The only evil of apartheid the protesters can see is that between the white man and the black man. They do not recognise the form of apartheid that exists on a political level as between white men. There was no protest against the Moscow Dynamo football team which was made up mostly of secret service police. The only ones who protested in this case were the Jews and they were protesting because apartheid was being applied to them in the U.S.S.R.

So we find there is no consistency whatever in the philosophy of the protesters to whom I have referred, and there can be none; because the question is not South African; it is not sport, and it is not apartheid. It is a question of whether these grubby, idle oafs can gain control of the Australian way of life. I pray, Mr. Speaker, that they may never be able to do this and I hope the Government of this country will not allow it to happen.

I pray that before our way of life becomes accustomed to being ground in the dust under the grubby sandals of these protesters, those in our community who have become fellow travellers and who pay lip service will wake up to themselves and realise what an insidious practice this is.

DR. DADOUR (Subiaco) [11.56 a.m.]: I would first like to congratulate you, Mr. Speaker, on your elevation to the high position of the Speaker of this House. I would remind you, Sir, that both you and I have the same predecessor so we both have a great deal to live up to.

Before I go any further I would like to thank my electors for having faith in me, and I can only hope that I am able to do them justice. My special thanks go, of course, to Hugh Guthrie, who helped me so very much. I would also like to mention the other people in my electorate who assisted in my election to this parliament.

I would now like to congratulate the new Premier and his Ministers and wish them good government for the sake of Western Australia. May I also be permitted to convey my best wishes to my fellow new members.

The selection of the subject on which I wish to speak today has caused me a great deal of concern. I have chosen to speak on rising hospital costs and in particular the rising costs that have occurred over the years at the Royal Perth Hospital.

I am prompted to do this because I am very worried as to where we are going in this matter. I feel we have reached a point where we can go no further without the system collapsing.

In the television session "Four Corners", which was shown approximately a couple of months ago an attempt was made to depict why hospital costs were rising. It astonished me to find how far off the beam the participants in the programme were, particularly when they talked about the costs involved and the fact that these could be curbed by the use of cheaper intravenous sets and equipment.

These costs are merely peanuts and I would like to indicate what really does influence the cost of hospitalisation. In this connection I would point out that I spent 3½ years as a resident at the Royal Perth Hospital and during that time I enjoyed myself very much. I learned a great deal and I also developed an affection and an affinity for the Royal Perth Hospital. Accordingly it grieves me to say what I am about to say, particularly as I know there are a great number of wonderful people who have been associated with the Royal Perth Hospital and there are a great number of others who are also doing wonderful work at the moment.

By saying what I am about to say I do not wish in any way to detract from the honour which these people should be given. In 1953, however, the costing of a bed per day at the Royal Perth Hospital was $7.71. I am told that today this figure is in excess of $40. The outpatient attendant fees in 1953 were costed at an average of $1.71 whereas today they are $11 plus. This represents an increase of between 500 and 600 per cent. At the same time we find that the cost of living has risen by approximately 100 per cent. only between 1953 and the present day.

I also wish to stress that in 1953 there were 600 beds in the Royal Perth Hospital and approximately 90 beds at the Shenton Park Annex. Today there are still 600 beds at the Royal Perth Hospital and approximately 200 beds at the Shenton Park Annex. The number of outpatients treated in 1953 was 134,000 and last year this figure rose to 187,000. This is a substantial increase.

What does it really cost the Government in subsidies? In 1953-54 the State Government subsidy was $1,300,000 while to the year ended the 30th June, 1971, the subsidy was approximately $14,000,000. I think we can budget for a $20,000,000 deficit this year.

This is a tremendous increase and it causes me a great deal of concern; because while I know that costs are going up and up I cannot find any real justification as to why this should happen.

While I was resident and registrar at the Royal Perth Hospital from 1953 to 1955 there were in all 27 residents looking after inpatients and outpatients. Apart from this there was the honorary medical staff.

Although we had a great deal to do, we also had quite a good time. It was always possible for us to play a game of solo, bridge, or table tennis.

Today there are 152 resident doctors and registrars at the Royal Perth Hospital. I keep asking myself why? When the Medical School began in 1957 it was necessary to find for the graduates positions as residents in hospitals where they could learn. The finals in medicine are merely designed to render a medical student safe; then he is given experience in a hospital before he practises among the public.

For that reason it was necessary to employ more residents in positions where they were not really needed, but this was done to enable them to finish their medical training. The irony of the situation is that of the 152 residents and registrars I have mentioned, 45 per cent. comprise non-Western Australians. I cannot find any justification for so many people from outside the State being in these positions, especially when so many residents and registrars are being subsidised. We should not end up with so many of them from other States and other countries.

In view of the fact that there are 152 residents and registrars at the Royal Perth Hospital, it will be realised that there is not a shortage of doctors, but only a shortage of working doctors. I could say the same for the teachers; we are not short of teachers, but short of working teachers.

I would like to point out to the House that it costs approximately $30,000 to put a student through six years of medicine. After that he is employed for two or three years at a hospital in a situation where he learns more about medicine, and this costs approximately another $10,000. This makes a total of $40,000 for training a student.

I am told that 16 per cent. of our graduates go into general practice. For a grand total cost of approximately $250,000 we get one general practitioner—the basic unit of our medical scheme. In my opinion the answer is this: Give the graduates two years of hospital experience, and then make available a very small number of positions to a few to enable them to obtain higher degrees in surgery or medicine, and sweep the rest out. If we did that, the position would be resolved. We would then have sufficient doctors going into general practice, and once they get into general practice most will remain, because a great deal of job satisfaction is obtained from general practice. To me, my general practice work is not work; it is just part of what I do every day, and part of my way of life. I believe that many of these doctors, after they have seen the level at which they are dealing with people, will be very happy to remain in general practice.

I wish to point out that 14½ years ago I myself went into general practice. I have been successful. I started on my own, and my job satisfaction has been total and complete. That is illustrated by the fact I have been elected to Parliament.

I regret having to hark back to the Royal Perth Hospital. It has quite a massive number of employees—in excess of 3,000—to look after 600 in-patients. This represents an employee to patient ratio of 5 to 1. That is one of the reasons why the cost of running the hospital has risen and why the subsidy is so high. I realise that it contains a number of specialised areas where patients can receive the best possible treatment; but all this costs a great deal of money.

The build-up in the numbers at the hospitals began in about 1955 when the Government of the day decided it would employ as many people as possible in Government and semi-Government positions. The build-up that started in those days has reached saturation point. In 1953 or 1954 there were 2,000 employees, but today for the same number of patients there are 3,000 employees.

In either 1955 or 1956 the then Premier (The Hon. A. R. G. Hawke) injured his finger on one occasion and decided to obtain treatment at the Royal Perth Hospital. His secretary rang the hospital to say he was going there for treatment. The matron eventually found casualty, and a little later the medical superintendent. The red carpet was laid out, and in came Mr. Hawke. He was duly treated and left. The officer in charge of fees, having a sense of humour, sent out a bill for 7s. 6d. by runner to Mr. Hawke and this was duly collected in Parliament House.

The personnel of the records section of the Royal Perth Hospital has built up from one full-time employee and one part-time employee to over 100. I cannot find any justification for this increase in number. At the hospital there are 1,100 on the nursing staff, there are approximately 200 doctors, and the rest of the employees come under the administration section.

Approximately two months ago a report appeared in the newspaper of an address given by a doctor from the Royal Perth Hospital to a Rotary luncheon, in which he said that the hospital was bursting at the seams and it would soon have to refuse admissions.

Then two weeks later the board of the Royal Perth Hospital decided to upgrade some of the beds so that private patient cases could be used for teaching. For this purpose two-bed wards with toilets attached are being provided. It is said that the hospital is bursting at the seams, but then the board upgrades the bed accommodation.

The cost of upgrading is estimated at $1,000,000, and in the process the hospital will lose 90 of its 600 beds. I can see no reason why this proposal should have been implemented. I have been told that the main reason for this was to enable the students to be taught, by using private patients. In the past a similar scheme failed at the King Edward Hospital, and I feel

the present scheme will fail at the Royal Perth Hospital. Private patients are private patients, because they consider their privates private. They do not want a finger stuck in every available orifice. They wish to be private and to enjoy treatment as private patients.

Subsequently, about a week later, it was reported that the Royal Perth Hospital had decided to acquire a "C"-class hospital in Mt. Lawley for an undisclosed sum—of $600,000. Extensive alterations are being undertaken, because the "C"-class hospital is not exactly what is required by the Royal Perth Hospital. I do not know how much these extensions will cost. There were to be 128 beds at that "C"-class hospital, but I believe the number has now been reduced to 80 beds. So, for the total cost of nearly $2,000,000 there will be a reduction of 10 beds. That is excellent management!

We have permitted the Royal Perth Hospital to grow and grow. I realise the cost of establishing that institution has been very high, and we will never be able to obtain the actual cost. The casualty section has been altered four times since it was first built in about 1952. Too often do I hear this remark: What does it matter if it costs $1,000,000 to save one life? When I ask myself this question, the only obvious answer I can come to is, "How many lives can I save for that $1,000,000?" This is the practical way to look at it, the only way to look at the problem. We are faced therefore, with the dilemma that there is a shortage of sufficient beds.

Then there is the irresponsible action of upgrading beds for teaching purposes on private patients and sometimes it is impossible to teach on these people because they will not be taught on. Then a "C"-class hospital is bought and there will be duty free petrol to run backwards and forwards to that all day, thus adding to the costs.

With all these doctors we still, day after day, hear about patients waiting three to four hours in casualty. I know there must be delays in casualty because there are X-rays to be taken and then developed. After this the resident has another look at the patient and the X-ray and then he says, "Oh, well, I had better get a registrar" He then gets a registrar who says, "I do not know whether we can put the patient in or not." We end up with the poor patient waiting three or four hours. This to me is stupid. Casualty is surely a clearing station. The resident should make up his mind what is wrong with the patient and whether he should be admitted or not admitted. It does not matter if he cannot pinpoint the diagnosis; that does not have to be done in casualty. Casualty's purpose is just to deal with the patients and get them into the wards or out of the hospital as quickly as possible.

I do believe that a lot of trouble could be overcome if there was better liaison. The relatives in the waiting room at the side and the patient in the cubicle both wait for hours and hours. There is no communication. If somebody were to communicate with these people at regular intervals and explain to them why they are kept waiting, both the patient and the relatives would, I feel, accept this situation far more readily.

There is this point that, as I said, there is no scarcity of doctors.

The next point, and I always remember this, is that the first and foremost thing the patient wants when he is sick is tender loving care. That is the proper thing. Mr. Smith wants to be known as Mr. Smith; Mr. Jones as Mr. Jones. He does not want to be known as the bloke in that bed over there or the woman in that bed over there. The patients desire a little bit of the personal touch.

I can always remember one dear old fellow who had a stroke. I sent him to the Royal Perth Hospital where he was duly admitted. This man had suffered a right-sided stroke, which means that his right arm and right leg were paralysed, and also his speech centre was affected. His wife went to visit him and as he was lying in bed he kept pointing to his mouth. His wife thought he wanted to be fed so she fed him. There was no communication with the man, he could not speak; he could understand but he could not speak and he could not write because his right arm was paralysed. On the third day he kept pointing, so his wife thought she would have a look in his mouth and she saw he did not have his right teeth. The next thing was that 19 mouths in the ward were emptied and his teeth were found and duly put in his mouth. This sounds quite comical, but these things do happen and can happen at any time; but it is a tragedy when a person is not getting the tender loving care that is needed.

However highly scientific and technical treatment is, we must be aware that it is the little things that count, the things that mean so much. Without the personal touch, it is a dreadful state of affairs.

This has been going on for years. I did feel it was better not to say this in public, but I do feel it should be said now. It has been said before by somebody else; but in my experience some of my patients actually cry because I am going to send them to the Royal Perth Hospital. They have heard from their friends of the impersonal attitude there. This does not happen all the time; this is only in certain cases.

What service do I, as a general practitioner, give? I ring up a doctor at the hospital who is admitting, I tell him I have a patient suffering from such and such, and I say I would like the patient admitted. I give the name and address,

and the hospital sends an ambulance. In the interim I write a letter and give this to the patient or the patient's relatives. This letter goes to the hospital with him—a fairly short concise history of what has been wrong with the patient and what medication he has had. I venture to say it would be in respect of less than one in 20 of all the patients I send to the Royal Perth Hospital that I would get any communication back at all. It has been the position for years now where I have to look at the death notices in the paper to find out who has died. I have been guilty of asking Mrs. Smith or Mrs. Jones how her husband is—this is months later—only to be told: "Oh, he died the next day." There has been no communication to me from the hospital, either by phone or letter.

Also, when patients are discharged, how do I know what has been wrong with them? I have no communication. I look at their prescription book and work backwards in order to determine what has been wrong. In this sphere too, we are not getting the service. The medical superintendent at the hospital is not worrying about the daily running of his hospital, he is planning for the future. Surely the concern of the medical superintendent is primarily with the every-day running of his hospital.

In 1964-1965, business consultants were called in to the Royal Perth Hospital to see how they could improve the running, costing, etc., of this hospital. Two people came and tendered for it: Personnel Administration Pty. Ltd. and W. D. Scott & Co. Pty. Ltd. Personnel Administration Pty. Ltd. jumped up and down with glee; they did not want to get the job. W. D. Scott & Co. Pty. Ltd. came out with a report that was never published.

The report took 18 months and Scott & Co. said it had never suffered such anguish, or met with such frustration and such a lack of co-operation in all its life. The result was that the report was ripped up and thrown out.

The report stated, I am led to believe, and I am sure it is true, that the Royal Perth Hospital should be chopped up into three separate components. How that is ever going to be done I do not know, but at that time in 1964 the report stated that it should be chopped up.

Another argument that may be put forward is that the Royal Perth Hospital has a great number of patients who are pensioners. But 32 per cent. of the gross income of the Royal Perth Hospital, and that includes our subsidy, comes from fees. At the Fremantle Hospital, only 24 per cent. of the total comes in as fees. The combined amount of subsidies to run the Fremantle Hospital, the Sir Charles Gairdner Hospital, and the King Edward Memorial Hospital, with a total of approximately 900 beds, is about five-eighths of the costs of running the Royal Perth Hospital where there are 600 beds plus the 200 sub-acute beds at Shenton Park.

There is a new increase in costs scheduled at this very moment and that is with regard to the honorary system. This system is starting to change at the Royal Perth Hospital and other public hospitals. This could be put down to one factor. A doctor or specialist doctor becomes an honorary in a hospital for two reasons. The first and foremost is because he wishes to give his specialist treatment to the patients who cannot afford it.

Secondly, either by intent or not it is his only means of advertising. He looks after patients and if those patients are grateful they tell their friends and relatives about him. In this way the specialist is able to advertise. Another method of advertising is through his resident doctor. If the specialist treats his resident doctor well, that resident doctor will usually return his thanks by referring patients back to the specialist. However, that form of advertising has been lost because the majority of resident doctors do not now go into general practice; they become specialists in the same field as the honorary himself. Within two or three years the resident doctors become competitors with the specialist, and his income is reduced because of this fact.

The specialists are now coming to be known as visiting staff, because some of them are being paid on a sessional basis. They work two or three sessions a week. and they are paid a certain sum for those sessions. Previously their services were totally honorary, but this system is altering and it will not be very many years before the system is completely reversed. Because of this change costs have gone up, and will continue to do so.

Another factor is that university doctors have a right to operate a private practice in addition to being full-time university lecturers. They are able to earn up to $1,600 a year. Any amount in excess of that is paid into a fund known as a travelling fund. When somebody goes to a congress his expenses are paid from the fund. It is a very good idea, and the fund depends on the honesty of the person concerned as to when he starts to earn more than $1,600.

The right to a private practice has also been granted to other full-time medical staff by the Perth Hospital Board. It has been brought to my notice that those people receive a very good salary. It is much larger than ours, even with the increment, and besides that high salary they have the right to a private practice which, as far as I know, is not limited. There might be a limit on paper, but there is not a limit in practice.

It must be remembered that every person who is admitted to the Royal Perth Hospital, is immediately classified as an

intermediate patient, if he is in a medical fund. The radiological department employs a full-time radiologist, and a couple of assistants. The radiologist is paid a very good salary, and he has the right to a private practice. This means that for every X-ray that he reads he is able to bill the patient. However, the hospital bills the patient for the specialist, and because the specialist is using hospital equipment, and film, the specialist and the hospital have struck a medium and they each receive half of the fee charged.

In May, 1970, it was decided that patients in hospitals were to be charged a flat rate, and were not to be charged extra for investigations such as blood tests and X-rays. The only money which the hospital now receives for X-rays is the Commonwealth subsidy, which is less than half of what was previously received. However, the specialist has stood out for his share and he is still getting half of the original cost. So the hospital finds itself in the most embarrassing situation of not only having to pay a large salary, but also having to subsidise the cost of the private practice. This involves a fantastic sum. I cannot for the life of me see why we should be subsidising specialists who are receiving a full-time salary, and I wonder whether this is the action of responsible people.

I know that the university offsets a fair amount of the cost by passing it onto the hospital through the resident doctors attached to the university. Those doctors are paid by the hospital, and the hospital costs go up so much more.

There is also a problem with teaching. We see a little advertising, hear a few speeches, and then all of a sudden something is sprung onto us. We now hear that the teaching facilities are not sufficient. One particular person has been quite vocal about this matter for some time. I maintain that if a teacher in medicine or surgery has any calibre at all he does not need to have a different patient suffering from every different disease. It would be impossible to have all those people in a hospital at the one time. A teacher can teach so much on a particular heart condition, and he can talk about other heart conditions, that is, if he is a teacher of calibre.

A notice can be put up in the students' room each day listing persons who have been admitted, and their complaints. It is then up to the students to ferret out the patients and make their own observations. Surely the teacher does not have to lead them around all the time. I maintain that a teacher of calibre does not need a great deal of material on which to work. If he sees one case of hernia he does not need to see a dozen others. That is how I learnt, and that is how I had to learn. Teaching requirements today are no different from what they were then.

There is movement afoot to have the complexes made bigger and bigger. I know there is an endeavour to have the Royal Perth Hospital enlarged to take 1,200 beds. The article which I read actually stated 12,000 beds, but that must be a misprint. If the hospital were large enough to contain 1,200 beds it would face a deficit of something like $100,000,000. With 600 beds it will face a deficit of $20,000,000, but the increase in size would involve Parkinson's law further, and the costs would increase.

I have been trying to say that although we are getting bigger complexes and more specialised treatment, the patient must not be considered as a necessary evil. He is a necessity, but not an evil. He has to be known by his name, and he has to be the No. 1 person in the hospital.

It is very important that a patient receives tender loving care. The nursing staff provides the tender loving care, and they give it willingly. However, there seems to be a breakdown beyond that level. On many occasions a patient does not know the name of his doctor. A patient can be in a hospital for two months and not know which doctor is looking after him. Often the wife has not had any communication with the doctor. Certainly this is her fault because facilities exist to enable people to talk to the doctor.

The happiest hospitals as I see them—and I have been over them fairly well—are hospitals such as King Edward, Sir Charles Gairdner, Princess Margaret, and Fremantle. The staff like working in them and all the staff know each other and mix well together. Consequently there is very little dissension in any of the ranks. This is because there is one matron who knows all her nursing staff. There is one medical superintendent who knows all his medical staff as well as what is happening in the wards. Further, there is one administrator who knows his staff. Consequently everybody in the complex knows each other and the result is an extremely happy hospital. Another result is that there is no deadwood. With everybody knowing each other it is not possible for a person to hide and not do a full day's work, as is just. There is very little chance of over-employment in such an establishment.

The ideal hospital from the point of view of the patients as well as the people who work there is a hospital which can accommodate between 300 and 400 patients. Yet, we are told that much larger complexes than this are needed for specialised treatment and other reasons. If it is not the answer, I believe it would be a workable solution at least to have hospitals of 300 to 400 beds placed at strategic points throughout the metropolitan area.

One could specialise and have all the equipment necessary to fully investigate neuro-surgical or neurological cases. Whilst it could concentrate on this aspect it could still attend to the ordinary, and perhaps humdrum by comparison, task of caring for people.

Another centre could concentrate on cardio-muscular surgery and ancillary treatment. Similarly, another centre could concentrate on renal surgery which needs the dialysis machines, etc. There could be free and total interchange between these centres. I am sure that happier complexes would result.

Under no circumstances would I permit anyone to be in charge of all these if he had any ideas of empire building. Unfortunately, we have such people in our midst. There is also the innocent empire builder, the enthusiast. I refer to a doctor who can see only his little area and builds it up and up. He does not know anything about costing and the expense becomes greater and greater. This type of person has no understanding of the cost factor himself and no-one seems to tell him that he is going over the fence and causing too much money to be spent. I believe we can learn a great deal from what has happened.

The SPEAKER: The honourable member has five more minutes.

Dr. DADOUR: I only intend to take one. As I was saying, we can learn a great deal from what has happened and from what has been allowed to occur in our midst. Large complexes should be avoided, if possible, for the simple reason that they seem to get out of hand. Undoubtedly once complexes go past a certain size they do get out of hand. This grieves me when I think that the Perth Medical Centre will become so large and will cost so much to run. I am not referring to the amount necessary to build the establishment but the amount necessary to run it. On that note I would like to finish.

MR. McIVER (Northam) [12.35 p.m.]: It gives me great pleasure to join with previous speakers in congratulating you, Sir, on your appointment as Speaker of this House. It is no novelty to see you in the Speaker's chair as you have had a great deal of experience beforehand, and I am sure you will uphold the dignity of the office.

I also congratulate new members on both sides of the House who have entered Parliament. I cannot give them any advice as I have not been here long enough myself. I can only say in all sincerity that we have the finest Parliament House in Australia. Also, we have a very fine staff who are helpful on every occasion and members are free to approach them for assistance.

I congratulate the Premier and members of the Ministry. I also wish to thank former Ministers for the assistance they afforded me in the three years I have been a member of Parliament. I would also like to make reference to the member for Canning.

Mr. Bateman: Good on you!

Mr. McIVER: He created political history in this State by being the first member to retain the seat of Canning for two consecutive terms. I say to him, "Well done."

Mr. Bateman: Thank you.

Mr. McIVER: I am amazed at the views expressed by members of the Opposition. The twenty-seventh Parliament has been in session for three days. All that has come forward from the Opposition benches is that the Premier did not do this; the Premier did not do that; the Premier should have said this; and the Premier should have said that.

Mr. O'Connor: I agree with you.

Mr. McIVER: I will get around to the former Minister for Railways directly.

Mr. Rushton: What has the Government done in those three days?

Mr. McIVER: Our State is facing the greatest crisis in its history in many respects. I refer to the young people who are being slaughtered on the roads. Many young people will spend the rest of their lives in wheelchairs or lying on their backs in hospitals. There is a crisis in rural areas and all the people who reside in country towns are facing bankruptcy.

I shall exclude the honourable member who has just resumed his seat from my next comment. I must say that it was refreshing to hear him speak and I congratulate him on the manner in which he delivered his maiden address. All other speakers on the Opposition side, however, have not put forward anything which is at all constructive or something to think upon. I am also appalled at Country Party members. The Leader of the Country Party had the temerity to take the present Minister for Agriculture to task over what he is doing in rural areas. The present Minister has hardly had time to unzip his briefcase.

Opposition members may feel it is a laughing matter, but I can assure them that farmers in my electorate, as well as those in the electorates of the members for Avon and Mt. Marshall, are most appreciative of the work which has been done already by the Minister for Agriculture. They have expressed appreciation to me on many occasions because the Minister has gone into the areas and spoken with them. He has seen at first hand the major problems which people in country areas are experiencing. They have also expressed the view to me that it is the