the time and, in particular, the regional general manager, Mr Kevin Eglinton, whom we appointed and who stayed throughout. He is an outstanding fellow. He is immensely gifted and broad in his views and his perception of what should happen. He was always ably assisted by Mr Rick Brandon. I worked very closely with those two gentlemen, along with a number of the regional managers around that Hills Mallee Southern region during my time on that board.

I cannot speak highly enough of the efforts of Kevin Eglinton and Rick Brandon. We always had our moments. If you do not have the odd row or dispute over things, you are not really achieving very much. So, from that side of it, I place on the record for ever and a day my thanks to those two fine gentlemen, the other staff and board members with whom I served over a number of years on the regional board.

I am very concerned that what is going to happen under this act when it comes into operation is that we are going to return to the bad old days where the glass tower in Hindmarsh Square is going to be bulging at the sides with people running around and filling out forms and not accomplishing anything. That is my chief concern. This has happened before. There was a widespread cleanout of the 'glass mahal' and that involved a lot of dead wood disappearing over the years and getting back to the core of actually doing something for health in South Australia.

I think now that with this debacle that is going on in the house at the moment with this Health Care Bill all you will see is more and more people working in Hindmarsh Square, running around and filling out forms. Health care, particularly in regional and rural South Australia, is going to be put under immense pressure. I do not think it is the answer; I never have. I think it is foolhardy and most disappointing. I think that the people of South Australia have been absolutely conned with this bill. I think it is a nonsense.

I look forward to the day when we sit on the other side of the house when, once again, we can fix up another mess like we did with the State Bank and God knows what else. What the government has done, in my view, with this bill is that it has forgotten the fundamentals. It all about people, and people have been forgotten. I think that the mandarins that run around on the top floor of the health department building in Hindmarsh Square would not know what people look like, quite frankly. All they care about is numbers and power and things such as that.

It is with a great deal of disappointment that I see the ultimate demise of boards. Earlier on the member for Schubert talked about the federal government's idea of maintaining boards in hospitals in South Australia, and I fully support that as one who has been a member of a board for a long time and who has put in a lot of hours. I know the value of boards and I think that what is happening is damned stupid quite frankly. The Prime Minister is on the right track coming out with that statement.

I think it is a sad day in South Australia when country hospitals and those in the metropolitan area are going to be screwed by this bill. We will have people sitting in that glass tower in Hindmarsh Square calling all the shots and riding roughshod over everybody. I hope they do not treat them as arrogantly as I am led to believe they have been lately. I think it is just a dreadful step backwards for South Australian health. We are going to wear it whether or not we like it.

The people have been forgotten. Over the next couple of years, I will be casting a fairly close eye over what happens and how people are treated. I tell you this: I will only have to get messages about ill treatment by administrative staff or senior bureaucrats and, believe me, I will be naming and shaming them in this house. They will wear it because what they propose is absolutely, totally and fundamentally wrong. It is just stupid and out of touch. It lacks the common touch and forgets all about people.

Mr HANNA (Mitchell) (17:00): I speak today in relation to the reforms to the health sector that the government is bringing into parliament. I have followed the debate about health care reform over the last few years. There was great promise in the Generational Health Review, led by Mr Menadue a few years ago. I am not sure that all the ideals of that review have been achieved, but this legislation is part of the process of implementing that review.

One of the most significant changes is to abolish the hospital boards; we will now have advisory panels to represent the interests of consumers. I acknowledge that, to some extent, there is a need for ministerial control of the hospitals and other health care agencies because, ultimately, the minister of the day will be politically responsible for what happens in the health care sector, so I can understand the government's reasoning. It remains to be seen how well these advisory panels will work. In my view, it will certainly be important to retain a healthy (pardon the pun) consumer representation on those panels.

The experts, including doctors, surgeons and all variety of health professionals, sometimes lose sight of what it looks like from the other end of the stethoscope. The interesting thing in terms of health care in the electorate of Mitchell is that I am receiving a lot more phone calls about dental care than probably any other aspect of health care services. From time to time, I receive calls complaining about waiting times at the Flinders hospital. Indeed, I had to take a family member to the Flinders hospital last year. I forget how many hours it was before a proper diagnosis and admission, but it was probably a couple of hours before they saw a doctor, let alone receive diagnosis and treatment.

So, I certainly feel for those who are ill and wait for hours to get proper medical attention. It does still happen. Perhaps it is inevitable that it happens sometimes, but one would hope that we are constantly improving emergency care services at Flinders and in our other hospitals. I know that the doctors, nurses and other staff work extremely hard. At times, they are called upon to work above and beyond the call of duty, but still the demand seems to overwhelm them at times, and that is when the government has to take responsibility for the deficiency.

A related issue to hospital waiting times—and I mean waiting times at the emergency department, for elective surgery and so on in public hospitals, such as Flinders—is the continuing delivery of community health care. For years I advocated the need for a replacement for the Clovelly Park Inner Southern Community Health Care Centre, and I was very pleased when the GP Plus centre at Marion was announced. I was not pleased about the name, and I have conveyed my thoughts about that to the minister. I do not think that there is anything wrong with calling it 'community health care' if it is health care in the community, that is, away from the major institutions.

The other problem with the name is that it has caused some aggravation with the 24-hour GP clinic next door, which assumes that a GP Plus clinic will have GPs competing with its private sector services. I have had some reassurance from the government that that will not be the case, but I have to say that the anxiety remains. It will, of course, be of tremendous benefit to the local community to have a range of non-urgent treatments provided by the GP Plus centre at Marion—perhaps kidney dialysis, counselling of various sorts, minor procedures that can be handled easily

and do not require an overnight stay, and so on. We have yet to see how that will shape up. The government has taken a good initiative in building a modern, up-to-date community health care centre, even though, in Marion, it is not called a community health care centre.

I return to the issue of dental care because I really do have a significant number of calls from people, mostly pensioners, who are not happy with the service. From people on the age pension to whom I have spoken about this, I hear that it is not unusual for them to pay up to half their weekly income on a visit to a private dentist. So, to receive timely treatment from the Bells Road dental clinic at Somerton Park is of tremendous value to them. Members of parliament have a fairly healthy pay packet and, if we had to pay $1,000 each time we went to the dentist, we might give more thought to how to make dental care more affordable. So, when we think of old age pensioners paying perhaps up to half their weekly income on a dental bill, it helps us to realise how significant that sort of amount is.

A number of pensioners I have spoken to have been in pain, but have been told that they have to wait many months—perhaps more than six months—to get dental care at the Somerton Park clinic. The alternative is that they go to a private dentist and pay accordingly. In some cases, the clinic has been able to subsidise visits to private dentists, but, as I understand it, at the moment, that funding has run out; so, it is the luck of the draw to some extent.

I can understand that, with the substantial and growing demand for dental care for those who cannot really afford private dental care, there should be some triage or some ordering of the priorities for people who wish to attend the Bells Road clinic. My understanding is that, really, if you do not have some pretty significant swelling or uncontrollable bleeding, you will not be seen urgently. There are a number of people with fairly significant and sometimes painful dental conditions who have to simply put up with it for substantial periods of time. This is clearly an area that needs to be addressed by the government. I recognise that, under previous ministers and under the current health minister, there have been real increases in funding for public dental care. Clearly, the demand is still growing faster than the supply of those services.

The other matter about which I want to speak, while I have the opportunity to speak about health care, is the GP shortage. In the Marion area, as I have said, we have a 24-hour medical service with a number of GPs, and there is generally not a problem in getting in fairly quickly to see at least one of those GPs, even if it is not the preferred doctor. In my southern suburbs—Sheidow Park, Trott Park and Old Reynella (soon, I will be looking after Reynella as well)—there is a shortage of GPs. It is quite astonishing that, in the Marion South area—that is, in the southern area of the Marion council district—there is approximately one doctor for every 2,200 people. The national average is one doctor to 1,400 people, I am told. So, we have a shortage of GPs which is actually more severe than in many country areas, and, yet, often it is in the country areas where we hear about a shortage of GPs, the need to subsidise GPs to move to those areas, and so on.

There is, I suppose, an answer to that. The government could always say, 'Well, those people in Trott Park can always drive over the hill to Marion, or they can drive down to Noarlunga,' but it is not always as simple as that. I do have a number of single car households in Sheidow Park and Trott Park. Quite often, one parent, perhaps the father, for example, is out at work—it may be shift work—and the mother might be left at home with one or two children. When it is essential to get to a GP in a fairly short time to check out a stomach problem, a continuing headache, a vomiting session, or something like that, it is no satisfaction to be required to get on a bus and get there by public transport, or to get a taxi, which the family cannot afford. That is a real issue, and I think the government needs to work with the federal government to address it.

In conclusion, I recognise that this government has taken some positive steps in health care reform. I appreciate the continuing commitment to community health care. There are some gaps, particularly in public dental health care, but I have no problem with the legislation that is today being dealt with in parliament.

Mr GOLDSWORTHY (Kavel) (17:12): I am also pleased to make a contribution to the legislation before the house—the Health Care Bill 2007. I understand that one of the key planks of this legislation is the dismantling of the current country hospital boards, which have served the communities so well over many years back through the generations, and which are being replaced by what will be called health advisory councils. I want to commence by commenting on the outstanding contribution that country hospital boards have made to their local communities. They are made up of community-minded and community-spirited people who have worked tirelessly for their local communities in volunteering their time to the service of their local community through the hospital.

I note the remarks from the member for Giles in her contribution. The honourable member stated that she has not received any real opposition or any real negative comments from her community in relation to the abolition of these boards. Well, it is a rhetorical question. Why would she? Part of the government's master plan is to renovate the Whyalla Hospital into one of these big, super-duper regional hospitals. So why would the member for Giles receive any negative comment, given that the majority of her electorate includes the town of Whyalla? As I stated, her electorate will have a new, big, flash regional hospital built there.

It is my opinion and also that of a number of people in my electorate, that what has happened over the past months and years is that those representatives of the local community who have sat on hospital boards have really been worn down by this whole process to a point where they have basically said, 'Oh, well, what's the point? The government's going to do what it is going to do. We're just going to hope for the best. The way the legislation will pan out is that our communities will hopefully not be negatively affected.' I think that the opinion of those people in my local community in the Adelaide Hills is that they have been basically worn down to the point where they have run out of the energy needed to argue against the proposed legislation. The bureaucracy and the government have just steamrolled through the process, and we see the legislation now before us.

Abolishing hospital boards means that the role of volunteers in the community will be significantly diminished. Other speakers (particularly members on this side of the house) have given quite accurate critiques on how the government may well be able to influence the health advisory councils that are to be formed. It really diminishes the role of volunteers, and we have seen that in some other areas of legislation which the government has brought to the parliament and which has, unfortunately, been passed in this and the other place—and I will give some examples of that in due course.

I have two hospitals in my electorate of Kavel: the Mount Barker District Soldiers Memorial Hospital and the Gumeracha District Soldiers Memorial Hospital. The structure currently in place is that the Mount Barker hospital has its own board while the Gumeracha hospital and the Mount Pleasant hospital have the one board that oversees the operation of those two hospitals. One board administering and overseeing the operation of both Gumeracha and Mount Pleasant hospitals has worked very well, and the community has been extremely satisfied with the way those hospitals have operated. Similarly, the Mount Barker hospital board has also administered the operations of that particular hospital extremely well. I would like to take this opportunity to congratulate and pay tribute to all those outstanding members of the community who have worked tirelessly and selflessly for their communities for the contribution they have made to those hospitals in my electorate.

As the member for Finniss highlighted, you could say that this is socialism at its best (if you want to take that angle) or at its worst. It is about centralising control, and we have seen it in other areas of legislation that this government has brought to the parliament. A striking example of that was the establishment of the natural resources management boards, where the role of volunteers has been diminished and these huge monolithic bureaucracies created that are questionable in their achievement of any outcomes in managing natural resources within the state. The current Minister for Health was the minister for environment and conservation at the time that legislation passed through the parliament, and I think it was to the credit of the Liberal opposition that it moved hundreds of amendments to try to knock that piece of legislation into some semblance of order.

Another example is the establishment of the South Australian Fire and Emergency Commission (SAFECOM). The opposition strongly believes that the role of CFS volunteers was diminished in that whole restructure. It wanted CFS volunteers to actually have a position on that board, but the government vehemently opposed that and the CFS Advisory Council (as I think it is called) is now hooked onto the side giving some advice to the board, but it depends whether or not they want to take any notice of it. These are striking examples of how this government is centralising control, showing the true colours of its socialist agenda. It is social engineering at its worst or best that takes away a significant contribution from the community through the volunteer sector and places it with a government department and bureaucrats. Government members can argue all they like, but that is the reality. It is disempowering local communities and centralising control in what will be an enormous bureaucracy called Country Health SA.

I would like to continue my remarks in relation to part of the so-called master plan (and there is a big question mark over that title) that the government has for restructuring the health services in this state. We have seen its major announcement in terms of building the new hospital at the City West precinct (the so-called Marjorie Jackson-Nelson hospital) and also its

announcements in developing Whyalla, Port Lincoln, Berri and Mount Gambier as large regional hospitals, and I want to give an example of how that will not service the regional districts. The member for MacKillop highlighted that in a speech he made to the house last week, I think, in relation to a motion moved by the opposition. He cited the example of a mother who lived at Cleve (an inland town on the Eyre Peninsula), who was not able to avail herself of any services for the impending birth of her child

She had to travel to Whyalla or Port Lincoln. No postnatal services were available at the local health service. No doctor, from my recollection, was able to give any postnatal treatment to this lady. This particular lady, who lives and works with her family in the middle of Eyre Peninsula, had the inconvenience of travelling some distance to seek medical help. Whilst on the surface the redevelopment of these regional hospitals might be attractive, the manner in which the services will be delivered to those communities that are removed from these regional services is a serious issue.

That takes my focus to one of the fastest-growing regions in the state, the Adelaide Hills, of which I represent a reasonable proportion. We see that the state's population in itself is not growing significantly. I know that part of the government's Strategic Plan—or some such thing—is to grow the population to two million people by whatever the target might be—2050 or whatever the airy fairy target is. At the moment we are not seeing the population growing to any real extent in the state; however, what we are seeing is significant growth in the population in the Adelaide Hills.

A recent announcement is that the Plan Amendment Report of the District Council of Mount Barker has been approved, and we will see at least 1,000 new homes built within the Mount Barker township. That is a significant population shift from around the state, presumably from the Adelaide metropolitan area. If the state's population is not growing but you can see a population shift into the Adelaide Hills, my understanding is that one key recommendation of the Menadue report is that you deliver health services to where the population is.

What we are seeing is a population shift into the Adelaide Hills, and 1,000 new homes. So, arguably, there will be 5,000 new residents in the Adelaide Hills based in and around Mount Barker. But what are the government's plans for improving the health services at Mount Barker Hospital and the Adelaide Hills Community Health Service? Tell me that, minister? I wrote to the minister several months ago—probably a year ago now—asking that question.

The Hon. J.D. Hill: What was the question?

Mr GOLDSWORTHY: What plans have you in place to meet the needs of the growing population in and around Mount Barker? Obviously the minister is not aware that this letter was written, but to his credit he instigated a report into that issue. That report and review has been carried out, and I have it here with me. It is entitled 'Great Expectations'! ‘A Review of the Pressures Impacting on Delivery of Health Services to Mount Barker and Surrounding Districts’. It is quite voluminous, minister. I was able to obtain this report through freedom of information, and it contains some quite interesting facts, figures and recommendations. There are 17 recommendations—

Ms Chapman interjecting:

Mr GOLDSWORTHY: No, none have ever been implemented. However, this document refers to another document with which I have not been furnished and which is called 'the extract'. I understand that the extract also has some quite interesting information. I was disappointed that my FOI request really was not completed in the way I requested. I asked for all documents, files and reports in relation to the review on service pressures in the Mount Barker district. I would have thought that all files, reports and other documents would have included the extract. I will look to FOI for that document. As I said, this document refers to the extract, and I will make an FOI request for the extract so that we have, perhaps, a clearer understanding of what the recommendations may be.

In terms of the pressures on health services in the Adelaide Hills, particularly at Mount Barker and the surrounding districts, as a result of the growing population what we need is an integrated health service. We need an expanded GP clinic. We have got a GP clinic which caters to patients outside normal consulting hours and which is located within the Mount Barker Hospital buildings. I understand that that was as a consequence of the federal government's providing the required funds to enable an after-hours clinic. I think the clinic is open until 9 or 10 pm. Really, what we need is an expanded service of the current facility, and there is ample area. I think that the total

hospital site is about four or five hectares and, perhaps, only two-thirds or even half that area has been built on. There is open space for further infrastructure development.

Another part of integrating the health services would be building some specialist consulting rooms. The information I have received from people in the district is that specialists would be more than happy to come and consult with patients in those rooms. So, it is my wish that the head of Country Health SA, Mr George Beltchev, takes notice of this report entitled 'Great Expectations'. That title in itself says something, that the district has expectations—great expectations—of the government and Country Health SA. I will be keenly interested, and so will the community, in what services will be delivered as a consequence of this report. As I said, I congratulate the minister for initiating the report, but I certainly hope it is taken notice of and not just filed on a shelf somewhere in an office to collect dust, because that is the risk we run.

So, if the government ignores the contents of this report, it is not facing up to the reality of the situation. I could speak about other issues in relation to that particular matter. I know I am digressing here, Mr Speaker, but transport infrastructure needs in the district are being ignored. If the government and the bureaucracy and the department is fair dinkum, honest and open in their attitude towards delivering an improved level of health service to the Adelaide Hills and surrounding districts, they have to take notice, and a considerable amount of notice, of this report and implement the recommendations.

Mrs PENFOLD (Flinders) (17:32): I speak on behalf of the constituents in my vast electorate of Flinders who, once again, are the victims of this government's citi-centric mentality—a government who, even today, admitted that 250 jobs will be removed from the region back to the city on another similar efficiency upheaval, with no understanding that one job lost in the country has a multiplier effect of at least six times, effectively leading to the loss of around 1,500 jobs in regional areas. A job lost in the city means the person gets another job in the city, whereas a job lost in the country means that they and their family have to leave, thereby affecting the whole regional economy. The Labor government, whose ethos is supposedly based on social justice, has again thrown justice out the window to favour itself with the metropolitan bureaucracy. We continue to hear rhetoric about the importance of the country regions and the value of the thousands of regional volunteers and how much they contribute to our state, but now, with one broad brush stroke, this government tells us that our volunteer board members really are not up to it, they do not cut the mustard, and they certainly are not intelligent enough to give proper governance to our hospital system.

Certainly, let us make volunteers feel good because they can go on an advisory board to provide advice to the minister about what is needed in their area, but it is only the minister and city-based bureaucrats who will be making any decisions. In fact, the board members will be gagged by the government from making any adverse comments to the very people they are supposed to be representing. It is laughable that these advisory boards will supposedly have access to the minister. What does that actually mean? Based on experience with the way government bureaucracies work, the minister will be even more removed from access to the people on the ground. But then, cynically, one must remember that it is the minister himself who will be appointing his HAC members, so perhaps we should expect some *Yes Minister* stalwarts who will not question the government bureaucrats or lobby for the local community. Heaven forbid that we have people who might rock the boat or expose shortcomings.

The gagging of customer advocacy groups under this government with withdrawal of funding continues (look at Consumer SA, Respond SA and the Australian Aiding Children Adoption Agency), as does the gagging of departmental employees, my most recent example being the government scientists who are not allowed to publicly comment adversely about the proposed Whyalla desalination plant. Even the press is being gagged wherever possible, with the *Sentinel* newspaper and ABC journalists in the last few days being advised that they could not attend SA Water consultation meetings being held across my electorate. It was 'invitation only' to what should have been meetings open to the public. One of my personal assistants and his partner, who did apply for an invitation, did not get a response and did not know that the meeting was being held. I suspect they were weeded out as undesirables.

I am sure this government would be happier with all South Australians living concentrated in the confines of our City of Adelaide, using the super-efficient super hospitals and super schools or, at the very most, living in the regional cities. Everyone else is just a huge inconvenience. But, of course, the government does not want to do away with our volunteers, because who else is going to continue to privately fundraise to help keep services in the region, man the phones and the ambulances, not to mention the home support and transport services, and keep people in the bush

earning the taxes and paying the charges and endless levies needed to support city bureaucracies? People in regions do not complain for complaining's sake. We do contribute significantly to this state's coffers. However, we are increasingly becoming more and more ignored.

Smaller country hospitals have been omitted from South Australia's Health Care Plan 2007-16, leading to the assumption that these hospitals are of no concern to the Labor state government, which actually appears to be planning for their demise. As the Lower Eyre Health Service stated, 'Generalities stated within the plan about country South Australia and, in particular, about smaller community hospitals in rural areas have meant that limited details are creating concerns about the implications of the entire health care plan.'

These concerns and assumptions are reinforced by past Labor action when previously in office. Labor made a start of downgrading country hospitals, but such was the outcry that the plan was suspended. In the meantime, we had a Liberal state government that supported and strengthened country hospitals and retained acute care services. A state government that governed for the whole of the state was greatly appreciated, and is being sorely missed. It is an indication of what would happen under a Labor federal government.

Small country hospitals that have been established through the tremendous sacrifice of those living in the district in order that their communities could have localised health care on Eyre Peninsula are clustered together to help gain further efficiencies. They work together in an integrated process of management and delivery that reduces wastage and management costs, but that is not what Labor really wants. Labor wants control, just as tyrants and dictators seek absolute control. Now, with the new hub concept, only Port Lincoln, Ceduna (some time in the future) and Whyalla are to be upgraded to provide services for the Eyre Peninsula region. Even then, will the state government really provide the funds needed?

In Port Lincoln, many services are now inadequate. The dialysis service does not even provide for the local need, with people having to go to the city. There are no resident psychologists and, even with a local gaol, no forensic psychologists. Mental health across the region, with the drought, is at crisis point. Many of the small regional hospitals elsewhere in the state are private hospitals, and I am beginning to think that this is the only way in which we will be able to keep adequate health services in our regions, particularly if the federal government will provide some help; otherwise, they will become aged care homes. The federal government has already provided the Wudinna and Tumby Bay hospitals with the funds to build properly equipped modern health centres.

I personally thank all the volunteers who have served so faithfully and well on hospital boards and auxiliaries. The work they have done for nothing in the country will have to be paid for in the city under Labor's empire building.

The Chairman of the Generational Health Review, Mr Menadue, is quoted in *The Advertiser* as saying:

> The long-term solution must be to get people out of hospitals and develop alternative areas of care in terms of super clinics that can attend to minor surgeries, minor accidents, and a whole range of services.

However, without acute care hospitals and doctors, there is no trained person and no equipment to attend to minor surgeries, minor accidents and other matters. Mr Menadue's use of the words 'super clinics' shows his aim quite clearly—an aim that has been adopted and is now being pushed by Labor, since it fits with its party's ethos of controlling everything. Super clinics will not exist in the bush, and the outcome will be a drop in health care as people try to treat themselves, which often has disastrous results, rather than seek medical help that is hours away. We already have a higher death rate than those fortunate enough to live in the city, and this bill will only compound the problem.

This is the state of health delivery that this government is trying to put forward as an advance. It will not meet the current challenges and demands of health—at least, not in the country—which is one of the claims made by the government with respect to the necessity for the changes. On Eyre Peninsula, we already have an excellent system of home and community care, which is funded by state and federal governments. A comment was made to me that the city just does not have the volunteers to provide the kind of service that we are able to provide at a minimal cost in the country, where every dollar is stretched far beyond what is the case in metropolitan areas.

This bill shows yet again that Labor cannot be trusted. It is yet another example of Labor's deceitfulness in making public statements along one pathway while planning the opposite action.

The government's health reform documents, which were published in June 2003, stated: 'There will be no forced closure of local boards in country South Australia.' Not only is closure on the agenda, but the total abolition of local boards is the aim of this government—and, dare I say, the complete abandonment of small country hospitals for the delivery of acute health care, including obstetrics.

Small country hospitals have worked together cooperatively in management and service delivery for many years. Each country hospital is a centre for its respective district, providing a mantle of safety to that particular region. I use the phrase 'mantle of safety' deliberately. It is a phrase that was used by the Reverend John Flynn to describe his vision for what became the Royal Flying Doctor Service, bringing health care to remote and isolated Outback South Australia. This is happening at a time when, because of the hub system proposed, retrieval of patients back to the bigger hospitals will be needed more than it ever has been since the small hospitals were first built. These retrievals are mostly carried out by way of fixed wing aircraft on Eyre Peninsula, and the local hospitals have to pay for them. I ask the minister: who will pay for them now? At the briefing we were given, the bureaucrats were unable to tell me. I do not think that they would have been aware that the cost is not covered (as are helicopter retrievals close to the city) by the government through the emergency services levy.

It has been proved many times over that the most effective, efficient—and, in the case of health, safe—management, is where decisions are made as close as possible to the action. This government's blinkered and inflexible move to centralise everything is a recipe for poor service delivery at the coalface, inevitable waste and mismanagement through the layers of bureaucracy and, ultimately, a reversion to a Third World standard of health care delivery for those who live in the geographic majority of the state. With the increase in mining activity, it would seem to be commonsense that our country hospitals and health services should be maintained and increased, not slashed to non-existent. The Lower Eyre Health Services submission on the Health Care Bill to the Minister for Health states: 'Limiting the effectiveness of any region through eroding its health services has significant implications for the future survival of these regions.'

The government has failed to state how a unified single public health system will improve the coordination and integration of services in country South Australia. Government bureaucracy is noted for its poor financial performance. This lack of financial performance cannot be laid at the feet of departmental heads and staff, since they are constrained by a great many (often petty) rules that they must obey and, of course, the minister, or ministers, who also have a big say in the management. Local boards know about the increased costs of time, travel, training, freight and recruitment in country areas. However, the 'one size fits all' scenario is this government's requirement.

Certainly, this bill gives the minister great control, which may be exercised against the advice and commonsense of departmental officers and local knowledge. In fact, by the time the various councils and committees are set up, more of the scarce health dollar is likely to go into administration located in the city than is now the case. The sweeping changes in governance issues are not being put in place to save money or to deliver better health care but only to fulfil the Labor Party's culture and goal to centralise and control and, ultimately, to eradicate freedom.

The changes to the ambulance service again demonstrate the city-centric, limited outlook of the Labor government and ministers. It is obvious that they look at ambulance services as vehicles being driven by paid personnel over sealed streets to transport people from home to hospital, or to attend accidents—which, again, occur on sealed roads. Country ambulance services are provided by volunteers: no volunteers, no ambulance. Volunteers undergo training, giving freely of their time and expense, to gain accreditation for their communities at no charge. Driving in all weather on unsealed country roads for hours, not minutes, requires expertise that drivers do not always have and, therefore, it presents dangers not found on sealed roads. A driver unused to corrugations, for instance, can easily overturn a vehicle, and this happened to a Swiss couple on an outback South Australian road and the couple and their infant were killed.

The recent fatality that occurred on the unsealed Wirrulla to Glendambo Road outside of any council area was attended by Streaky Bay's volunteer ambulance service. They had to drive to the accident, deliver first aid, then drive back to Ceduna Hospital with the victims and then back to Streaky Bay before returning to their homes or place of employment, a distance well over 40 kilometres.

Emergency services work and train together, each appreciating the skills and responsibilities of the various services. This close working relationship will not be enhanced by the proposed changes; however, it may be put in jeopardy by an extended chain of command. It is easy to see why Labor does not want local boards of health since this would erode their control, but

it is the seamless delivery of health care that boards provide, including links to the areas that are seldom written into law. One of these areas is the contact between the public, the health services of the hospital, ambulance or whatever, and the decision makers.

The local board is the primary point of contact between consumers, carers and the community and the local health service. The proposals for advisory councils do not adequately pick up this role. It has been recognised for decades that the advances in medical science mean that no government can ever fund health so that every procedure or treatment that can be done scientifically can be paid for. In other words, choices about what is done and where the health dollar will be spent have to be made.

Therefore, it is more imperative now that the hospital auxiliaries and support groups continue their volunteer work and fundraising activities. Port Lincoln hospital is classed as a regional hospital, yet fundraising is essential. A local doctor in Port Lincoln paid for an expensive machine out of his own pocket so that he could treat his patients. This is not an isolated incident. Hospital boards are being duped into becoming fundraisers rather than the local linkage between consumers, carers and the community with the responsibility to maintain and develop local priorities.

The current strong connection between the hospital board and the community spills over into the greater support for volunteer ambulances, St John's, the CFS and the SES services and the like. Local contact encourages residents to volunteer for their health services. Overall, this bill is another example of Labor's ability to increase bureaucracy and the number of public servants required to administer the bureaucracy in the city with a corresponding decline in the number of workers at the coalface. Our state and our people deserve better.

The Hon. J.D. HILL (Kaurna—Minister for Health, Minister for the Southern Suburbs, Minister Assisting the Premier in the Arts) (17:48): I thank all members for their contribution to this debate thus far. I intend to make some statements which I think will probably take me 20 minutes or thereabouts, so I will seek leave to conclude my remarks after the dinner break.

I start by saying that the major contributions made by members opposite relate to the provisions in the bill to change the power and the name of the country health boards, so the majority of what I have to say relates to that. I put it on the record that this bill is about more than just the governance arrangements associated with country hospitals. This is making contemporary health legislation in South Australia and, of course, it deals with the ambulance services and a whole range of other matters.

I say to the house and to all those reading *Hansard* that the government comes to this legislation not with a political agenda in the sense of a party political agenda nor with an ideological agenda—that is, that we are somehow socialising the health service—far from it, in fact. We come to this legislation and the health portfolio with the agenda to make our health services sustainable and to make them integrated in order to provide assurance in relation to health care in South Australia wherever you happen to live.

I could sum it up by saying that we want a safe, affordable and complete health care system in South Australia and that very much derives from the work that was done by John Menadue who produced the Generational Health Review for us. We want a health system which is safe so that, when people go to a hospital or a health clinic somewhere in our state, they can be assured of getting the very best service with the minimum risks associated with the provision of that service. We want it to be affordable, not only to the individual—and that is certainly a key factor, and the member for Mitchell raised the issue about dental health care—but also affordable to the state.

We know now in South Australia that the cost of the provision of health care services through the public system in South Australia is growing about 8 to 10 per cent a year (that is about twice the rate of the revenue basis of our state) and we know that by somewhere around 2030 to 2040 our entire state budget will have to be spent on health if we are to continue providing the same kind of level of health services in the same way that we currently do. That is not sustainable and it needs to change.

It needs to change in a couple of ways. First, we need to have a much more efficient and effective system in place to provide health care in the best possible way so that we can get the best bang for our buck. The second thing we need to do is change the focus of our health services away from the provision of acute services to the provision of primary health care and, particularly, prevention. A whole lot of strategies are in place through the GP Plus health care system which is

aimed to that end. This legislation is not about all of our health reform package but it is a significant part of it, particularly as it relates to governance.

I want to refer to the issue of the country health boards, the matter which has caused the greatest amount of concern for members opposite. I would hope that they would actually think about this and listen to this. We do not want to get rid of community advocates associated with local country hospitals, far from it; in fact, we want to strengthen their role.

What we want to do, what I want to do and what the government wants to do is make sure that we have better systems in place to manage four key areas that are currently the province of the local boards. They are: first, safety and quality issues, or safe performance of health care; secondly, financial management; thirdly, employment situations; and, fourthly, contracts. I will give some examples of where the current system has failed and failed people in country South Australia quite badly.

Before I get into that, I say one other thing about the new health advisory councils proposed by this legislation. The reality for members of country health boards at the moment is this: they go along to a meeting, they are elected to the board, they serve a period of time, and they attend the hospital for a meeting on a regular basis (usually once a month or so). They receive reports from the general manager of the hospital and from other officials. They look at the budget, they make a range of decisions, based on advice from the CE of the hospital, and then they go back to their homes. The chair would probably be more actively involved, and there would be a secretary, a treasurer or other key members of the board who would have greater involvement.

Effectively, that is what they do: they receive reports from the hospital, from the people responsible for the day-to-day management of the hospital, and they say yea or nay. They operate very much in the way school council members operate: they meet the principal, they look at the budget, they get advice about particular programs, they express their opinion in relation to a number of things, and then they go home and come back in a month's time. In the proposals I have before the house, the real changes will be negligible because all those things I have described will continue to be the experience of people on the health advisory councils. They will go to monthly meetings, they will receive reports and the budget, and they will get advice about the overall policy framework. They will be able to have input into what they think the strategic direction of the hospital should be, they will have input into the grounds and they will have input, in particular, into the selection of the senior staff. All those things will stay the same.

The reality for individual members of health advisory councils will be just the same as it is for those who are currently on the boards. The only difference will be that the statutory responsibility they currently have for the management of the hospital when things go wrong will be removed from them. We will have a system in place so that that responsibility will, ultimately, end up with me as the responsible minister. The minister of the day is the person who comes into the house and is answerable for things that go wrong in our health system, and I think it is appropriate that that is the case. At the moment, in relation to country health, the individual boards are responsible for things that go wrong.

During debate, a number of members on the other side raised issues of concern about things that were not as they would like them in country hospitals. In fact, I think that the member for Kavel and a number of others raised the issue of the provision of birthing and other services at the Cleve hospital as an example of something that was not working. I say to that member: that is part of the system we currently have, where we have a local board. The local boards are responsible for all those things and, clearly, they are not able to manage them because they just do not have the resources or the capacity to try to deal with those kinds of complex issues in a modern health system. The system I propose will help provide a system-wide approach of dealing with those complex issues. It does not necessarily mean that every hospital will get everything it wants, but at least we will have a system in place where there is some clarity about what you can expect and what can be delivered.

Members interjecting:

The SPEAKER: Order!

The Hon. J.D. HILL: Thank you for your protection from some of my colleagues, Mr Speaker.

Mr Venning: Rabble!

The Hon. J.D. HILL: I would not use that word, but you might. Another general point I make before going into some of the detail is that a number of members opposite said that this is the government trying to centralise the management of the system. That is not the case. The existing regions will continue. There will be a central northern region, a southern region, the children's, youth and women's region, and there will be a country health region. Those regions will still be the decision-making bodies. At a hospital level, at an individual unit level, there will still be managers who will make decisions at that level. There will also be clinicians who will make decisions of a clinical nature in hospitals, in wards and in surgeries on an individual basis. That is not changing at all. We are not centralising the process. What we are centralising is the responsibility. The buck has to stop with the government, and we need a system in place to ensure that that is the case.

In the Generational Health Review, John Menadue identified the need to re-orient efforts to prevent illness, provide greater primary health care and reduce the emphasis on acute care in hospital services. In relation to country health services, he found that there was considerable duplication of effort, with separately funded planning, advisory and governing bodies which made decisions about health which had little impact on improving health outcomes. We dissolved the seven health regions last year and created Country Health SA, which brings together the administrative elements of the seven country regions with the administrative element that was in the Department of Health. Effectively, we have taken out a layer of bureaucracy in the management of country health.

We have also announced expanded health services in four country hospitals: Whyalla, Port Lincoln, Mount Gambier and Berri. Surprisingly, a number of members commented on that decision in a negative way. I would have thought that the provision of more services in the country would have been welcomed. The decision to expand services in the country does not mean that just those hospitals will have expanded services. What we would like to see is those hospitals become locations from which doctors, who are based in those locations, can travel to other hospitals and nearby regions and provide services on a regular basis. For example, an orthopaedic surgeon may well be based at Whyalla who can travel to other towns and, on a regular basis, provide surgical assistance to those communities through those local hospitals, if there is sufficient demand and sufficient capacity to aid patients in the recovery stages.

So, rather than taking services away from country hospitals and putting them into major country hospitals, we want to take services out of the city and put resources from the city into the country to expand the capacity in those country regions. The new Health Care Bill is the next step in creating greater integration and coordination of services across rural areas, with common standards and policies for its safety and quality, common corporate systems and the equitable distribution of resources based on population need.

[Sitting suspended from 18:00 to 19:30]

The Hon. J.D. HILL: I was going through some notes which reflect upon the reasons for the government introducing this bill, and I will go through them reasonably rapidly. There are a number of things that I want to put on the record and then there are some comments I want to make which respond to statements made by other members, and I will go through those relatively quickly, but I do want to get them on the record.

The new Health Care Bill is the next step in creating greater integration and coordination of services across rural areas, with common standards and policies for safety and quality, common corporate systems and the equitable distribution of resources based on population need. We need consistent mechanisms to work with rural doctor organisations, local government and the federal government so that we can attract the best doctors, nurses and allied health workers to staff our country hospitals. Gone are the days, I believe, of stand-alone hospitals run by volunteer boards. Health is far too costly, too complex and too important for that.

We know that many of the boards have done a terrific job, and I do commend them and advocate hard for their communities, but things have changed and moved on. We cannot afford to let our country health system continue in the way that it is being run at the moment. Local community members will continue to play a vital role in health, advising me and the Department of Health on the priorities for the local area and shaping the services needed.

I will just pick up a couple of points made by members opposite, who may not have had a chance to read the draft constitutions which I have tabled. I think there is a misunderstanding amongst some members opposite that the minister of the day will be selecting members of the health councils. That is not the case. The majority will be elected by the local community, similar to

the way boards are now elected. The local doctors will have a rep, the local government will have a rep, the staff will have a rep and the local member of parliament will also be able to participate or have a rep, in much the same way that secondary school councils have parliamentary representation.

That will give local members of parliament a very strong role to ensure that the HACs do their job and are not denied access to knowledge and information. In addition to that, the minister of the day will be able to appoint three persons. That is similar to the powers that the minister currently has in relation to at least some of the boards. At the moment, the boards have a whole range of constitutions, so this will, in fact, standardise the constitution, but the majority of members will be chosen by the local community.

I will look at some of the issues that have come to my attention over recent years in relation to individual country boards. I have to say that we have 40 or so country boards in South Australia at any given time, most of them probably doing a pretty good job, but there are occasions, too frequent to ignore, where individual boards have not done a good job. I will go through some of those examples. The member for Giles, I think, highlighted the fact that there have been a couple of occasions recently (in the last 12 months) which have resulted in bequests not being used consistently with the terms of the bequest, and that has led to successful challenge and the loss of the bequest, worth nearly three quarters of a million dollars on one occasion. The other required Supreme Court approval to change the way the funds are used. That highlights, for me, the need to ensure that the financial management systems are system wide, rather than just specific to individual hospitals.

In relation to clinical governance, there has been an inconsistent approach across many country health sites. The example of the Riverland hospital where colonoscopies were done on something like 200 people without the piece of equipment (the colonoscope) being properly cleaned, was the result of a failure at the hospital level. I went and spoke to the board about it and, of course, they were very upset about it. I said, 'It was your responsibility to ensure this happened.'

Two things had happened in that case: one, the best practice protocols about the management of inspections of systems had not been complied with, so for 12 months the mistake had not been picked up because those protocols were not being followed; and the colonoscope itself had not been cleaned properly because the staff in the hospital had not been trained properly. That was clearly a responsibility of the individual board. Fortunately, nobody had AIDS, nobody had an infectious disease which could be passed on, but we could have had a disaster where 200 or so people could have been seriously affected.

There was another example at Wudinna, where all sorts of allegations regarding nursing staff and the resident GP came up. The review, as has been said before, found a lack of appropriate leadership and management practices over a number of years and recommended corporate governance training for all board members, annual board performance reviews, and performance reviews for all executive and management staff. These are examples where local boards just did not get it right and problems occurred. It is no good for members opposite to come here, as they did in relation to the Wudinna case, asking questions of the minister of the day and accusing the government of failure, when it was precisely the structure that we have in place which meant that the minister of the day was not responsible. It is to address those kinds of issues that I have introduced this legislation.

In the case of Wudinna, medical and nursing care did not meet contemporary standards at that time. There are other examples of country hospitals not having in place proper drug protocols for morphine dosage and administration. A coroner's inquest into the death of one patient recommended that all hospitals be sent copies of the morphine administration protocols used by the RAH, and that was done, of course, in July last year. In relation to the recruitment of staff, there are many examples of difficulties that boards have faced in recruiting and negotiating contracts with staff.

At times boards have not understood their corporate roles and responsibilities, and this has resulted in some boards negotiating outside of government policies and delegations. We all know about the Gawler obstetricians at the Gawler Health Service. That was just an appalling situation. I do not blame exclusively the Gawler Health Service. I think that, with the regional board and the department itself, there were problems at all levels. I think there was a confusion of responsibility that produced those problems.

We have had examples at the Mount Gambier hospital where a South African specialist, who was recruited from New Zealand, arrived at Mount Gambier hospital, changed his mind and

returned to New Zealand on the next available flight. There is another case of a doctor who was recruited at Wudinna from India, and left within a week. The director of nursing hired by the Lameroo community fled before a welcome party was held. These are examples of recruitment and management of staff. They are issues that I think need to be managed at a departmental level.

Another example involves poor contract negotiation, which led to the delay in pursuing a tender for medical imaging services at a large major country hospital. It almost led to the hospital being without an imaging service. Because of its frustration at the delays in managing the contract, the company involved was about to set up a new service in the town, which would have meant that the hospital was excluded.

The department found out about it, and we intervened and fixed it up. I spoke to the chairman of the board, and he said, 'Well, we weren't told by the general manager', and that is precisely the point: boards are not necessarily hearing all these things. If we had had a strong management structure in place, that general manager would have had to report to somebody in Country Health, and there would have been supervision.

I want to make sure that major contracts, employment, financial management, and safety and quality issues are all managed at an appropriate level; that is, at Country Health SA level, not at individual board levels. The Health-Care Bill will give greater authority in those areas. Those areas are crucial to the management of the health service and to the delivery of better health services for people in the country. The existing arrangements for those examples that I have given have been disastrous for country communities. In every case, it is the state government through the Department of Health that has had to intervene and fix a problem that has occurred because of the decisions that were made at the local level.

I now refer to some of the particular issues raised by the deputy leader and other opposition speakers. The deputy leader raised questions about increasing the powers of the chief executive and the minister. I advise the house that it was the Hon. Dean Brown, who was the then Liberal minister for health, who transferred the powers of the Health Commission, under the Health Commission Act, to the minister and the chief executive of the department, leaving the commission with residual functions around standards of public and environmental health. Effectively, the Health Commission has been gutted as an organisation for quite sensible reasons. I do not criticise Dean Brown for doing this: he did it for very good reasons.

He also amended the Health Commission Act to give the minister power to direct incorporated hospitals and health centres, and there are very complex provisions in the act to do that. He recognised, as has every health minister in recent years, including minister Armitage, that the current system is not working and needs to be improved.

There are clear and strong community expectations that the Minister for Health be accountable for the public health system, as I have said many times. The buck stops with me. I come in here and get to answer the questions. We would have an absurd position if one took seriously the existing arrangements where I deferred every question back to the board and said that I was not responsible for that as there was a board in place. That would be the outcome if Prime Minister Howard had his way.

In addition, the bill provides for transparency and accountability if the minister uses the power to transfer services or property assets, or to dissolve or amalgamate HACs. These mandated requirements include consulting with HACs, as prescribed in regulations; be satisfied the community is being consulted; have prescribed grounds for dissolving or amalgamating; require remediation before transferring property; and give two months public notice in the *Gazette* before transferring property.

It was the Statutes Amendment (Public Sector Employment) Act of 2006, passed last year, that gave powers to the chief executive to employ and allocate staff. Largely that issue has been managed and this act brings it into line with those provisions. There has been a lot of talk about the bureaucracy. The total staff employed within the health sector is just under 27,000, of which 711 (or 2.7 per cent) are in central office, so there are a relatively small number of central office bureaucrats. It is interesting that the opposition—

Ms Chapman interjecting:

The Hon. J.D. HILL: I am just about to get to that. It is interesting that the opposition criticises the health system for having too many bureaucrats yet, when we try to centralise the services, as minister Wright is attempting to do, we get criticised for taking public servants out of regional areas: you cannot have it both ways.

The second issue I refer to is the Health Performance Council. The deputy leader indicated that the HPC would be relying on data provided by the department, which could be skewed. She also indicated that the HPC would not be independent, because it would be supported by the department rather than having the ability to employ its own staff. The Health Performance Council will be provided with the same data the department provides for national reporting purposes, including the commonwealth Department of Health and Ageing, the Australian Institute of Health and Welfare and Australian Bureau of Statistics, and it conforms to national processes and standards.

The Health Performance Council has two or three main roles, one being to provide me with advice that it chooses to give me about issues of the day and another is to provide me with advice about issues on which I ask it to provide me with advice. For example, I would want regular advice given to me about the provision of services, particularly for Aboriginal people, particularly around children and birthing. We need an independent view on that, regularly looking at it and goading us into action. The service itself might provide information on any other service. I am sure the Minister for Mental Health would want regular advice on mental health issues.

In addition to doing those things as part of its regular ongoing role, it would also provide every four years a state of health report for the parliament as well as for the government. That could be akin to the State of the Environment Report that the EPA produces every five years for the parliament. I chose four years so there would be at least one every parliamentary term.

The purpose of that will be not just about the state of the Department of Health but the state of health of our citizenry, covering public, private and all sorts of institutions. It would give us information about how many babies were born underweight, how many children died within the first 12 months—all the statistical information about South Australia and how it relates to our State Strategic Plan. It will be a very useful guide to allocating resources and developing our strategies for the future. It will be used in the same way by government departments as the State of the Environment Report is used.

There was an issue about advice provided by health advisory councils. A HAC will provide advice in the same way that boards have currently been doing. They can come directly to me; there is nothing in between them and me if they choose to use me. In addition, and as I have already said, there will be a local member of parliament or their representative on there, so they have a background way of getting information into parliament if they choose. The bill does not in any way change the value in input of this advice. According to its constitutional rules, a HAC can advocate or promote the interests of its community and provide advice on the provision of health services, programs, issues, priorities, plans or other matters referred to it by the minister or the CE.

The principles outlined in clause 5 explicitly require health services to take into account the needs of people living or working in the country and to engage with the community in the planning and provision of services. It is the advice of HACs in the country regions that will be a primary mechanism to enable service providers to work with the community to ensure that they can apply these and other principles drafted in the bill, and the model constitution tabled in the house enables a member of parliament, as I have said, to be on it. I encourage members to look at those provisions.

The member for Goyder stated that volunteers would be less likely to participate, given that the HAC would no longer own or control the assets. I think that is inaccurate—in fact, I believe it is more likely that we will get people involved—and at this stage I seek to table a document that details all the AGMs held in the period 2005-06. It is a purely statistical document that names the hospitals, the meeting quorum, the actual attendance at the meeting, and who was eligible to vote.

It is worth highlighting that out of the 44 boards, eight failed to get a quorum at their last AGM—and that is where quorums are in the region of 12 to 18 or thereabouts. Another half a dozen or so just barely reached their quorum. I think it would be fair to say that in very few of the boards were there large attendances.

The ACTING SPEAKER (Hon. P.L. White): I ask the minister to clarify whether he wants to incorporate that information into *Hansard*.

The Hon. J.D. HILL: Yes, I would like to do that. I seek leave to have this information inserted in *Hansard* without my reading it.

Leave granted.

Annual general meeting information re country health units incorporated under South Australian Health Commission Act 1976

Incorporated Health Unit	Annual General Meetings		
	Actual Attendance	Quorum	Who is eligible to vote
Balaklava and Riverton Districts Health Service Incorporated	13	18	Community consumers
Barossa Area Health Services Incorporated	13	18	Resident electors (i.e. 'a person who is enrolled as an elector in pursuance of the Local Government Act 1934, and resides within the service area of the Service')
Bordertown Memorial Hospital Incorporated	26	15	Community consumers
Burra Clare Snowtown Health Service Incorporated	16 (12 apologies)	15	Community consumers
Ceduna District Health Services Incorporated	15	16	Community consumers
Ceduna Koonibba Aboriginal Health Service Incorporated	19 (5 apologies) (1 non-Aboriginal)	15	Community residents (i.e. 'an Aboriginal person who resides in the area')
Coober Pedy Hospital and Health Services	17	11	Community consumers
Country Health SA Incorporated	-	No requirement in constitution to hold an AGM	
Eastern Eyre Health and Aged Care Incorporated	19	16	Community consumers
Eudunda & Kapunda Health Service Incorporated	21	18	Community consumers
Gawler Health Service Incorporated	30	25	Community consumers
Hawker Memorial Hospital Incorporated	18	15	Community consumers
Kangaroo Island Health Service	18	15	Community consumers
Kingston Soldiers' Memorial Hospital Incorporated	20	12	Community consumers
Leigh Creek Health Services Incorporated	15	15	Community consumers
Lower Eyre Health Services Incorporated	17	16	Community consumers

Loxton Hospital Complex Incorporated	25	16 residents	Residents ('any person who is enrolled as an elector on the House of Assembly roll for the District Councils of Loxton and Brownswell')
Mallee Health Service Incorporated	21 (16 apologies)	15	Community consumers
The Mannum District Hospital Incorporated	17	16	Community consumers
Meningie and Districts Memorial Hospital and Health Services Incorporated	28	20	Community consumers
Mid North Health	No AGM as only incorporated on 1/7/2006	15	Community consumers
Mid-West Health	39	16	Community consumers
Millicent and District Hospital and Health Services Incorporated	10	12	Community consumers
Mount Barker District Soldiers' Memorial Hospital Incorporated	18 (4 apologies)	12	Community consumers
Mount Gambier and Districts Health Service Incorporated	10	8	Community consumers
The Murray Bridge Soldiers' Memorial Hospital Incorporated	32 (11 apologies)	16	Community consumers
Naracoorte Health Service Incorporated	22	16	Community consumers
Northern Adelaide Hills Health Service Incorporated	16 (8 apologies)	18	Community consumers
Northern Yorke Peninsula Health Service	13	10	Community consumers
Penola War Memorial Hospital Incorporated	11	15	Community consumers
Pika Wiya Health Service	19	15	Community residents (i.e. 'an Aboriginal person who resides within the district of the Corporation of the City of Port Augusta including Davenport Aboriginal community and surrounding communities, namely Quorn, Hawker, Leigh Creek, Copley, Nepabunna and Marree')

Port Augusta Hospital and Regional Health Services Incorporated	12	No quorum has been set for AGMs	'Any person who is enrolled as an elector in pursuance of the Local Government Act, 1934, as amended, within the municipality of the City of Port Augusta'
Port Broughton District Hospital and Health Services Incorporated	27	25 (absentee) (5 apologies) (no absentee votes)	Community consumers
Port Lincoln Health Services Incorporated	46	15	Community consumers
Port Pirie Regional Health Service Incorporated	26 (no voting occurred at this AGM, so no absentee votes)	15 (absentee votes allowed)	Community consumers
Quorn Health Services Incorporated	13 (5 apologies) (no absentee votes)	15 (absentee votes allowed)	Community consumers
Renmark Paringa District Hospital Incorporated	25	No quorum has been set for AGMs	'Adult residents of the districts of Renmark and Paringa'
Riverland Regional Health Service Incorporated	24	18	Community consumers
South Coast District Hospital Incorporated	18	15	Community consumers
Southern Flinders Health Incorporated	Not incorporated until 1/8/2006	15 (absentee votes allowed)	Community consumers
• Crystal Brook District Hospital Incorporated (2005 AGM)	15 (7 apologies)	15	Community consumers
• Rocky River Health Service Incorporated (2005 AGM)	19 (15 apologies) (no absentee votes)	15 (absentee votes allowed)	Community consumers
Strathalbyn & District Health Service	15	20	Community consumers
Tailem Bend District Hospital	29	15	Community consumers
Waikerie Health Services Incorporated	17	12 (absentee votes allowed)	Community consumers
The Whyalla Hospital and Health Services Inc.	39	15	Community consumers
Yorke Peninsula Health Service Incorporated	17	15	Community consumers

The Hon. J.D. HILL: Ironically, the one board that had a rather large attendance was the Port Lincoln Health Service, which had 46 in attendance while their quorum was 15. The Port Lincoln Health Service is probably the most enthusiastic of all the boards in favour of the reforms that I am making—and I would just like to bring that to the attention of the house.

I believe that taking the burden of responsibility off the boards will allow people to be more enthusiastic about participating in the HACs and allow them to focus on things that communities are best able to do, and that is to do the work that volunteers like to do in country health—support the hospital, raise funds, participate in planning for the site, advocate for their hospital, help select the CE, and those kinds of things (which I think I have outlined before).

I have made the point previously that regions will be maintained under the legislation; we are not actually getting rid of regions, we are just getting rid of the boards that operate within the regions. So it is not centralisation of decision-making: decision-making will still be made at a regional level and at individual unit levels. What will be in place will be a network or system of responsibility links so that the individual hospital or individual health unit is linked to the region, the region is linked to the head office, and the head office is linked to me. So there is a clear chain of command and a clear chain of responsibility, which is vital.

There were various other references made which I will not go through, other than that regarding private hospitals (and the deputy leader made a large point about private hospitals). This bill, with the amendments we are making, is about the public health system: it is not about the private health system. Despite her claims that we are trying to take away the boards and private hospitals (which is not the case), we have no intentions in relation to private hospitals whatsoever.

I merely make the observation that the provisions in the legislation have been around for some time. They probably need to be looked at in the future, but there is no particular agenda or plan to do anything in relation to private hospitals. If and when we do go through the process of amending that legislation, we will do it as a result of close discussion and consultation with the private health sector.

The deputy leader also referred in passing to the number of injured hospital workers. She made the claim that the number had quadrupled over the past three years. I forgive her for making that claim. Unfortunately, it is an incorrect claim. The honourable member was basing it on an article that was in *The Advertiser*. The data in *The Advertiser* in 2006-07 was for hospital performance in both registered and private self-insured arenas. The hospital injury number in 2003-04 (which was the first group) did not include the public sector. The first set of figures was the private sector and the second set was both sectors. Obviously, those figures could not be compared.

New claims numbers for public sector hospitals over the past four financial years are: 2003-04, 1,203; 2004-05, 1,195; 2005-06, 1,188; and 2006-07, 1,198. It is a relatively steady performance. There is a slight decrease by a couple over that time so it is trending down. The total health portfolio new claims for the past four financial years are: 2003-04, 1,873; 2004-05, 1,868; 2005-06, 1,719; and 2006-07, 1,768. It is a decline of about 6 per cent over that time.

Finally, the deputy leader talked about the government's commitment to funding the health system. Between 2003-04 and 2005-06, the Australian Institute of Health and Welfare estimated that total health expenditure in South Australia increased by $830 million (14.2 per cent). If we take the last budget into account it is over $1 billion. The state's share has increased by $306 million (20.6 per cent) and the commonwealth's share by 14.8 per cent. In relation to public hospitals, the total expenditure in South Australia has increased by $310 million (20.5 per cent). The state's share of this has increased by $221 million (29.9 per cent) and the commonwealth's share has increased by 11.5 per cent.

The total health expenditure per capita in 2005-06 was $3,912—4.1 per cent above the national average and higher than anywhere except the Northern Territory—which is contrary to the figures the deputy leader brought to the attention of the house. The increase in expenditure which the state provided (over 70 per cent) was necessary to meet the increasing demand on our health system. Emergency department attendances increased by 5.8 per cent in 2005-06, total separations increased by 4.2 per cent and elective separations increased by 7.2 per cent.

An additional $38 million had already been provided for the period 2006-07 to 2009-10 to increase the level of elective surgery activity. In 2005-06, South Australian hospitals were efficient, with the lowest average cost per casemix adjusted separations in Australia (10.8 per cent below the national average). I do not want to suggest that our health system does not need work—it certainly does. This legislation is part of the government's plan to reform, strengthen and better integrate the health system.

Finally, in relation to Country Health, I think the member for Schubert said that there was a cut of $35 million. In fact, the 2007-08 budget of $560 million represented a $55 million increase on the 2006-07 budget. Some savings are required in Country Health, but they will be ploughed back

into Country Health for bureaucracies; and, also, we will be getting funding for aged-care beds from the commonwealth (which I understand it is prepared to do in many cases) rather than from the state.

A number of other things were said by various members and I will quickly go through them. In particular, a number of members spoke about their local hospitals. The member for Finniss spoke about local hospitals and how outraged they were. The honourable member mentioned particularly the South Coast District Hospital. I am advised that the chair of that hospital spoke to one of my staff this week and said that the board supports the creation of incorporated HACs to manage assets. He said that they wanted a more informed and timely consultation process and that they support the concept in principle of health reform and regard the bill as progress. I am also advised that the chair of the Kangaroo Island Health Service chose not to make a submission, and indicated that if he had concerns he would have voiced them to me, as the minister, during my recent visit to KI.

The member for Flinders also made some comments about health services. I am advised that the chair of the Eastern Eyre Health and Aged Care Service advised us that she supports the bill now that it provides for incorporation. Her only concerns relate to the future service role but she understands that that is not a matter for the bill. The chair of the Lower Eyre Health Services indicated support for incorporated HACs, wants to select the chair for the HAC, and wants the minister to consult with the local community before changes are made, which we have done. They want the incorporated HAC to hold assets, which we have also done. Mr Tim Scholz, chair of Mid West Health which covers Wudinna, said, I am told, that the bill resolved all specific concerns regarding the role of the HAC and control of assets, the ministerial subcommittee, and supports the bill.

In the case of the member for Schubert, I am advised that the Barossa Allied Health Service generally supports the reforms to the bill but wants HACs incorporated to hold assets. It wants members to be elected by the community, and for the health care manager to be obliged to support and interact with HACs. It indicated it did not want fundraising incorporated in the role of HAC. We picked up all those issues. I am advised that the Northern Adelaide Hills Health Service (which also covers the electorate of Schubert) is also supporting the bill.

As the minister, I spent an enormous amount of time consulting with the various representatives of the existing boards, as did the department. We have had a number of meetings. I set up a focus group, which represented a range of people from various country boards. They self-selected: they were not chosen by me. We worked through the details of their concerns, and I am pleased to say that I think the overwhelming majority of the people are satisfied with the direction we are taking. Many of them are enthusiastic, some less so. Only three or so boards of which I am aware are openly opposed to it. The great concern for many was that the assets should be held by the local board, and we have set up the system in such a way that the incorporated health advisory council will own those assets and will have absolute control over how those assets are used.

I think we have worked very hard to make sure that the local board members have had proper consultation and have had a strong opportunity to have a say. I am very confident that the balance of the legislation picks up their concerns and will provide them and people in country South Australia with a much stronger health service over time. I commend this bill to the house.

Bill read a second time.

In committee.

Clause 1.

The Hon. G.M. GUNN: I refrained from making comments during the second reading. However, in relation to the short title, this is an opportunity clearly to put my views on the record. Having listened carefully to what the minister had to say, I was very happy to see the regional health boards removed, because I did not think they played any significant role. However, I am very passionate about the role of local communities and I think under this legislation there is a lessening of their influence, and I think that is disappointing. I also think that a pretty hard sell has been done by the bureaucrats to bring people around and get them to accept this proposal, from my information.

Further, we know that administrators do not like local people being involved, just as ministers and heads of departments do not like backbenchers. They are a nuisance: they ask questions, they talk, and they express their views. However, that is democracy, and democracy is

also about having decisions made as close as possible to where services should be delivered. If you have local people involved with a considerable amount of authority, they will vigorously stick up for maintaining their services. No matter what is said here, if I were a wagering person—and I am not—I would say that within 10 years there will be a lot fewer services at rural hospitals than there are today, because there will be attempts to centralise and rationalise them under the guise of improvement.

So, I hope I have made my point clear: I do not agree with these changes. I was totally in agreement with getting rid of regional health boards, and I attended some of the meetings when the story was being broadcast about amalgamating hospital boards. I know that one bureaucrat got terribly cross with me and he said to me after the meeting, 'You have an iron fist covered with a velvet glove.'

The Hon. J.D. Hill: What, he did?

The Hon. G.M. GUNN: No, I had, about what I had to say at the meeting. I said to him, 'That's just because you don't like what I had to say. I had more people on my side than you had at the end of the meeting.' They agreed with me when I told them they would lose services, and that is what is happening. So, minister, I sincerely hope—I will not be here in 10 years' time, and people will probably say that is a good thing, but I want to—

The Hon. J.D. Hill: Lloyd Hughes' record is there to be broken.

The Hon. G.M. GUNN: Well, someone else can break the record. There are only five people who have been elected 12 times to this place; I am one of them, and I do not intend to be the odd one out and go one more. I think that I have probably—

The Hon. S.W. Key: You must have been a baby when you were first elected.

The Hon. G.M. GUNN: I was full of energy and vitality, and came here fresh faced. I came here because of bureaucrats, and I suppose I will still be fighting them when I finish, because of those nasty experiences I had as a young person which I have never forgotten.

So, I sincerely hope that these provisions are not used to downgrade local facilities and local decision making. During the next 2½ years I intend to take a very close interest in what is going on in the hospitals in my area. I recall that some years ago the people in power (the bureaucrats) told one of the administrators at my hospital that he was not allowed to talk to me as a local member, because they would make a decision that the locals did not want; the locals would come to me and I would ring the minister and have the decision overturned.

The people concerned were really angry. Of course, the moment they gave that instruction, the person in question could not get on the phone quickly enough to tell me, and I went to the minister again. I sincerely hope that we are not going to have this imposition from a great height by Sir Humphrey Appleby, or one, two and three, because the minister would know, as a former minister for transport, how one of the CEOs tried to gag people from talking to members of parliament.

One of those characters we had to put up with sent a fax saying that they were not allowed to talk to people like me. The funny thing was that, within two minutes of that fax being sent, one came through on my fax machine. When I read it back to him at a meeting of the Economic and Finance Committee, he did not like it very much, but that was the end of that. I hope that this bill is not used to curtail free speech.

The Hon. J.D. HILL: I thank the father of the house for those comments. I will make some observations about what he said. I will try to give him some assurances—and, in part, I share the concerns he has—that the system I am trying to set up is to do not what he is suggesting. The first point is that I thank him for his support of the abolition of the seven regional boards (which he gave publicly), and I agree with him completely. The second point is that, if one looks at the services in rural South Australia now with the current arrangements with the existing boards compared with 10 years ago, there are fewer services in parts of rural South Australia, particularly in the area of obstetrics.

That is not driven by the government's arrangements that are in place. That is driven, in part, by the availability and willingness of doctors to work in particular communities. A number of members have raised concerns about Cleve and the fact that the obstetric service is no longer available. That is not something over which the hospital board, Country Health, the department or the government has any control, because the provision of health services in country South Australia largely is driven by the private sector funded by the commonwealth government through

the provision of GP specialists. If they choose to leave, or if they are given a bigger office somewhere else, they will leave.

I am not saying this about the guy from Cleve, but I do know that a corporate health provider who runs the corporate GP clinics based around Sydney and Melbourne—there are fewer of them in South Australia—is offering country doctors $500,000 to buy their practice and take them and their provider number and put them in a GP clinic in one of the inner city areas, because they cannot get doctors either. They are going around offering bribes. How can a rural community face that and deal with it? There is just no way they can. There is no way we as a system can deal with that either. A whole lot of things need to be changed, and that gets into the state-commonwealth relations.

One thing of which I am sure, member for Stuart, is that, if we have the model we are proposing not only through this legislative change but also by developing a country health plan, we may not be able to provide birthing in every community that wants birthing, but we will have a pretty clear idea where we can have birthing, what support systems need to be put in place and how it can be managed into the future so that it is sustainable. At the moment, every individual hospital is responsible (and has been historically) for selecting, choosing and getting staff. Often, when one hospital is short of a doctor or a nurse, they advertise and they pinch the person from a hospital down the road which then has to advertise for staff. There is this multitude and a never-ending series of appointments and recruiting processes.

We are doing all that at a central level now. It makes sense to have one ad saying, 'We need a doctor here, here and here and a nurse here, here and here.' We want to manage that not only through country health as an entity so that we can try to fill the gaps where best we can but also by the provision of extra services through four or five general hospitals—Whyalla; Port Lincoln; Port Augusta, to a certain extent, especially in Aboriginal health; the Riverland; and the South-East.

We want to build up a team of doctors and nurses who are specialists in those areas and who can not only provide the bulk of services at that location but also provide services where appropriate and where possible at adjacent networked hospitals. For example, a specialist surgeon might be at any one of those towns, but they could then travel to other communities.

I was recently in Ceduna, and I met one of the doctors from Ceduna who travels to Whyalla—or he might have been in Whyalla and he was travelling to Ceduna; I cannot recall. He provides a peripatetic sort of service. We want to see more of that and, if we can build up those four hospitals where greater medical services are provided, we know we will attract more doctors and a better range of services. We will also be able to train more doctors and get more country kids to train in country locations. We are more likely to get doctors who will want to work in the country.

That is the theory behind this. I recognise that there are many aspirations in all this, and one cannot guarantee anything. There is nothing more certain than that over the next 10 years country health will change. However, we want to make sure that that change is carried out in a planned, managed way, so that we can maintain the maximum amount of health outcomes and services that we can.

In terms of the boards being answerable to the ministers, I just make the point to the member for Stuart that, under the new model, he will be on every single hospital board in his electorate if he chooses to be, and he will hear exactly what is said around the health advisory council. There will be reports from the CE and the doctors. He will know intimately about any of the issues and be able to raise them in this parliament or in any other context.

So, if you like, that is the government taking a risk by trusting that the system will work in a transparent way. We have it with schools, and I do not see members of parliament misusing that right or responsibility. We all go to our schools as often as we can, or we appoint people to go there. In the same way, members of parliament will have direct representation on those HACs. So, if it is not working, I would expect members of parliament to tell me or raise it in the public arena so that the issues can be addressed.

Ms CHAPMAN: Given the government's objective to establish in this bill a unified single public health system, and the importance of its being integrated and being a model that, in the restructure the minister has identified, will therefore be a better health outcome, why did he not deal with a 20 year old piece of legislation, which also relates to the health of South Australians and which is under his jurisdiction, namely, the Public and Environment Health Act 1987?

The Hon. J.D. HILL: As the member knows, that is a separate piece of legislation, and work is being done on it. I would expect, in 12 months or so, to bring to the parliament—and, before

that, to the attention of the public—the proposed changes to that legislation. We will go through a proper consultation process. The member is right: that act also needs revision.

Ms CHAPMAN: An explanation was given in the minister's second reading speech as to why he did not proceed to review the private hospital licensing legislative process which, as I understand it (and I have not checked it word for word), has largely been lifted from the SA Health Commission Act and placed in this bill, to apply until such a review takes place. He has added more recent comments since my contribution to the effect that there is no agenda on the part of the government in that process, other than the fact that it is part of a licensing process within legislation that is 30 years old and, therefore, needs some review.

However, he also said that he did not want to introduce issues in relation to what it was necessary to reform in that area (to use his words), because it would confuse the matter. Even if there is no sinister or adverse agenda for private hospitals, what prompted the minister to indicate to the house that there were reforms he had in mind, but that he did not want to confuse the matter?

The Hon. J.D. HILL: The provisions in this legislation are about the public health sector, and that is what we have been focusing on, because that is ultimately what I am responsible for. I have no ambitions—we have no policy, in particular—in relation to the private sector, except in one regard, in that we want to cooperate with the private sector. It seems to me that, in a whole range of areas, it makes sense to cooperate with the private sector—not just the hospital sector but also the aged care sector, pharmacies and the like. I want to see us work more closely with that sector, particularly so that we have an integrated delivery of services to people who might cross between sectors—people who go to private pharmacies and private doctors and end up in public hospitals, private nursing homes and sometimes in private hospitals.

So, to be able to work across all of those sectors in a cohesive way makes sense. We would want to do more training of our staff in private hospitals. They are the beneficiaries of the public training system, and I think they would welcome, in many cases, the participation of trainees in the provision of their services. If there is a capacity for research, or networking the research processes in public with the private, I would like to see that. Of course, there is the opportunity for some services to be delivered through the private sector when the public sector does not have the capacity, whether it is equipment or surgery space and the like. So, I am quite open about that; we need to cooperate together.

However, I have no agenda or particular issues in relation to the way in which the private sector operates now. I merely make the observation that the legislation is 30 years old, so it is probably time for it to be looked at in terms of making it contemporary. However, that is not to say that there is any agenda, and I want to assure the operators of private hospitals that I have no agenda in relation to them. We have no time frame for reviewing the legislation; it is just something we recognise that needs to be done at some subsequent time.

Ms CHAPMAN: I will come to the question of submissions, then. Whilst you make the comment, minister, that that is something that can be dealt with down the track, and you have reaffirmed that there is no negative agenda on the part of the government in relation to the private sector, you did see fit in this bill to introduce as a new item amongst your areas of responsibility (and this will be discussed further in clause 6) 'to promote a positive relationship between public, private and other health sectors'. Whilst I do not doubt that it is an objective you want to incorporate in the bill, it seems rather unusual that you would start out with what your new objective is going to be but not review that sector. In any event, we will see what happens in relation to that issue. In relation to the submissions themselves, some of which you referred to in the second reading explanation and some in your response, a number of the submissions are published on the website. I ask the minister: why it is that only some and not all of the submissions were published before this debate?

The Hon. J.D. HILL: I asked for all of the submissions to be published. We felt that the institutional ones (that is, from a public board or public entity) could be published without seeking approval. In the case of submissions from individuals, we asked them whether they would object to their submission being published. Most said yes, but I gather that a few said they did not want their submission published. I guess it is something for future reference for me that, in seeking submissions in the future, we should ask the people in advance whether they are happy to have their submission published. However, we wanted to get all of the submissions out on the public record, where the biddees were happy to allow it, and I gather that was pretty well most of them.

Clause passed.

Clause 2.

Ms CHAPMAN: I thank the minister for providing that information. However, I indicate that on our search of the website we found that the minister has made reference to some of the submissions, particularly in his recent response, of current boards and area boards of hospitals that have not been published on the website. So, I am disappointed that the minister has given a direction but, from our assessment, that direction has not been complied with, other than in the case of submissions from individuals. The opposition clearly respects their request for privacy in that regard. However, the opposition has not been able to locate some of the submissions the minister has referred to.

The Hon. J.D. HILL: I inadvertently misled the member. We asked all of the organisations as well; and the majority said yes. Some did not get back to us and some, I think, said no; there might have been one or two who said no. However, our intention was to put everything on the website. The information I gave during my response was not based on formal submissions. After all this process, I asked my staff, in the past week or so, to phone all the boards and get advice about what their current views were, and I did this as an informal record for my own purposes, and I conveyed some of that information. I summarised it by saying that I think the majority were reasonably comfortable, some were quite enthusiastic, and a handful were dead opposed, which is what you would expect, I guess, in relation to any change.

The ACTING CHAIR (Hon. P.L. White): Deputy leader, if your question is on clause 2, the commencement of this act, you may proceed.

Ms CHAPMAN: The commencement of the act, of course, is all of which passes; hence, I will be asking some questions about how that is going to be effected. I ask the minister firstly: how long after the passage of this bill is he proposing the commencement of this act and, in particular, have all the regulations been drafted and are they ready to support this legislation?

The Hon. J.D. HILL: Our intention is not to commence until at least the middle of next year, and I have given an undertaking to all of the boards that we will do that. I particularly wanted to do that for country health because we are going through the process of developing a country health plan and I thought it was sensible and appropriate that the existing boards should maintain their responsibilities and powers during that process.

The regulations have not been produced. I have tabled some draft constitutions, which are still subject to final negotiation with the boards, but we think we have got them pretty right. Of course, the regulations cannot be drafted until after we have got the legislation through, because there is always the possibility (particularly in the other place) that the legislation may be different when it comes out of the parliament than when it went in.

Clause passed.

Clause 3 passed.

Clause 4.

Ms CHAPMAN: In respect of clause 4, which sets out the objects of the act, one of the proposals is to dispose of the boards. In fact, it is the repealing of the SA Health Commission Act and its death which will be the feature of the conclusion of the current boards' powers upon proclamation, which you have indicated will be no earlier than 2008. Will the boards continue to have authority to maintain an employer/employee relationship, as they currently enjoy (notwithstanding the legislation which came into effect on 1 April), until the time of the conclusion of the boards, or will they just continue in their form without that power?

The Hon. J.D. HILL: The legislation, as you know, which I think was passed last year and put into action this year, assigns all staff now to the CE, who then reassigns the staff back to the body from which they came. The CE assigns whoever works for the Port Lincoln Hospital to the board of the Port Lincoln Hospital, and we are not intending to change that. There will be no interim arrangements.

Ms CHAPMAN: In the submissions that have been put, particularly by a number of country boards, the question of achieving these objectives is one where they have taken a different view as to the capacity for that to occur, given their abolition. A few of them have put forward a number of concerns about that matter, and I think the objective, particularly subparagraph (b), relates to the services that you are making available across the state for South Australians.

The Balaklava and Riverton District Health Service, for example, say that they support in principle the intended repatriation of patients to country SA for their medical needs wherever possible and conducting elective surgery closer to the homes of country residents. They specifically said that they do not support the abolition of local boards but, if they have to have the health advisory councils, they want them to be incorporated. No doubt, that is a theme, as the minister has acknowledged, which came through loud and strong in the consultation period.

This group raised the theme, which has been espoused sometimes by the minister in the house and at other times by Mr George Beltchev in a number of these consultations, that the government's objective is to provide services in the country which will allow it to relieve the high demand in metropolitan hospitals and to provide a service closer to those in the community. Indeed, a very significant number of country residents undertake procedures and medical treatment in metropolitan hospitals, about which they do not have any choice in many instances.

This is the category we are talking about when we say that they could elect services, if they had the services available in the country. From my understanding, the provision of those services is at a cost of about $100 million a year, so we are talking about a significant amount for services for which, if available in the country, patients could be repatriated back out there to use the Balaklava example.

They support that but, of course, Balaklava is a long way from Whyalla, Berri, Mount Gambier or Port Lincoln, which are the locations of the four hospitals that have been identified to be enhanced to provide these extra services. I ask the minister how he proposes that the people in this Mid North area can expect to be part of that transition for which they have indicated their support.

The Hon. J.D. HILL: I thank the deputy leader for that question. We acknowledge the common sense of the propositions. The practicalities, of course, will depend very much on where people live, what is wrong with them and what is the best transport connection. All I can say is that at the moment country health is going through the development of a country health plan to try to give us some guidance about the best way of managing these things, and it will occur over time.

We will not suddenly flick a switch and all of the services that are currently provided to country people in the city will be provided in the country. We will obviously have to recruit and it will be a bit of a piecemeal, patchwork quilt type of approach, but the long-term strategy would be to have four substantial general hospitals in the country with a broad range of services, which I think I have defined in public in the past, and then to have those services linked to other hospitals and other health providers in order to make available the services where appropriate.

Mr Venning: More across the state, all right?

The Hon. J.D. HILL: Yes, but the point I am making is that at the moment they are all concentrated in Adelaide. If, for example, I see a specialist who flies a light plane and he travels from Adelaide on a regular basis to a country hospital and provides some surgical procedures from Adelaide, that is fine, but it is not necessarily the most efficient way of doing it. We want to have those surgical teams based in the four regional hospitals in order to be able to provide services within those hospitals which can then travel from those hospitals into other country areas so that you build up a network of health services in rural areas.

Clearly, in the most remote parts of the state and in other parts of the state—and Balaklava may be an example; I have not looked at that in detail—it may be difficult to do a lot of that. It also depends on the capacity of the people working in those hospitals to manage the recovery of patients who have received treatment. For example, a surgeon might be able to come from Whyalla to work in a smaller town like Cleve and be able to provide services there on a regular basis (once a month or so), and he might be able to perform particular operations but, if we do not have the skilled nurses there and appropriate GPs to manage the recovery process, there is not much point putting a surgeon out there to do it, so you have to have a team around it.

This is the process that we are going through now. As I said, we are leaving the boards in place until we have articulated what that is. We want to be open and honest about this: it will require some thinking through, and we are going through that process now. This bill does not go into the detail: it sets up the philosophical and legal framework for the things that we want to do. I am just giving you some colour about the direction in which we are heading. How that will eventually be articulated will, of course, depend very much on a whole range of factors, including—and especially—the planning process that we are currently going through.

Mr VENNING: I appreciate what the minister just said. I will give you a true-life scenario of two hospitals: Port Pirie and Crystal Brook. Crystal Brook is where I come from, and I know the hospital well. It is a brilliant hospital. When the member for Little Para was minister, she opened a wing of that hospital. The facilities there are fantastic, yet it is 36 kilometres from Port Pirie. The member for Little Para knows this, because she was there. She has her name on the wall there, and you, minister, might get your name there if you are lucky.

The Hon. J.D. Hill: If I'm good, you were going to say.

Mr VENNING: If you're good. The minister just told the house that, under regionalisation, all the impetus and energy will be going into Port Pirie because it is a larger hospital. Crystal Brook is just 36 kilometres away but, through local support and very good local doctors, it provides a brilliant service. The facilities are fantastic. My mother just passed away in that hospital, and I cannot speak more highly of it. A lot of people from Port Pirie actually come down to Crystal Brook to have their babies, and it works very well. But, under your scenario, minister, how is Crystal Brook going to survive? All the doctors will support the hospital and keep it as it is, but what if the direction from the top is, 'Hang on, you're too close to the larger regional hospital. We will put the money and the emphasis into the regional hospital. You'll just have to provide aged care services, and that's about it'?

The Hon. J.D. HILL: This is all hypothetical. We are developing a country health plan, and I would point out that Richard MacKinnon, who is the doctor at Crystal Brook—

Mr Venning: He is my doctor.

The Hon. J.D. HILL: Well, he is a terrific doctor, not that he has given me service. He is a terrific person and I am sure he is a terrific doctor.

Mr Venning: Blunt.

The Hon. J.D. HILL: He has been blunt to me, too. He is a member of the Country Health SA Board—I put him on that board. I visited him in his surgery—

Mr Venning: I didn't know that.

The Hon. J.D. HILL: Yes. I visited him in his surgery and I visited the Crystal Brook Hospital. I am aware of the services and, in many ways, it is an ideal country hospital. It is very close to Port Pirie, so that does raise issues about what services should be in which hospital. I cannot tell you what sort of plan will occur for that particular region, but I can tell you one thing: Richard MacKinnon is going to be very much involved in the development of that plan, because he is on the board. I am very optimistic that Crystal Brook will be an important part of our structure. It may well be that the two hospitals will work more closely together so that certain things happen at Crystal Brook and certain things happen at Port Pirie; I do not know. I have not thought about it as a particular example. I am just saying that we will think through the issues.

Port Pirie was not the one that we identified as providing a more general hospital service. Down the track, we might have additional hospitals, but it was not that hospital. We want to build up the four hospitals by putting more capacity in there so fewer country people have to go to the city. We are not saying that they have to go to the country. The member for MacKillop suggested that people would rather go to Adelaide from Millicent than to Mount Gambier. Well, some might, and they can still do that; we are not compelling them to go to Mount Gambier, but others may have family and friends in Mount Gambier and find it a better option.

We want to put more capacity and do more training in the country so we can have more doctors, allied health workers and nurses coming out of those hospitals. Then those people who work in those four general hospitals can also be mobile and provide services elsewhere.

It is about developing a plan. At the moment, we do not have a plan. We have 40 or 50 hospitals all trying to survive and do what they can for their community. Lots of good things happen, and we do not want to lose that innovation, but it is not a plan: it is haphazard. You are lucky if you live in Crystal Brook because you have terrific services but, if you live in another country town, where the GP has decided to leave, it is terrible. That is not a good way of running a service. We want to have a planned service.

Ms CHAPMAN: I think the submissions have made it very clear to you, your departmental representatives, and certainly to the opposition, that they strongly oppose the move to abolish boards. They are particularly keen to retain a relationship with and involvement in the selection and employment of their staff and to have a major decision-making role in the services they provide and

in relation to the assets which, given the bill now before the house, are irrelevant for the purposes of the discussion, because you have given the option for those to be retained.

I think that you could not have a clearer message than that from the Bordertown Memorial Hospital Board, for example. It has sent petitions to the parliament and put submissions in writing about its objection. This is a hospital which, apart from Keith and Murray Bridge, provides health services on a major freeway into Victoria. It provides accident and retrieval and other services for many people passing through, not just their local regional residents.

I am sure that you are mindful of the position of the District Council of Elliston, which is quite opposed to the government's model and even put up a model of its own. It is very strong on the loss of identity. That hospital plays a major regional role in the provision of care of the aged for the whole of the West Coast, and it has excellent facilities for people with dementia. We have submissions from Streaky Bay that make it abundantly clear that, in their role as a country hospital board, and in relation to the involvement of the hospital in the community itself (it is a major employer and the like), they have very grave concerns not only about the changes to the boards but also about the fact that, in their opinion, the advisory councils would be toothless tigers, to use the description in the submission. They made their position very clear.

The Repatriation General Hospital also made it very clear to your predecessor, the former minister for health, and the Premier that it wanted to remain independent of the proposal to amalgamate boards at a regional level. Not only was it exempted from that requirement at the time but an undertaking was also given in this parliament by the Premier, and indeed statements were made by the former minister confirming and supporting that. Even through this process, it is allowed to survive. From what I understand, for a public hospital it is the only board that will survive in this state.

So, if it is good enough for the Repatriation General Hospital to keep its board, when it has asked to maintain its independence, why is it not good enough for the communities in the regions? Unless they have some bad medical record or something of the kind (and they certainly give assurances to me that they provide an excellent service to their communities), they should be allowed to keep their board, just as the Repat Hospital has, so that they and any other board or community that have expressed that request can be added to the schedule as well.

The Hon. J.D. HILL: I will go through the issues as I recall them. In relation to the health advisory councils (HACs), the questions were: what powers would they have, or would they be toothless tigers and the like; and would they be involved in the selection of staff? Under the draft constitution, the health advisory councils will be involved in the selection of senior staff. Obviously, they will not be involved with every person who is employed in the hospital. I doubt whether they are now. I am sure that most of those things are delegated to the general manager, and that would continue to be the case. The senior staff, the senior personnel in the hospital, the Health Advisory Council, would be involved in that decision.

They will own the assets. That was one of the big issues that a lot of the boards were most concerned about, that property which was owned by the community, and often in many cases donated by local farmers or local community groups, should be retained by the community. I have absolutely no problem with that. I did have a different device for doing it which would have produced the same result, but I guess that may have been seen to be a little bit too remote from the individual communities, so I was happy to go back to creating incorporated bodies wherever they were wanted. I think in practically all but two or three cases they wanted incorporated bodies, and I would expect that over time some of those boards will say, 'Well, we would rather the Country Health Board acted as a trustee for us'. As long as we have certain protections we would be happy with them running it, because there are some advantages. You do not have to have annual reports and all those audited processes.

In relation to the Repat General Hospital, the member is correct: the Premier and I, and previous ministers, have given an undertaking to the board, and particularly to the veterans, that they will not have that responsibility taken away from them unless they choose. I guess the reason they are separated out is that they are veterans. They represent veterans and they have a particular view about health service delivery, and we have honoured that commitment because of the special nature of the people. However, the legislation does provide a mechanism for the veterans' community, if they choose, to get rid of the board and become part of the Southern health region. I would expect that over time that will be seriously considered by the veterans.

Under the legislation we will establish an unincorporated health advisory council at a state level which will provide advice to the department and to me on veterans' affairs issues. I think that

will provide a very satisfactory mechanism for veterans to have a say in the provision of health services. You need to remember that probably fewer than 50 per cent of veterans would now use the Repat hospital. They tend to use private hospitals or their local public hospital, wherever they happen to be based. So, to have a central state-based health advisory council on veterans' affairs possibly would offer them a better option in terms of getting their voices heard. I am not putting any pressure on them, but I believe that over time it is likely that they will consider being incorporated in the general structure.

The member then said, 'Well, you have allowed it for them, why not allow it for everybody?' If I did that, I would not end up with a system approach; I would end up with exactly what we have. I have given ample reasons why we need to change. The broader reason is that we need to have a system rather than a whole series of institutions. Secondly, I have given examples of a range of country hospitals which have got into trouble in terms of the contracting of services, employment, financial management and safety and quality issues. As the health minister, it is my responsibility, under the existing legislation, to ensure that all of the system is managed to a very high standard. Currently, the legislation does not provide me with the tools, it would not provide the member opposite with the tools, and it has not provided any other minister with the tools, to adequately do that job.

Time after time ministers have come into this house, on both sides of politics, and been asked questions about things that have happened in hospitals. It would be ridiculous for the minister of the day to say, 'It is not my responsibility. It is the responsibility of the Bordertown board. Go and ask the chairman there why a particular event happened.' Of course the minister of the day is responsible and, if you are responsible, you must have the mechanisms to make sure that you know what is going on and you can manage a situation before it becomes a problem. This is about creating a better health system for country people. I say to you that it is not out of any political ideological desire I have; it is about trying to make the system work better.

Clause passed.

Clause 5 passed.

Clause 6.

Ms CHAPMAN: The notable additions to the functions from the previous legislation relate to emergency ambulance services, for reasons which are clear from the contribution, and the promotion of a relationship between public, private and other health sectors. In relation to the latter, how often do you presently meet with representatives of the private sector to ascertain what they are doing to promote this positive relationship between the three?

The Hon. J.D. HILL: I meet periodically with various members of the private sector. I have visited private hospitals, I have met with people representing private hospitals, insurance companies, pharmacy organisations, aged care providers, a whole range of bodies such as the Cancer Council, and others, but there is no systematic approach in place. That is what I have asked the department to do some work on: to provide us with a platform where we can all come together. My goal is to produce a compact or a charter, or something of that order, where all the providers of health services in South Australia and allied services can come together with a common set of goals. That could include groups such as SACOTA, the AMA, nurses, and all of these other advocacy groups, if you like, or groups that represent particular people who work in health—a broad range of organisations which are involved in health care delivery. My goal is to get us all together, organise a set of agreements about where we will work together and what we can do to work together, and then have a regular set of ways of engaging.

We would need to talk with all those folk about how we would do that, but that would be very sensible. I think it would be very helpful, particularly in the achievement of public health goals. For example, let us take issues of obesity. Everybody is concerned about obesity. All of those organisations have probably made statements about obesity. All of them would have ideas and, possibly, programs in relation to obesity. Pharmacies might be doing certain things, private hospitals might be doing other things, and the AMA might be doing something else. It just makes sense, if we are all interested in this, to see how we can work together to have a campaign which would operate in all those in areas of activities. So, if we are going to promote healthy eating, it could work in all those institutions at the same time. That is a goal that I have, and I am very keen to sit down with all of the groups who constitute the private sector in health, and see if we can develop a common platform to work from.

Ms CHAPMAN: I am pleased to hear that, minister, because there is nothing stopping a continued consultation, whether informal or formal, if the objective is to develop a greater and better health outcome for all of the South Australian community. But, in saying that, is it your commitment in including this function that you will formally meet with them, and when you do review a particular area of health significance, you will consult with the private sector, which obviously plays an integral role? Let me just give you an example.

We received Monsignor Cappo's report on the review of mental health services in South Australia, which is obviously a very significant health service both in public and private arenas. One of the comments in his report was to identify certain sites that provide mental health services by the private sector, namely, Adelaide Clinic and Fullarton Private Hospital, to name just two that I can think of that neighbour my electorate. And that is good. He went on to say that it is important to understand what services they are providing, to be able to identify the needs of the development of the Glenside Hospital site, or other community mental health services. That all seems logical. The problem is that I am informed that, when the minister conducted his review, interview and assessment, he did not even contact Ramsay Health, for example, the owners of the private sector for provision of services for mental health in this state. That was a recent example of the fact that what the minister is saying, which sounds admirable, appropriate and encouraging, is not actually being translated out in the real world. If we are going to deal with identifying what is important, for example, in the redevelopment of Glenside Hospital, and identifying what services we need to pick up, we clearly need to know what on earth is going on in the other services, so I am pleased to hear that.

Do I have the minister's assurance that in undertaking this function he will ensure there is consultation with the other sectors and that there will be a formal invitation to these people to have meetings with the minister of the day, and not just in a response situation, which the minister has said he is doing by attending facilities, answering inquires and dealing with insurance companies?

The Hon. J.D. HILL: I made plain that there are informal connections and I would like to make it more formal. We are working on a set of propositions that we can then put to members of the institutions in the non-government sector. I have raised the issue at a number of meetings where I have spoken and the feedback I have received every time I have made that statement has been very positive. I think the private sector would welcome that and it can help create a platform where various groups can interact. I meet regularly with a whole range of organisations.

It is clear that there is not as healthy an interaction between the public health sector and elements of the private health sector. I meet pharmacy groups regularly, and particularly did so during the construction of the legislation. We do not necessarily interact with pharmacists on a regular basis on a whole range of things, but it may be a sensible thing to do. The public health campaign springs to mind. It would be sensible for us to have a strong relationship with nursing homes, particularly over prevention of primary health care service provision. I met recently with a group from a private nursing home who advocated some strategies whereby we may be able to work closer together. I give a commitment to working in a way so as to create a platform or place about a set of ideas and strategies where we can get better cooperation between the public and private sector, which makes sense for everybody.

Ms CHAPMAN: The notable omission from the minister's functions, which appeared in the SA Health Commission Act, are the provisions of section 15(1)(m), which ensures that people live and work in a healthy environment. I wonder why it has been deleted.

The Hon. J.D. HILL: I will take some advice, but I would have thought that it is covered in objects of the act under paragraph (b), which is 'to facilitate the provision of safe, high-quality health services and focus on the prevention and proper management of disease, illness and injury'. That probably covers the field, does it not?

Ms CHAPMAN: That is in the objects. As the objects are set out, we then go through the principles and the functions for the minister the chief executive follow through as to who gets the job to do it. Until the passing of this legislation, it is the minister's function and that is what is being deleted. Has it been transferred to someone else or is there an explanation as to why it is not there?

The Hon. J.D. HILL: I do not think there is any particular reason. If the honourable member would like to move to have it reincluded, I would be happy to accept it.

Ms Chapman: There may be a good reason why it is not there.

The Hon. J.D. HILL: Well, there is no particular reason. I think we believe that the language currently in the act covers the field, but I am happy to have a look at it between now and the other place, if the honourable member likes, to see whether it has been omitted for some unforeseen reason. If it has, I will put it back in. It may well be that, given its focus on environment, that element is covered in the Public Environmental Health Act which was introduced subsequent to the Health Commission Act, and it may be that that act is considered to be the one that deals with that particular policy area. However, as I said, I am happy to have another look at it and, if it make sense to include that omission I will happily put it back in.

Ms CHAPMAN: I appreciate that, because the Public Environmental Health Act had its predecessor, which was the Health Act of 1935-1975. So, it had its own origins; it is not as though it was peeled off. Hopefully that can be clarified.

Clause passed.

Clause 7.

Ms CHAPMAN: This clause introduces the functions that will now apply to the chief executive. I suppose it is fair to say that it is the area of his or her proposed functions, and the significant expansion of the role, that has attracted a number of comments by me (on behalf of the opposition) during this debate. I also think it is fair to say that, apart from some of the redefining here, a large portion of what has been published in this clause is consistent with the powers the chief executive has already. Like you minister, his or her direction power is restricted insofar as it relates to any direction that concerns the clinical treatment of a person. This is part of section 29C of the current act, and it restricts ministerial directions basically from interfering with services provided, assets or staff employment.

Given his or her more expanded role, particularly regarding the overall management, administration and provision of health services, essentially he is the employing authority for the whole 27,000-odd employees in the health department to whom the minister has referred, and they are all accountable, either directly or, in the case of the ambulance service, through their chief executive officer, to him.

The chief executive already has a very significant role, and one of things that occurred during the consultation process for this bill is that, as opposition health spokesperson, I have corresponded with the chairs of the health services and hospitals, both public and private. I particularly refer to my communications (of which there are quite a lot) to country board chairs—some by letter, some by fax and some by email. As the minister may be aware, the most recent correspondence I forwarded to the attention of the chairs of the hospitals was intercepted by the chief executive, and he wrote to me saying that he considered information that I had communicated to the hospital boards was inaccurate, and he had therefore directed the hospitals to which the correspondence had been forwarded not to pass that correspondence on to their board.

I will not go into detail about whether there might be a breach of federal law in relation to intercepting correspondence, but it is a matter of such seriousness that I have raised it with the Speaker of the house. There is a fundamental protection for people in the community, especially when we are consulting about laws which affect them and which are being made in this chamber, to freely correspond with any of us in this parliament in order to ensure that their views are expressed and that their communication is not interfered with. Minister, did you direct the Chief Executive or authorise him to intercept that correspondence and issue the direction that my correspondence not be forwarded on?

The Hon. J.D. HILL: Talk about long bows! I am not aware of the circumstances to which the honourable member is referring. If she had raised this matter with me outside this bill, I could have sought advice. As we are dealing with this bill I cannot give her any information whatsoever. All I can say is that under the provisions we are putting in place she, and anyone else, can write to health advisory council chairs, and what they choose to do with the letters they receive will be up to them.

Ms CHAPMAN: I thank the minister for his answer because it highlights exactly the problem that I have put to the parliament on this matter; that is, things are going on in the minister's department about which he is not told. I suggest that they are very serious matters in relation to conduct. The minister might have a view about the issue, if he had been briefed on or informed about it. Copies of correspondence from me to the Speaker of this parliament have been forwarded to the minister's chief executive, and he is telling the parliament that he knows nothing about it. I am not suggesting that is inaccurate in any way, but it highlights the point about what is going on

out there which the minister does not know about and which the chief executive has not seen fit to tell him about.

That is of great concern, and that is why the opposition is strongly opposed to handing over more power to the chief executive in this type of situation. It is dangerous enough already. It ought to be a matter of concern to the minister rather than his handing over more power to run what is now to be the overall management, administration and provision of health services. It is simply not enough to say, 'But the law says he is ultimately accountable to me.' That may be so but, if the minister does not know what is going on and he is not told about it, how can he reasonably be expected to act upon it?

That is the difficulty. When it is all placed in one person's hand, there are no checks or balances (which we have currently) by being able to understand the existence of other processes, by having checks and balances involving those who are otherwise supervising other people in the department. At this stage the structure is established, which is all the way up to the top to the chief executive, and the minister is sitting out there on a limb. I indicate to the minister that we will be opposing this clause.

The Hon. J.D. HILL: The deputy leader, with all the drama she can muster, is making an allegation. She says that I don't know. Well, there are 27,000 employees in the health system. No-one knows what everyone is doing all the time. That is impossible.

Ms Chapman interjecting:

The Hon. J.D. HILL: If the member was so concerned about this alleged breach, why did she not raise it with me at some other time?

Ms Chapman interjecting:

The Hon. J.D. HILL: Why?

Ms Chapman interjecting:

The Hon. J.D. HILL: You might consider it to be a matter of great moment. If you raised it with the Speaker, I am not sure what processes you are going through. I will tell the deputy leader the things I am most concerned to hear about. I am not concerned about the spat between the deputy leader and the chief executive. What concerns me is when I find out that a particular hospital board failed to sign a contract with the provider of an imagining service, which meant that the hospital may not have an imagining service into the future and that the lives of people in that community will be potentially at risk because of the failure of the board to deal with the issue. The board did not know. That is what concerns me.

What concerns me is when I find out that a couple of hundred people have had colonoscopies and the machinery used was not properly cleaned. I find out after the event, and that is what concerns me. That is where I want certainty. If the deputy leader is alleging that individual public servants have done something wrong, a range of procedures are open to her to do deal with them. One of them would have been to raise the matter with me. She chose not to raise it with me, and now she gets offended or upset because I do not know about it. I will seek information, but I will not make any comment about the allegation until I have sought further advice.

This legislation is about providing a proper chain of command and a proper chain of responsibility. It is important that the chief executive has appropriate powers to do the job that is required of a chief executive, in the same way that a chief executive of any other government department has similar kinds of powers in order to do the job that we require of them.

Ms CHAPMAN: While we are on the centralising of the power of the chief executive, the minister identifies illustrations of either some omission or act by a board that has potentially resulted in a health risk, and he has detailed a couple of examples. What about the example of the minister's department being notified two years ago of a person who was HIV positive and who was having unsafe sex with members of the community? Your department was informed but you claim that you had not been told about it until recently—I think about Easter this year. You then acted on the information.

That is exactly the same situation. You can raise criticism and cherry-pick some little events where there has been some potential risk because some hospital board has failed to sign a contract or follow a protocol, but what about your own department? There is no difference. There can be mistakes, there can be negligent acts and there can be consequences when a board

negligently fails to undertake its duty. In the example I have just used nothing happened other than the fact that an inquiry has been conducted to try to make sure it does not happen again.

There has not been any consequence in relation to the person or persons in your department who may have been responsible for that which we now know may result in negligence claims in relation to the victims—and that case actually had victims, unlike the situation where a local board has not signed a document and possibly put people at risk because it has not entered into a contract. There is a very real example in your own department where nothing has happened, and you are trying to tell us that you need to have a unified single system under one person who has already failed to deal with something right under his nose, and you want to give him more power.

The Hon. J.D. HILL: Again, the honourable member is drawing a long bow. The relevance of that question to the legislation is tenuous at best. Before I answer that, I will provide more information to the committee in relation to the matter the honourable member raised previously. One needs to be very careful in addressing statements made by the deputy leader because she does not necessarily give all the facts.

The deputy leader said that the chief executive intercepted a letter she had sent to the board. In fact, I am advised that the deputy leader sent a letter to the chief executive of the department and asked him to send it to the various boards. When he received that letter he chose not to do that because it contained inaccuracies, some of which may have been slanderous, defamatory.

In particular, she made claims about the role of the chief executive of Country Health, which were untrue so he, quite properly, wrote back to the member, corrected the errors and referred the matter to her.

Ms Chapman interjecting:

The Hon. J.D. HILL: As I said, Madam Chair, the claims made by the deputy leader always have to be tested very carefully because she often is prone to exaggeration when it comes to her statements about the behaviours of others, and I have seen that repeatedly in this house.

In relation to the matter about HIV/AIDS, it is true that the department's management of this case was not at the standard one would have expected. The person who was responsible at the time is no longer working with the department.

Ms Chapman: He's in someone else's department.

The Hon. J.D. HILL: He is not in someone else's department.

Ms Chapman interjecting:

The Hon. J.D. HILL: The member once again makes claims which are not true. He does not work for a health department at all. He works outside the health department in New South Wales, as I understand it, so he is not subject to any control that the health department or the government of South Australia may have. If there are legal actions pursued by some of the alleged victims of the person who had HIV, that is up to the courts to resolve. I think just generally I would say to the member, and to all members, that ministers in their day-to-day business do not know everything that goes on. It is a bit like the vice presidents of America—you know what you know, you don't know what you don't know, and you know what you don't know—and all those kinds of things. Not everyone—

Ms Chapman interjecting:

The Hon. J.D. HILL: Well, the trouble with that interjection is that it is inaccurate because the boards of individual hospitals do not know what is going on. The trouble is that the CEs of the hospitals do not have anyone to whom they are accountable other than the boards. So, if the boards do not know what is going on—and how would they, because they only meet once a month—

Ms Chapman interjecting:

The CHAIR: Order, the deputy leader!

The Hon. J.D. HILL: —then if no-one is pursuing the interests of the hospital and no-one is supervising the individual managers, there is no supervision at all, and there are potentially disastrous problems, which I have highlighted.

In relation to the HIV case (and I am not sure how it is relevant to this particular legislation because the powers in relation to that are not affected whatsoever, as understand it, by this legislation), that matter has been dealt with appropriately. There was a review and new procedures have been put in place and, of course, it has highlighted issues at a national level because a lot of the protocols that were being followed in South Australia were, in fact, nationally agreed protocols that had been put in place by the former Liberal minister for health at the national level, Dr Wooldridge.

The committee divided on the clause:

AYES (24)

Atkinson, M.J.	Bedford, F.E.	Breuer, L.R.
Caica, P.	Ciccarello, V.	Conlon, P.F.
Fox, C.C.	Geraghty, R.K.	Hill, J.D. (teller)
Kenyon, T.R.	Key, S.W.	Koutsantonis, T.
Lomax-Smith, J.D.	Maywald, K.A.	McEwen, R.J.
O'Brien, M.F.	Piccolo, T.	Portolesi, G.
Rankine, J.M.	Rau, J.R.	Snelling, J.J.
Stevens, L.	Weatherill, J.W.	Wright, M.J.

NOES (10)

Chapman, V.E. (teller)	Goldsworthy, M.R.	Griffiths, S.P.
Kerin, R.G.	Pederick, A.S.	Penfold, E.M.
Pengilly, M.	Pisoni, D.G.	Venning, I.H.
Williams, M.R.		

PAIRS (10)

Rann, M.D.	Hamilton-Smith, M.L.J.
Foley, K.O.	Evans, I.F.
Thompson, M.G.	Redmond, I.M.
Bignell, L.W.	McFetridge, D.
Simmons, L.A.	Gunn, G.M.

Majority of 14 for the ayes.

Clause thus passed.

Clause 8 passed.

Clause 9.

Ms CHAPMAN: This commences the clauses to facilitate the establishment of the health performance council, which is a new initiative of the government. Essentially it is to consist of 15 persons appointed by the Governor on recommendation of the minister. They are to have a high level of knowledge and expertise, represent diversities within South Australia's community and have such expertise, skills and qualifications as will enable them to carry out those functions. They are to consult with bodies, report to the minister, give him high level advice, etc.

On behalf of the opposition, I have made our view clear; that is, no matter how brilliant are those people appointed by the minister, clearly this minister can obtain a high level of advice from the 27,000 employees he has to choose from within his department who have access to all the data and reports which we have listed. To create another body under the pretext that this will provide some great panacea of advice to the parliament which is independent and which will provide some guidance about the current performance of health services in Australia and assist us in our deliberations regarding the direction of future health services is pointless. It has no foundation and its independence will be severely hampered by the fact that the very people from whom it is supposed to be independent—namely, the department—will comprise the secretariat that supports it.

It will have no separate budget to select its own staff, and it will have people from the department who are allocated to provide a service who have a commitment to the other master, which is the chief executive. They will be drawing on the data that they already have available to them, which a special data unit in their own department produces.

We have raised these matters, and our concern is that there are also myriad other people in the community who already represent the diverse interests. The Australian Medical Association, for example, is an important advocacy body, which obviously has as its membership those in the medical world to provide advice. I have no doubt that, from time to time, it obtains advice (as it should) from the Australian Nursing Federation, which would give available data and advice about the services that that very valuable part of the health industry provides. My question is: given that the minister will have this new health advisory council, will he still retain Dr Chris Cain as his adviser on health matters?

The Hon. J.D. HILL: That is a ridiculous question. The answer, of course, is that I do not have Chris Cain as a medical adviser: he gives advice to the department.

Ms CHAPMAN: One of the things that are coming out of the functions is that the chief executive will not be giving the minister performance advice any more. That has come out of his functions, because there will be this health performance council. Is the minister saying to me that the adviser whom he has appointed to help the department—that is, Dr Cain—in relation to medical matters will go to the chief executive (or someone else in the department, perhaps, but let us assume it is the chief executive)? He does not have that role now; that is for the health advisory council—or will he get it from both? If the minister says, 'I would expect that I would still get some advice from the chief executive, because of the other relationship we have with respect to the functions and accountability in relation to him,' and if the health advisory council advises him to go in direction A and the chief executive advises him to go in direction B, which one will he take?

The Hon. J.D. HILL: Despite all the rhetoric, and the sound and fury, the member made a reasonably sensible point in the question; that is, it is potentially the case that the department and the health performance council will give me different advice. That is a good thing; that is why we are setting it up. I point out that the health performance council will give the government and the parliament broad advice about the state of health in South Australia, not on a day-to-day basis but on a longer term basis. It will also have responsibility to investigate issues which I would refer to it and which it may decide of its own volition to investigate. That is outside anything that the department may be doing.

I thought it was important that we had an external body to do this. This is very consistent with what John Menadue recommended. He recommended that there be an independent body to provide advice to the government on how the reform process was proceeding, and I think that is a very sensible thing. So, one of the things that the health performance council will do is to give advice on how that is going.

I think it is important for the department's sake to have an external body looking at how it is going; it puts pressure on them to perform at a higher standard. I refer the member to paragraph (g) in relation of the chief executive's responsibilities, as follows:

> (g) to provide advice to the minister in relation to the operation or administration of this act, the provision of health services within the state, or the protection or promotion of public health within the state;

So, clearly, the chief executive has responsibilities as well. However, I as minister, and any subsequent minister, will now have a second source of information, which will be high level information provided by a specially chosen group of people who are specially skilled, who will be able to review the performance of the department and the performance of health generally. That is to the good, I would have thought.

Ms CHAPMAN: The health performance council is to provide an annual report, as the minister has indicated, and a four-yearly report which will provide much more information, with a review of the future direction of health services, which all sounds good. Is it the case that the current performance indicators and commentary in relation to those matters will no longer be contained in the annual report of the chief executive and, if it is to be included in the annual report, will it therefore be included in both reports, bearing in mind that this information and data is all collated by the department?

The Hon. J.D. HILL: No; the department's responsibilities will continue as they are. The health performance council will be an independent body that will be established to give me and the parliament separate advice on the health performance of the department and the health performance in our state. The member is confusing the two sets of responsibilities. It is a different body to give independent advice not just to me but to the parliament. I would have thought, from an opposition point of view, this is rolled gold, because the parliament will get advice from an

independent body on how the government and the department are going in delivering health services. This is a greater level of scrutiny and a greater transparency than has ever existed.

Ms CHAPMAN: At present, the chief executive provides an annual report and, in fact, regional boards and even individual units currently provide reports. We currently have 50 or 60 of these reports going through this parliament each year, and those reports provide information about the performance in relation to the particular area of responsibility. I assume that under this new arrangement only the chief executive will provide a report because these other organisations will no longer be required to provide one.

In relation to any overlap, is there anything we currently get in performance and commentary reporting—usually an explanation for a large increase in the number of required surgical or elective procedures, or a big change in employment levels, or a high level of claims and those sort of things—in the chief executive's annual report or, currently, by officers at the lower level? Can I have an assurance from you, minister, that, no matter how well the health performance council program is ultimately carried out, there will be no reduction in the information that is currently reported to the parliament through the chief executive's report and those other reports we currently get?

The Hon. J.D. HILL: I thought I had answered that question, but I will try again and perhaps explain it by way of analogy. At the moment, the chief executive reports on an annual basis, through me, to the parliament on the operations of the health department in financial terms, yet that does not stop the Auditor-General every year going through that and making comments upon the performance of the health department in regard to its financial performance.

What this body will do is address the performance, from an outsider's point of view, of the health department and all its ancillaries in relation to all the issues I have already described. It will not be taking away from the CE his obligations to report to me on his perceptions of the performance of the department similarly to the way he currently does, and each of the other hospitals created under this legislation will have a similar requirement. They will all report in the way that they do now, but there will be an additional level of reporting by the Health Performance Council which is analogous to the level of scrutiny that is provided by the Auditor-General. It is an outside view, looking in, on the health system; it is not less, it is more.

The committee divided on the clause:

AYES (23)

Atkinson, M.J.	Bedford, F.E.	Breuer, L.R.
Caica, P.	Ciccarello, V.	Conlon, P.F.
Fox, C.C.	Geraghty, R.K.	Hill, J.D. (teller)
Key, S.W.	Koutsantonis, T.	Lomax-Smith, J.D.
Maywald, K.A.	McEwen, R.J.	O'Brien, M.F.
Piccolo, T.	Portolesi, G.	Rankine, J.M.
Rau, J.R.	Snelling, J.J.	Stevens, L.
Weatherill, J.W.	Wright, M.J.	

NOES (10)

Chapman, V.E. (teller)	Goldsworthy, M.R.	Griffiths, S.P.
Kerin, R.G.	Pederick, A.S.	Penfold, E.M.
Pengilly, M.	Pisoni, D.G.	Venning, I.H.
Williams, M.R.		

PAIRS (10)

Foley, K.O.	Evans, I.F.
Rann, M.D.	Hamilton-Smith, M.L.J.
Simmons, L.A.	Gunn, G.M.
Thompson, M.G.	Redmond, I.M.
Bignell, L.W.	McFetridge, D.

Majority of 13 for the ayes.

Clause thus passed.

Clause 10.

Ms CHAPMAN: Of the new members of the HPC, which is some 15 persons, can the minister tell me what is the budget that is proposed to pay for this new council annually and how much are each of the members going to be paid?

The Hon. J.D. HILL: I cannot advise the committee of that because the legislation is yet to go through. It will be a modest amount. We will seek advice in terms of payment of individuals from the Public Service Commissioner who assesses those matters, but no budget has been set as yet. It will be a modest amount.

Ms CHAPMAN: How many staff will be allocated to service the HPC?

The Hon. J.D. HILL: All I can say to the member is that it will be a modest provisioning. Some staff will be associated with the HPC. We have not worked through the detail of this at this stage. It will not come into effect until the legislation is proclaimed which should be in the next budget year, so we will start thinking about the cost of this legislation once it is through. Other elements may have costs which we will need to take into account. The expectation I have is that this will be a relatively modest amount. I am happy to give the information once we have made that determination.

Clause passed.

Clauses 11 to 13 passed.

Clause 14.

Ms CHAPMAN: This clause proposes that the HPC may, provided it has your approval, minister, or, if relevant, a responsible public sector instrumentality, make use of staff, services and facilities of an administrative unit or other public sector instrumentality. I am not quite sure I understand that. Is there some body other than your department that is going to be required to submit material if requested by the HPC and, if so, who?

The Hon. J.D. HILL: The advice I have from parliamentary counsel is that it is just a standard provision. It could be the minister and, if not the department, it could be a statutory authority. For example, something like the IMVS or another research facility could allow the body to use a room or get access to whatever services they may wish to provide. It is really to empower other bodies to help the HPC rather than in reverse.

Ms CHAPMAN: Is this to facilitate an obligation on behalf of basically any other organisation which might receive government funding in relation to health to cooperate with requests, with the proviso that you have agreed? They cannot just ring up the IMVS and say, 'I want the whole of the last century's data on some contagious disease.' You have to be able to approve the extent of the information they might seek or the costs and so on. Is that the way it would work?

The Hon. J.D. HILL: I do not think it is to do with information provision: it is to do with access to facilities and staff. For example, I could say the body could use the boardroom on the ninth floor, which is close to my office, for the purpose of holding their meetings or provide staff to carry out research or, alternatively, the IMVS, for example (or another statutory body) could say, 'We have a staff officer here who would be ideal for the sort of research you want into epidemiology' (or something to that effect) and they can make that staff member available on their own initiative. So, it is really to provide resources from a range of public sector unspecified sources just for flexibility's sake.

Ms CHAPMAN: How often is it proposed that the HPC will meet?

The Hon. J.D. HILL: I refer the member to schedule 1, which gives the authority to the HPC to determine its own meeting schedules.

Clause passed.

Clause 15.

Ms CHAPMAN: The health advisory councils are the new bodies, Mr Acting Chair, as you would be aware by following this debate and being riveted by it. You would have a full understanding of what new roles this group will have across the state when we abolish all the boards. Apart from the repealing of the SA Health Commission Act—which comes later in this bill—it is this clause, and a couple that follow, that really put the nail in the coffin of boards and conclude the death by a thousand cuts that they have endured so far. The boards that currently exist for the

metropolitan region health services are the central northern, southern, children's and women's health, and the like. There are three of them and, currently, they are paid members of boards.

The board positions that currently provide the overall management of the policy making and reporting responsibilities—which include reporting to parliament—are paid positions. Mr Ray Griggs is the chair, and he has half a dozen others who are currently on the central northern board which meets monthly. They are paid positions and, of course, they have support from the regional chief executive. I cannot think of the current chief executive. Dr David Panter occupied that position last year but he has moved on. The current chief executive's staff provides executive support to the regional metropolitan health board. In its case, it has responsibility for $1 billion of spend out of a $3 billion budget, so it is a pretty big one. My understanding is that there will be health advisory councils for these regions. Will these regional positions in the metropolitan area continue to be paid positions?

The Hon. J.D. HILL: I think the question was: will the metropolitan regions have boards associated with them? Is that the question?

Ms CHAPMAN: Yes, will they have HACs?

The Hon. J.D. HILL: Maybe, maybe not. We will think through the best way of doing it. This is like a toolbox provision. There certainly will be incorporated HACs in relation to the country health units. There will be a country health board; a HAC associated with volunteer ambulance officers; a HAC associated with veterans; and there will be flexibility in relation to other unincorporated HACs. I think it is highly likely, but there may well be more than one HAC associated with the regions. For example, there might be a HAC associated with each of the individual health units in the northern area. I am not saying there will be, but that is a possibility. I think it is likely that there will be at least one, but there could be multiple HACs. They will not be paid bodies, as I understand it.

One of the things that Menadue said very strongly is that those who deliver health services are very skilled at the delivery of these services. They are not necessarily very skilled at involving consumers (patients) in a whole lot of decisions.

The typical way governments have gone about addressing issues such as this is to create a board and put on it representatives of consumers. That is one way of doing it. What I want to happen through this process is that the whole system becomes conscious of the needs of the consumers of the services (the patients) and the carers of the patients. For example, we have set up clinical networks, which are networks based around particular issues, such as cancer, renal problems and so on. On those networks are doctors, nurses, allied health workers and representatives of consumer groups. Those groups work together to work through what the service plan ought to be for that particular area of health speciality.

That is one way we can involve consumers; HACs are another way. For example, in a big area such as the north, there may be a number of these groups that give advice to the region on how it can best meet the needs of the community. I cannot anticipate at this stage what they will be, but I anticipate that there will be some. To make sure that the department is properly consulting with communities and involving patients, carers and so on, the health performance council will have as one of its tasks the monitoring of how effectively and really they are doing that. So, it is not just paying lip service to it. It is a complex set of arrangements that are being put in place to achieve that kind of outcome, and the HACs are a tool that will be used to achieve that.

Ms CHAPMAN: Wherever the HACs may apply, are they also able to meet whenever they like and set their own arrangements? I will come to the constitution and the set of rules later.

The Hon. J.D. HILL: The draft constitutions, which I tabled yesterday, have provisions in relation to both incorporated and unincorporated HACs. From memory, I think they state the frequency of meetings, and they might have some minimum standards but, of course, the HACs would be able to meet more frequently if they so chose.

Ms CHAPMAN: I will come to the constitutions and the set of rules that apply, subject to whether they are incorporated or not incorporated, as they are referred to in clause 17. I appreciate that the minister has tabled these; I had a quick look through them, but I could not find any obligation with respect to them. As I understand it, the health performance council, which will have obligations to report to the parliament, can meet whenever it likes. It will be paid, but the HACs will not be paid. They do not have any obligation to provide anything other than advocacy and advice on request, having read the constitution template rules by which they will be bound. Apart from having a role to manage assets, if they elect to become incorporated they will have a financial

report to give you about the management of those assets—once a year, from memory. Is it your understanding that they will have an obligation to meet at a certain frequency?

The Hon. J.D. HILL: I am relying on the fact that that would be in there; however, if it is not, we will correct that. These are draft constitutions. I would expect that there will be minimum meeting provisions; that is, they must meet at whatever frequency it is. Section 28 on page 14 of the constitution for the incorporated HACs provides that the advisory council will hold at least four ordinary meetings in any 12-month period, and these meetings will be held at regular intervals. I imagine that there would be a similar provision for the unincorporated ones.

The unincorporated HACs are really replacing what is in the current Health Commission Act, and they are called 'ministerial advisory committees'. The minister can set up a committee on anything, for any purpose and without any rules. There is a variety of ministerial advisory committees that we have at the moment. I would expect that some of them would merge into HACs. The capacity is also there to have a time-limited HAC. So, if we were looking at a particular issue, stem cell research, for example, I might want to set up a HAC for six months to give some advice about that and then it just stops operating. It is really just replicating what is already there. They are powers already under the existing act and they are called ministerial advisory committees, and now they are called health advisory committees.

Mr WILLIAMS: Minister, is it not the case that the health advisory committees (HACs) are only there as a sop to try to get us through this process of disbanding the boards, which have some real power? We have stripped them of power and we are putting in place a supposed advisory committee. How can the parliament be convinced that these advisory committees will have any real teeth at all, or any real purpose? In considering your answer to my question, I draw your attention to the Occupational Health, Safety and Welfare Act, under which your government, back in 2005, at great pains, established the SafeWork SA Advisory Committee. On my reading of the bill before us, and of the act, and reading the debate when that committee was established, it is a similar sort of process.

Your colleague the Minister for Industrial Relations at the time argued vehemently that this was a very important committee and set out how it was to be established, the terms and conditions of the office, etc., how they would hold their meetings and, indeed, the functions and powers of the committee. Earlier this year it came to my attention, as shadow minister, that one of the very important functions of that committee, and the thing for which your colleague the Minister for Industrial Relations argued vociferously, was that it would give him advice on matters. One of those matters involved grants in the OH&S area, yet it came to my attention that your colleague had actually established a grant to his mates in the unions of $3 million, which the advisory committee (which was specifically set up to advise the minister on these sorts of issues) had not even heard of and was never asked about and on which it never had the opportunity to advise.

Is this not really just a sop to the health community, and particularly those people who have given thousands of voluntary hours to help our system work—those people who have worked on hospital boards—to try to convince them that you are going to be listening to the community? Your colleague the Minister for Industrial Relations, by his very demonstration earlier this year, has shown that the committee established under the Occupational Health, Safety and Welfare Act is just not worth anything. Its functions may not be there; it is just a waste of the parliament's time and of the time of those people who have been appointed to that committee, because the minister in that case chose not even to discuss that very important matter with them.

The Hon. J.D. HILL: I move:

That the sitting of the house be extended beyond 10:00.

Motion carried.

The Hon. J.D. HILL: Before the break, the member asked me a question about HACS and whether they are a sop. I would say to him that they are not a sop. There are two kinds of health advisory committees (HACs) that we are creating under this legislation. One, which I just referred to in answer to the question from the deputy leader involves unincorporated health advisory committees, and they replace the ministerial advisory committees, which are currently extant. Ministers use those to a greater or lesser extent, depending on their own inclinations and the policy initiatives that they wish to pursue.

The incorporated health advisory councils, which are associated with individual health units, or clusters of health units, which will replace the boards, will have particular powers, responsibilities and functions under the legislation; so, they are not a sop. In particular, the

incorporated health advisory council owns property and assets on behalf of the community, and has particular responsibility to manage that property. They have particular responsibility in the selection of senior staff of the hospital. They have the responsibility to meet on a regular basis with the senior staff, the CEs, and so on, to go through issues such as the budget, planning, the grounds, and those kinds of things.

In many ways they are analogous to the responsibilities that a school council would have in relation to the running of a school. They do not choose the curriculum, and they do not hire and fire the staff, but in every other way they are involved in the planning and the decision making about how a school should operate. The health advisory council will be the same in relation to the hospital. In addition, of course, by the nature of their membership, they will bring together in a community the medical practitioners in a town, the staff of the hospital, local community groups, the local council, the member of parliament, and up to three appointments that the minister should choose to make.

There will be a very good forum for the discussion of health issues and strong capacity for advocacy. As I have pointed out on a number of occasions now, the local member of parliament can be a member of that board. The local member of parliament or his or her representative, by participating on a regular basis, will be very aware of the issues and will be able to raise concerns if those issues are not properly addressed.

The committee divided on the clause:

AYES (24)

Atkinson, M.J.	Bedford, F.E.	Breuer, L.R.
Caica, P.	Ciccarello, V.	Conlon, P.F.
Fox, C.C.	Geraghty, R.K.	Hill, J.D. (teller)
Kenyon, T.R.	Key, S.W.	Lomax-Smith, J.D.
Maywald, K.A.	McEwen, R.J.	O'Brien, M.F.
Piccolo, T.	Portolesi, G.	Rankine, J.M.
Rau, J.R.	Snelling, J.J.	Stevens, L.
Weatherill, J.W.	White, P.L.	Wright, M.J.

NOES (10)

Chapman, V.E. (teller)	Goldsworthy, M.R.	Griffiths, S.P.
Kerin, R.G.	Pederick, A.S.	Penfold, E.M.
Pengilly, M.	Pisoni, D.G.	Venning, I.H.
Williams, M.R.		

PAIRS (10)

Rann, M.D.	Hamilton-Smith, M.L.J.
Foley, K.O.	Evans, I.F.
Thompson, M.G.	Redmond, I.M.
Bignell, L.W.	McFetridge, D.
Simmons, L.A.	Gunn, G.M.

Majority of 14 for the ayes.

Clause thus passed.

Clause 16.

Ms CHAPMAN: I refer to the health advisory councils. Assuming they exist, the minister sets them up and they are a useful tool in ensuring that we have advocacy and the view of the community is maintained in a link with the minister. How often will they meet with the minister?

The Hon. J.D. HILL: As they need to. There will be something like 50 or 60 of these things. I do not propose to meet with them regularly, but I would expect with country health advisory councils that there would be annual or biannual conferences of members. We have had a couple with existing boards since I have been minister. I have met with them in that forum and I would expect it to be instituted on a regular basis. The advisory HACs I would meet with on an as needs basis.

Ms CHAPMAN: One of the most concerning aspects for the opposition is that, assuming they are operational and meeting with the minister as required, notwithstanding how important they

are (and the minister has reaffirmed this to the parliament), in giving this advice the minister can get rid of them if he wants to. Specifically, the provisions of this part require that, if the minister thinks that a HAC should not exist and it does not agree with the minister's view (that is, it wants to exist), even if it holds assets the minister can get rid of it, provided he demonstrates in writing that he has consulted with them, given his reasons for wanting to get rid of them, and a mediation process with a moderator has taken place. I understand that this process commits the minister to genuinely listening to their view and being required to get it. The minister can decide he does not want them, and he is then able to refer that area of responsibility into another HAC.

Given that I have seen nothing here that requires the minister to put the matter into a HAC next door, if the minister did not want to keep Streaky Bay, for example, in the West Eyre Peninsula regional HAC (even if they wanted to be there) he may think they would be better placed in Ceduna, even though they were not very happy with that, and may even ultimately decide to put them with Mount Gambier, Port Augusta or Port Lincoln. In implementing a decision to dispose of a HAC that the minister does not want to exist any longer, what is the intention in terms of ensuring it is absorbed into a geographically neighbouring HAC?

The Hon. J.D. HILL: It is always a balancing act between flexibility and certainty, as well as the use of arbitrary power. The health department and I, through negotiation with the current boards, came up with that set of words to provide what we all thought was a reasonable compromise. If a health unit decides to amalgamate with another health unit—and they do this all the time; it has been happening under the current boards, and that is a good thing—some mechanism is needed to allow that to happen, and that is the mechanism that we believe will do that.

If I, or any other minister, were to use that power arbitrarily without proper consideration then there is a mechanism to allow that matter to be adjudicated through an independent mediator. So, there is a process in place to ensure that that power is not used in any unfair or unreasonable way. You would only do it if it were to aid the provision of health services; not just as some arbitrary act to include Streaky Bay with Mount Gambier, as the member suggested.

Clause passed.

Clause 17.

Ms CHAPMAN: The minister presented to the parliament yesterday a template for the constitution and rules, and I thank him for that. Essentially, this is some kind of precedent constitution or rules and it is my understanding that, under this clause, these will have to be adopted—or is it the case that these are just provided as a guide with which they can prepare themselves? I am not quite sure whether this is to be enforced or whether it is just a helpful guide.

The Hon. J.D. HILL: The proposal is a model which we would expect the HACs to use as a starting point. They may wish to make variations, depending upon local circumstances, and I think that, with my authority, those variations can be made. I think that is pretty well the case now with the constitution. They are the existing provisions.

Ms CHAPMAN: Each of them includes a clause which, in fulfilling its roles of advocacy and of obtaining information in both its local geographical area and its area of expertise, seems to be (in all three) the constitution template. There is also a second constitution—

Members interjecting:

Ms CHAPMAN: Mr Acting Chair, it appears that the minister is unable to hear because of the noise in the chamber.

The ACTING CHAIR (Mr Koutsantonis): Order! I agree; the members for Unley, Goyder and Schubert will show due respect to the member for Bragg. Members to my right will also keep their voices down.

Mr Venning interjecting:

The ACTING CHAIR: I apologise to the member for Schubert. The member for Bragg.

Ms CHAPMAN: There are two things that these advisory councils appear to be doing in these templates. One is telling them that they must act in accordance with the bill (which, I assume, will be the act in due course) and give effect to the policies from time to time determined by the minister. Secondly, they have to operate consistently with the strategic objectives of the government of South Australia, either generally or specifically, and not act in any way to adversely

affect the rights or interests of the government of South Australia under the terms of any agreement.

Minister, what on earth is the point, if you tell them they have an important role in providing you with advice and identifying what is important to their community, if they are hamstrung by the rules which say that you have the right to tell them what policies might be effected that are inconsistent with your direction or a government policy or strategic objective? In other words, they can only give the advice to you if it is consistent with what you say is determined policy or published government policy.

The Hon. J.D. HILL: I think the member is exaggerating what this means. It is not the government as in the Labor Party but, rather, the government as in the crown. Individual health units cannot take actions which are contrary to actions taken by the government. For example, if the government of South Australia entered into an agreement with the commonwealth to ensure Aboriginal children were provided with a particular service, the local hospital board cannot decide it will not provide that service.

Ms Chapman interjecting:

The Hon. J.D. HILL: They cannot do things which are contrary to general commitments the government has made. They cannot sign contracts outside the rules under which the government operates. They cannot enter into financial arrangements with some other body if it is contrary to the general provisions of the government of South Australia. For example, if they own property, they could not sell that property to a group that was to do something which is contrary to the interests of the people of the state (as represented by the government). I cannot give a particular example. It is a safety clause to ensure that they do not do things which are contrary to the interests of the state.

Clause passed.

Clauses 18 and 19 passed.

Clause 20.

Ms CHAPMAN: This provision allows for the transfer of assets with the minister's permission, as I understand it—or is it your transfer, irrespective of a HAC's permission? I am not sure about this new section.

The Hon. J.D. HILL: What is the question?

Ms CHAPMAN: Is that a clause to provide for HACs being able to transfer their assets and be restricted by what you direct them to do or is it the other way round?

The Hon. J.D. HILL: The new section provides that the minister may do certain things, either on their request or after the minister has gone through a number of processes. Section 20 provides:

> (3) The minister—
>
> (a) may not act under subsection (1) to transfer assets or rights of a HAC unless the minister is acting at the request of the HAC, or the minister has taken reasonable steps to consult with the HAC.

That consultation process is specified elsewhere. It continues:

> (b) must not act under subsection (2) unless the minister is acting at the request of the other entity.

This is to allow decisions. For example, if a HAC owns land and it decides to transfer the use of the land to another community group, say a childcare centre, nursing home, or whatever, it has to seek permission from the minister. I think that is consistent with the current rules under the Health Commission Act; I am not entirely sure. There was one occasion recently. Under the Health Commission Act they can transfer assets, as long as they are consistent with the provision of health services.

If they are doing it outside of health services, they need to get my permission. An example recently was where one of the boards tried to provide land to something, I think it was a kindergarten or childcare centre, which was not considered to be part of health provision but, obviously, it was a sensible thing to have in that setting. It is to allow those kinds of decisions to be made. I guess there is an ability there if a sensible request was made by perhaps a group of GPs to build a service centre on a hospital site and the hospital said it did not want it. I guess there is

the capacity there for the minister to say, 'I have gone through this process of consultation. It seems to me a useful thing to happen, and I will authorise it anyway.' So there is that power there for the minister to do it.

Clause passed.

Clauses 21 to 24 passed.

Clause 25.

Ms CHAPMAN: This clause basically enables the HAC to get information as necessary to find out about its local district—what services are presumably there already and how it is performing, and so forth—from the department in its role of advising the minister. However, it has a provision in it that anything that is currently protected under regulations cannot be handed out. More importantly, there is a provision here that the chief executive can also veto information they are getting. I would ask for some explanation as to why that would occur given that it is already restricted under subclause (1), which provides:

> ...to be necessary or expedient to assist in the performance of its functions.

In other words, it cannot ring up the department and say, 'I want the entire financial history of the board or of a neighbouring area that is unnecessary for the purpose of giving you this advice on what the contemporary needs are in each district.' What is the purpose of having this chief executive veto—

The Hon. J.D. Hill interjecting:

Ms CHAPMAN: Well, I am sorry, but it says that it does not extend to information excluded by either the regulations or the chief executive. He has the power to say no, and alternatively he can impose conditions.

The Hon. J.D. HILL: The purpose of this is to protect information which is confidential. In relation to the imposing of conditions, the HAC might seek information about a particular contract that is being proposed to deliver machinery, services or whatever to the body. It would be reasonable for them to get that information, but a condition would be that you cannot make this publicly known: you must consider it in camera.

In relation to information that the chief executive may exclude, one example might be personal information about a matter that is perhaps before a court, or a matter that is personal to an individual patient's circumstances. There could be a range of things which cannot be foreseen by regulation. I imagine that most of those matters would be excluded by the regulation.

Ms CHAPMAN: The reason I ask this particularly is that there is a whole provision in this legislation to deal with confidentiality of personal patient information, and that is for good reason. Certainly, there are exemptions (which we will come to later) for quality improvement and research purposes, also for good reason. But it seems that HACs, which are an advisory body specifically to the minister, will be restricted by what the chief executive may decide they cannot have.

There can be commercial confidentiality reasons sensitive enough for the chief executive to say, 'Of course you can have this information. We will be getting it to you because we are directed to provide it to you, but a condition of it is that it not be published or copied'—or be returned at the conclusion of the meeting, or whatever, because it is fairly sensitive. All I am putting to the minister is that there is a whole lot of other protection for all the normal requirements to protect for privacy, but this is something that HACs must have imposed on them, which I have not seen similarly for the Health Performance Council.

The Hon. J.D. HILL: I will get some advice about the Health Performance Council, but in relation to this the HAC, of course, is always entitled to approach the minister, and any HAC has direct access to the minister. If they believed that the CE, as my delegate in all these matters, was acting inappropriately, they could come to me and then I have power to direct the chief executive, except in areas relating to things that he has exclusive province over, notably, the employment of staff.

So I think there is plenty of capacity to deal with this if the chief executive was misusing his power, which is really the point I suppose the member is getting at. In addition to that, of course, the health unit based HACs will have a member of parliament on them so, if the member of parliament felt the HAC was being denied information by the chief executive, I am sure they would rapidly raise the matter in here or in some other way with the minister of the day. So, I think there is reasonable protection.

In relation to the HPC, the language is different. In relation to the HAC it is entitled to request information. In relation to the HPC it may request information, so it is a softer use of language. And the chief executive may impose conditions that the HPC must observe in relation to the receipt, use or disclosure of information provided under subsection (6). So I think the provisions are right but, given they are slightly different language, I am happy to have another look at it, but I think the balance is about right.

Ms CHAPMAN: I cannot recall now which district put in the submission, but one of them raised the question of representation by a nominee of local government and, in particular, that they appeared to be servicing two local government areas. Of course, unless the boundary went straight through the middle of the hospital, obviously it can be physically located in one but on the boundary and therefore servicing another. So, is there some mechanism, if they are to get only one from local government, by which the local community can make that determination as to which council they have the representative from?

The Hon. J.D. HILL: The way that operates is that in most cases where there is a single health unit it will be within a particular local government area but, where there are multiple campuses, as there are in some parts of the country, obviously they could be in two local government areas. The way we have set this up is on page 11 of the draft constitution, which is still subject to further consultation, but this was the preferred way: there must be one member appointed by the advisory council in the following manner as a nominee of local government and, in the case of the employment of such a member to the advisory council—and it goes through the processes.

Essentially, what it boils down to is that if there are multiple councils the mechanism is such that we would get the councils to work with each other to try to identify who will represent the councils. If they cannot work that out amongst themselves and there are multiple nominations from a variety of councils, the health advisory council itself will choose a nominee. So, I would hope they would choose in such a way that they would circulate the responsibility across the various local councils over time.

If there is an issue about the member of parliament, we have a similar mechanism. There could be two members of parliament who are associated with various bodies of a HAC. If they cannot sort it out between themselves, as I understand it, the advisory council can appoint members of parliament and then they will just work out a way of sharing the responsibility over a three year term. Each nominee will serve an equal and consecutive term such that the aggregate term of all members combined is equivalent to three years. It is a way of sharing the role.

Clause passed.

Clauses 26 to 28 passed.

Clause 29.

Ms CHAPMAN: This is the commencement of part 5 of the proposed legislation to incorporate hospitals. As I understand it, this part comes into this legislation because, as has been identified, the Hospitals Act 1934-1971 is also to be repealed. That act has had this function to date. The current Hospitals Act does identify the provisions for the management of public hospitals, the determination of the powers of the minister to nominate the district hospitals and various powers.

Currently, part 3 of the Hospitals Act enables the Royal Adelaide Hospital to enjoy the unique status of having a division dedicated to it. This hospital has provided services to the colony and then the state for well over 100 years, and it enjoys certain privileges and responsibilities. The passing of this bill will repeal the act and therefore will remove the status that this hospital currently enjoys completely—it will just line up with the rest of them. The opposition has expressed great concern about part 5—the incorporation of hospitals—which identifies what the new obligations and powers will be, as well as the employment of staff. They will be centralised in this part under the exclusive management of the chief executive.

A very important section in the current Hospitals Act says that the Royal Adelaide Hospital shall be a school of medical and dental instruction in connection with the University of Adelaide, and any person who has been admitted as a student of the said university and is studying in the medical course or the dental course thereof shall be entitled to attend at the Royal Adelaide Hospital for instruction in connection with any such course, subject to any statutes and regulations made by the council of the said university and any regulations made by the board. That hospital has the unique statutory authority and responsibility as probably the major training hospital in this

state. It has a very close and personal relationship with and a statutory obligation to accommodate students of the University of Adelaide.

This is all about to go—and how convenient, because the government wants to discontinue the Royal Adelaide Hospital and build a new one at the other end of North Terrace. It does not want the name 'Royal Adelaide Hospital' any more, that name not having been previously available until 1939 when, by proclamation of the then governor, there was a recording of the consent given by the reigning monarch, who had granted permission for the state of South Australia to give the royal title to this hospital. There is a statutory obligation, which existed even back then (this act predates to 1934), that it shall be a hospital for a medical and a dental school in cooperation.

We are going to see the death knell of this hospital, as announced by the government, and I think that is a shame, because not only does that link have statutory endorsement but also the two institutions are right next door to each other. There is also a very close relationship with the Institute of Medical and Veterinary Science and the Hanson Institute, which is quite a new building near the rear of the North Terrace site of the Royal Adelaide Hospital, accommodating a new, well patronised emergency department.

That is all to go, and it is something that the opposition does not support. The severance geographically between the state's major tertiary hospital and training facility for the medical and dental professions is a move which we do not support and which we think will be detrimental to the future training of students. I indicate that this clause will be opposed. Clause 29 provides:

'The Governor may, by proclamation—

(a) alter the name of an incorporated hospital;

(b) dissolve—

It does not even say 'or'. I am not sure of the grammar there, but also there is the power to dissolve an incorporated hospital. It would be a sad day when this occurred and, accordingly, I indicate that we will be opposing this clause.

The ACTING CHAIR: Before I call the minister, I inform the committee that George VI was the reigning monarch at the time.

The Hon. J.D. HILL: Thank you very much for that piece of contemporary history. When this act was enacted, I am advised that the Royal Adelaide Hospital was the only public hospital in Adelaide. So, quite clearly, the provisions that existed related to it. However, of course, since 1934 (some 73 years ago), things have changed. We now have more hospitals, we have more medical schools and different arrangements are in place. So, it is absolutely appropriate that we make contemporary what is already happening in a de facto sense. The opposition expresses great outrage at this. However, I have to say that no-one else has expressed any opinion about it whatsoever, and all the relevant parties have been given an opportunity to do so. In fact, I am in regular communication with the Dean and the Vice Chancellor of the Medical School at the University of Adelaide about their ambitions to be part of the new Marjorie Jackson-Nelson hospital, and they are very excited about the opportunities that hospital will provide. Indeed, they have entered into negotiations and discussions with the University of South Australia and the Flinders Medical Centre to have some combined teaching facility in the new hospital. Time has moved on. I recognise the rhetorical and other points the deputy leader has made, but the reality is that the provisions we are making reflect contemporary behaviour and standards.

The committee divided on the clause:

AYES (24)

Atkinson, M.J.	Bedford, F.E.	Breuer, L.R.
Caica, P.	Ciccarello, V.	Conlon, P.F.
Fox, C.C.	Geraghty, R.K.	Hill, J.D. (teller)
Kenyon, T.R.	Key, S.W.	Lomax-Smith, J.D.
Maywald, K.A.	McEwen, R.J.	O'Brien, M.F.
Piccolo, T.	Portolesi, G.	Rankine, J.M.
Rau, J.R.	Snelling, J.J.	Stevens, L.
Weatherill, J.W.	White, P.L.	Wright, M.J.

NOES (10)

Chapman, V.E. (teller)	Goldsworthy, M.R.	Griffiths, S.P.
Kerin, R.G.	Pederick, A.S.	Penfold, E.M.

Pengilly, M. Pisoni, D.G. Venning, I.H.
Williams, M.R.

PAIRS (10)

Rann, M.D.	Hamilton-Smith, M.L.J.
Foley, K.O.	Evans, I.F.
Bignell, L.W.	Redmond, I.M.
Thompson, M.G.	McFetridge, D.
Simmons, L.A.	Gunn, G.M.

Majority of 14 for the ayes.

Clause thus passed.

Clauses 30 to 48 passed.

Clause 49.

Ms CHAPMAN: This part incorporates ambulance services and the process whereby they are to be licensed, and the restrictions which are to be imposed on the services that provide emergency transport and non-emergency transport for health patients in South Australia. Essentially, the repealing of the Ambulance Services Act 1992 will be supplanted by this new part. I make the point, on this part, that what is new about part 6 and the procedure that has, until now, applied is—

The ACTING CHAIR: Order! If members do not wish to be in the chamber, please go to your offices and listen attentively to the debate, because we cannot hear what the member for Bragg is saying.

Ms CHAPMAN: It is largely similar, but the distinctive new addition is that the South Australian Ambulance Service is to be the sole provider (which is now to be legislatively entrenched) for the provision of emergency service. The current licensing structure has been transferred to enable the provision of non-emergency ambulance services by a body, an agency or organisation provided it complies with the licensing requirements of the act and as directed by the minister when he gives such approval.

Importantly, the minister claimed in his second reading contribution that SA Ambulance Service would remain as the single provider for emergency ambulance services and, in so doing, it would not be inconsistent with the national competition policy principles on the basis that, even though it was the sole provider, it complied with or at least came within the 'of benefit to the community' provision.

The South Australian Ambulance Employees Association has had a bit to say about this new initiative, to the extent of bringing the ambulance act and the tier of responsibility being transferred from the chief executive of the SA Ambulance Service directly under the minister, and indicating that, under the new regime, the chief executive of the ambulance service will be responsible to the chief executive of health, who is ultimately responsible to the minister. They are not too happy about that in the sense of what they have conveyed. As to the submission from the SA Ambulance Service, it was not too happy about that. It would have preferred that the SA Ambulance Service—and it claims to have been functioning very well under the current structure—be able to have its CEO directly accountable to the minister and not under another party designated by the minister. It is a significant shift for the service.

I suppose it is fair to say that, in exchange for putting up with that power now being transferred through another chief executive and not having direct access to the minister, it picks up the monopoly contract for the service which is now to be legislated. Once this legislation goes through it will make it clear that there is no other capacity for the minister just to appoint another service to provide this in most circumstances. There are a couple of exceptions to that, and I think they should be recorded.

It picks up the exclusive contract and it will have legislative endorsement, so I suppose for a bit of pain of the restructure it is not surprising that, overall, it is compliant with the terms of the new bill. It has sought, as I understand it, under this part some protection of its employees against any adverse response to their entering a property in a circumstance where they believe that someone is in need of health services—that is, uninvited or when the occupants do not want them to come through the door—and they are to be given some protection from any claim.

I think it is just civil liability arising out of that but, in essence, they are given that protection. The opposition does not have any objection to that. It seems that, if you are going to give the officers this power of entry, which is qualified by the reasonable belief restriction, then it seems to me that there needs to be some corresponding protection. It appears that the licensing regime now has a much heavier range of penalties for anyone who undertakes an emergency ambulance service without licence or, indeed, even holds themselves out to be a service provider of emergency services without having that licence.

It is quite a strict new regime, but overall the opposition does not express any dissent from incorporating it under health. It is noted that ambulance services have had a bit of a chequered history in the past 10 or 15 years. They were in health in the sense that, although they had separate legislation, they were accountable to the Minister for Health in the 1980s. At some stage (I think about mid-1995) they requested that they be transferred to emergency services.

On some investigation of that, the former Liberal government acceded to that and agreed to it, but it had something to do with wanting to get a slice of the emergency services levy in its budgets which it thought would be beneficial financially for the service. Largely, that was achieved. It enjoyed some financial benefits from that transfer. However, it is this government's determination that it should be more appropriately seated with services in health. In effect, it has been its responsibility, and now it will have legislative endorsement in the repealing of the current act and being incorporated here.

Clause passed.

Clauses 50 to 63 passed.

Clause 64.

Ms CHAPMAN: I want to place on the record that my understanding is that this is largely a replication of the regime that currently applies in respect of the activities necessary for quality improvement and research. On the basis that that is the case—as we have been advised in briefings—the opposition does not have any specific objection to this process.

Clause passed.

Clauses 65 to 67 passed.

Clause 68.

Ms CHAPMAN: This is the commencement of part 8 of the bill, which deals with the analysis of adverse events. There is an important principle of protecting the privacy of people's medical information balanced against the also important provision of having processes that will protect the integrity of events to the extent of enabling that information to be used to make sure that, if there is an adverse event—that is, some sort of mishap or death arising out of someone's act or omission—it could be remedied if information is made available to ensure it does not happen again.

A simple example is having a protocol in a hospital which is designed to protect against a person having a medical procedure or intervention accidentally as a result of that person having the same name as another patient. If, for example, someone has the same surname as someone else and they get the wrong records that do not disclose that that person has a history of an allergy to penicillin or some other pre-existing condition like asthma, the procedure progresses and, consequently, it is discovered that they were the wrong records, the question then is: how do we use that information to make sure that a protocol is developed so that it does not happen again? For example, a patient can be asked their name and address several times, and whether they have any relevant history, so that there can be some capacity to ensure that such an adverse event does not occur again.

It is the balancing of these things that is important, as well as trying to ensure that a member of staff, whether medical, nursing or otherwise, is encouraged to come forward, provide information if they have made a mistake or acted in a way that was negligent, and confess. A third alternative involves someone who is present, or who is also involved in services to the patient (a nurse, for example) and who observed a failure—that is, an act or omission by a medical person; for example, a witness to a situation of the wrong drug being administered and so on. Such a person will be immune from any repercussion of disclosing information if that person acted in good faith.

Clause 68 provides that 'no act or omission of a person in good faith for the purposes of an approved activity' of the root cause analysis team 'or for the purposes of an activity that the person reasonably believes' to be an activity of the root cause analysis team 'gives rise to any liability against the person, or against any governing body or other entity involved in authorising' an RCA team to act under this part.

So, there are competing interests here. Again, I am advised that, largely, this part is a replica of what existed in the previous legislation and follows on from the provisions in part 7, which we have approved. I would like to say one thing, however, about adverse events, and Mr John Menadue has been quite prolific in his writing about this issue—that is, the importance of hospitals addressing adverse events and understanding how expensive they are financially (to the government and/or taxpayer), let alone personally (to the patient, their family or friends) if they survive the adverse event. He says that $4.17 billion is the estimated cost of harm in hospitals through adverse events, which represents 23 per cent of recurrent costs in all hospitals—one-fifth of the costs of all hospitals in Australia.

He has written about the Bundaberg hospital episode as being a very public example of where the system goes wrong and the enormous cost involved. He considers that at least half the adverse events are preventable, and he claims that there would be a very substantial saving of $1 billion if it were addressed. With all the proposed new structures—namely, a health performance council to advise the minister, the central control of the management of the hospitals to avoid the risk to patients by sloppy management of current boards and so on—the reality is that, unless you undertake the required root cause analysis reporting, you still have a problem.

I think what is important here is that there is little point in having all this process, which already requires hospitals to provide information; that is, to disclose this to the department, report on it, and there are obligations to actually investigate these events and to provide reports on them. You can have all this process, just like we are setting up a whole new process, but unless you actually do it and report on it then there seems to be a situation where you cannot possibly learn the lesson from the analysis of these situations.

On 26 June this year, I asked the minister to explain how many of the 42 sentinel events which occurred in South Australia from 2004 to 2006 had still not been analysed to identify why they occurred and to prevent them from occurring again. The freedom of information documents related to the sentinel events show that there were five in 2003-04, 20 in 2004-05 and 22 in 2005-06. The responding document stated:

> The Health Department requires hospitals to document and analyse all sentinel events as soon as practicable in order to identify what occurred, how it occurred and how to prevent it occurring again.

The root cause analysis report that was then published for 2004-05, some two years ago, has only now, in the past few months, been put on the website. We know that there has been some inquiry and, from what we know, that is under the new proposed electronic reporting for events that occurred two and a half years ago, but it contains no detail of them.

Here we have a situation where we have all these rules and the minister says that we are going to have this new centralised, unified system, with the restructure, and we are going to be able to follow through with these obligations, but the reality of it is that this data is not being dealt with, I suggest, in a timely manner, and it is it is not being reported so that we can make sure that there are no further mistakes.

I will give you an example of a published story this year, in July, when a 41-year old woman, who was taking legal action against the Lyell McEwen Hospital, claimed that surgeons had left a piece of plastic tape inside her. The Lyell McEwen Hospital is not being looked after by some local hospital board that is responsible. This is a specific act by a surgeon. No hospital board can be responsible for the act; this is a direct action of the surgeon.

This woman claimed that it had ruined her long-term health, etc. She had a bowel operation in the hospital in 1995. She said that she had suffered dramatic weight loss and severe pain. Doctors told her that they could not find the cause and, four years later, when she had a hysterectomy, the surgeons found the piece of surgical tape. So, this is exactly the type of case that we need to know about and which, accordingly, John Menadue AO says is costing us $4 billion to $5 billion a year; that is, 10 per cent of the total health budget wasted because the government has not investigated the matter.

I think what is important is that, in making all these rules to make sure that the information is available and that it balances against the protection of privacy of information of the patient, the

information is made available and actually analysed. So, it is very important that we get on with doing it.

The Hon. J.D. HILL: I cannot allow those comments to go without addressing them. The health system takes very seriously incidents that occur. A whole lot of protocols are put in place which this legislation describes, and there are other things as well to make sure that the system is self-learning and that mistakes that are made become the basis of new systems. All the comments made by the member were not addressed to the legislation but could well be addressed to me by way of questions on notice or by letter. I am happy to find any details she wants if she has concerns. I think the principles in here are absolutely unimpeachable.

Clause passed.

Clauses 69 to 78 passed.

Clause 79.

Ms CHAPMAN: This part addresses the question of the licensing system for the private hospitals. We have covered this in debate, and my understanding is that the minister indicates that this is an area that has been transplanted from the current legislation as it is in need of some review, and he will be doing that in due course. There is no sinister motive or undisclosed objective of the government to do anything adverse to private hospitals. I simply ask the minister that the licence of each of the private hospitals currently licensed in South Australia will continue and that no other conditions of licence will be imposed in the foreseeable future, that is, which is being proposed.

The Hon. J.D. HILL: That is a question that is not really related to the legislation. I have said before that the private hospital sections of this are exactly as is currently the case. The member could ask me that question on any day of the week from now until this legislation is passed. It would apply to the current legislation. Clearly, if individual hospitals breach the rules their licence will be threatened or, if they want to change what they do, their licences may change, but I have no other mechanism in mind which would affect the way private hospitals operate.

Clause passed.

Clauses 80 to 100 passed.

Schedule 1 passed.

Schedule 2.

The Hon. J.D. HILL: I move:

Clause 3, page 64, line 31—

Delete 'Part 4' and substitute:

Part 2

This is really a technical amendment. In the drafting the wrong part was referred to; it should refer to part 2 rather than part 4.

Schedule as amended passed.

Schedule 3.

Ms CHAPMAN: This relates to the special provisions that are provided to the Repatriation General Hospital Incorporated, which, of course, after the passing of this legislation will be the only hospital in South Australia to have its own board. There is provision in this part for the minister to have the power to remove a member of the board from office on any ground prescribed by the regulations. As we do not have any regulations, will the minister give us some indication as to the circumstances that would apply?

The Hon. J.D. HILL: I advise the deputy leader that existing regulations would be translated into this legislation, to cover somebody who is no longer capable of performing a role as a board member.

Ms CHAPMAN: There is also provision in clause 4 of the schedule for the dissolution of the board: 'the minister may at the request of the board dissolve the board'. There is nothing in here to require the minister or the board to consult with the veterans before such action is taken. It is fairly clear that the Premier has made statements in this house with words to the effect, 'They would have their board unless the diggers said otherwise' or something like that. It is our

understanding that a very clear commitment has been made by this government at the highest level, the Premier, and it would not just be a board that said that the minister could get rid of it.

Presently it has two representatives from the RSL on it, but they are all members appointed by the minister. He could have anyone on them who could simply say to him that they agreed to the board being dissolved. The clear intent from the Premier was that there would be no dissolution of this board, that the Repatriation Hospital would have its own board, without the veteran community being in agreement. It seems that the only way of ensuring that that is covered is that there be some provision in the legislation that there be some referendum of the membership or stakeholder bodies before such action could take place. Is that the minister's understanding of how this is to operate, that is, that he would not act to dissolve the board unless there had been some process explored to canvass and obtain consent from the veteran community? If so, would he consider an amendment in another place to tidy it up?

The Hon. J.D. HILL: The political promise has been made by the Premier and by me that, unless the diggers (to use the generic term) are happy, we will not dissolve the board. It is hard to articulate that in a legal sense. The process I have gone through is to have discussions with the Veterans Health Consultative Committee, which has representatives on a range of bodies such as the RSL, Legacy, Vietnam vets, war widows and others. That is the body I would use to consult with the various membership groups. If they were of a mind to change it, that would be a reasonable reflection of what the veterans thought. I am happy to consider a way of articulating that between here and the other place. I am happy to talk to those groups about that. They have expressed nothing but satisfaction with the language here at the moment, so I am not sure that it is an issue.

Schedule passed.

Schedule 4 passed.

Title.

The Hon. J.D. HILL: Before I conclude, I gave some advice before about local government that if there were multiple local government authorities who wanted to put someone in a country health advisory council then the health advisory council itself would make the decision. I have been advised that that is largely correct, but technically that decision would then be referred to me and I would enact that.

Mr Venning interjecting:

The Hon. J.D. HILL: Ivan, it is a late night. I have to formally do that, but it would be the health advisory council that would make the recommendation.

I would like to thank all members for their contribution to the debate on the bill. I would also like to thank representatives of the health agency for their assistance, particularly Dr David Filby, Nicki Dantalis, Rob Smetak, Rebecca Horgan, Kelly Sims, Alicia Tsogas, Ann Johnson and, of course, Richard Dennis, the parliamentary counsel.

Title passed.

Bill reported with amendment.

Bill read a third time and passed.

STATUTES AMENDMENT (INVESTIGATION AND REGULATION OF GAMBLING LICENSEES) BILL

The Legislative Council agreed to the bill without any amendment.

PASSENGER TRANSPORT (DISCIPLINARY POWERS) AMENDMENT BILL

Received from the Legislative Council and read a first time.

At 23:19 the house adjourned until Thursday 25 October 2007 at 10:30.