## HOUSE OF ASSEMBLY

Wednesday 18 September 1991

## ESTIMATES COMMITTEE A

**Acting Chairman:**
Mr K.C. Hamilton

**Members:**
Dr M.H. Armitage
Mr S.J. Baker
Mr V.S. Heron
Mr P. Holloway
Mr C.D.T. McKee
Mr J.K.G. Oswald

*The Committee met at 11 a.m.*

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**The ACTING CHAIRMAN:** Any changes to the composition of the Committee will be notified as they occur. If the Minister undertakes to supply information at a later date, it must be in a form suitable for insertion in *Hansard* and two copies are to be submitted no later than Friday 4 October to the Clerk of the House of Assembly. I propose to allow the lead speaker for the Opposition and the Minister to make an opening statement, if desired, of about 10 minutes but no longer than 15 minutes. The approach in respect of asking questions will be flexible, based on about three questions per member, alternating on either side. Members may be allowed to ask a brief supplementary question to conclude a line of questioning.

Subject to the convenience of the Committee, a member who is outside the Committee and who desires to ask a question will be permitted to do so once the line of questioning of an item has been exhausted by the Committee. I remind members of the suspension of Standing Orders that allows Estimates Committees to ask for explanations on matters relating to Estimates of Receipts. Questions must be based on lines of expenditure and revenue as revealed in the Estimates of Payments and Estimates of Receipts. Reference may be made to other documents, for example, Program Estimates, the Auditor-General's Report, etc. Members must identify a page number in the relevant financial papers from which their question is derived. Ministers will be asked to introduce advisers prior to commencement and at any changeover. Can the Minister indicate a timetable for the examination of the Estimates of Payments?

**The Hon. D.J. Hopgood:** I usually put myself in the Committee's hands in these matters. I would have thought that the critical decision is the point at which the Committee concludes its examination of the Minister of Health lines and starts to examine me as Minister of Family and Community Services. I would be happy to have an indication from the Committee.

**Mr OSWALD:** I have discussed this with the Chief Executive Officer of the Department for Family and Community Services and suggested that her officers be in attendance by 3.45 p.m.

South Australian Health Commission, $1 119 167 000

**Witness:**
The Hon. D.J. Hopgood, Minister of Health.

**Departmental Advisers:**
Dr D. Blaikie, Acting Chairman, South Australian Health Commission.
Dr D. Filby, Executive Director, Planning and Executive Services.
Mr P. Davidge, Executive Director, Finance and Information.
Dr M. Jelly, Acting Executive Director and Chief Medical Officer, Metropolitan Health Services Division.
Ms C. Johnson, Executive Director, Community Services.

**The ACTING CHAIRMAN:** Does the Minister wish to make an opening statement?

**The Hon. D.J. Hopgood:** Yes, Mr Chairman, but I will not use the full 10 minutes. The Committee would be aware that it is my usual practice to allow the maximum exposure of officers to the Committee to provide as much information as possible about our budget lines. As to the global budget, these days we talk about billions of dollars. It may be difficult to follow given that we have blue books and yellow books and a change in accounting between this financial year and last financial year. I think some members could be forgiven for thinking that these changes—which I assure members are all Treasury driven—result from a deep, dark plot to make life more difficult for the Estimates Committees. So far as I am concerned, that is not what happens; we are told the form in which these figures are brought down.

What is important is the net draw from the State budget. It comprises recurrent and capital payments less receipts (including Commonwealth funds), of $775.9 million. It is those additional receipts that take us into the billion dollar category. For this financial year the recurrent payments budget has been set at $1.287 billion, which represents an increase of $73.3 million (or 6 per cent) over 1990-91. In real terms I am advised that that provides for a $33.3 million (or 2.7 per cent) increase. I think it is important to point that out because in the past I have talked about our overall budget being a 1 per cent reduction in real terms. However, that includes our capital budget, which has been reduced somewhat, and I will explain that shortly.

A number of high priority initiatives have been funded in the system. I will not go through all of them, as I am sure that members will draw them out of me as the day proceeds but, for example, the hospital enhancement previously funded by the Commonwealth is $4.2 million; and the additional funds to the Noarlunga Hospital which, of course, is still in its growth phase, is $3 million. We had to find an additional inflation allowance (which went from 2.5 per cent to 3.6 per cent) of $3 million. Costs of transfer of nurse education to the tertiary sector amounted to $1.7 million; and the fee for services for visiting medical officers comes to $1.1 million. All the other initiatives fell below the $1 million class and I will not delay proceedings further in relation to that. The system must absorb a number of costs this year, and this is one of the differences between the accounting for last year and for this year. Last year one or two members were able to make cheap political points by comparing what we spent in the previous year with what was allocated for that year. I was at pains to explain that that is not comparing like with like.

The whole point was that in the previous year there had been money from round some allocation added in to what we had spent, and that put the new allocation in a less than favourable light. I had to explain all that at the time. This time around I could have played the same game and compared our allocation this year with what was spent last year, but that would be to ignore the fact that award restructuring and award increases have to be found as a result of this

allocation that we have been given. I did not think that I could play the game for which I had condemned others for playing in previous years. Structural efficiency is being implemented in all health units. They are reviewing management structures to provide a more efficient and effective service and release savings to offset the increased cost of structural efficiency, which could cost around $8 million this financial year. Also, Treasury has provided funding for 2.5 per cent national wage increases, but there could be other award increases, and at this stage it is very difficult to get any specific handle on exactly what that ought to be.

Finally, I refer to the capital works program overview. The details of the program compared with 1990-91 are as follows: overall 1990-91 ran out at about $55.3 million; this year we are allocating to capital $43.6 million. That still compares very favourably with expenditures in the early 1980s, which did not get above $20 million and averaged about $17 million per annum. It follows significantly higher expenditures in the second half of the decade where expenditure reached a record level of $71.3 million in 1989-90. The big project which we are keen to move into as quickly as possible and which will be responsible for a good deal of these funds is the Medical Centre for Women and Children project. As we move into that over the next two or three years, it will certainly absorb a large amount of the capital budget. It is important that we get on with it.

There are a number of other projects that we see as being important. I make the point that the AMCWC amalgamation will cost $45 million and be the largest hospital project undertaken in this State since the Flinders Medical Centre. I have a number of other pieces of information at the table on capital in country areas, but that is enough by way of general introduction. I will be only too happy to provide more detail as it is requested.

**Dr ARMITAGE:** I refer to page 39 of the Program Estimates, and I note that the specific target for 1991-92 is the commencement of building work for the AMCWC ACH campus, as the Minister has just said. In other parts of the budget papers we are told, in relation to the AMCWC, amongst other things:

> The provision of a new kitchen, cafeteria, pharmacy and helipad is also planned.

I refer the Minister to the report of the Parliamentary Standing Committee on Public Works on the AMCWC (page 10) which deals with site access and, in particular, emergency helicopter access. The report states:

> Detailed consideration was given to the provision of a helicopter landing platform on the roof of the Queen Victoria building, but a study of anticipated usage did not support the considerable expense involved ($1 million). This service will continue to be provided by the university oval.

When taken together, these observations indicate clearly that the Government is planning expenditure of $1 million on a helipad which the study indicates is not supported by potential usage. Why does the Government intend to press ahead with the wastage of $1 million on a helipad that is not supported by proposed usage?

**The Hon. D.J. Hopgood:** I make the point that the honourable member is referring to an opinion of an important committee of this Parliament that is not binding on the commission or on the Government: it is advice that we can accept or reject on the basis of what we feel is appropriate. I will ask Dr Jelly to respond in detail to that question.

**Dr Jelly:** Consideration was given to placing a helipad on top of the AMCWC building during the discussions leading up to the presentation to the Public Works Standing Committee. However, because of the relatively low usage expected by the AMCWC, because of the very significant increase in capital cost that would be incurred to strengthen the building to accommodate that facility, and because a lift component would have to be installed on top of the building, creating some problems in terms of planning, it has been decided not to proceed with that provision.

**Membership:**

Mr Quirke substituted for Mr Heron.

**Dr ARMITAGE:** I recognise how much was to have been spent—we were given that information by the Public Works Standing Committee—but I do not understand why the Government is proceeding with this plan given that the study indicates that the anticipated usage is not justified. It is stated in the budget papers that a helipad is planned.

**The Hon. D.J. Hopgood:** I regret if the honourable member and the Committee have been misled by what is contained in the budget papers, because the Committee has just been told that any plans for the building of the helipad have been abandoned. I assume that in that circumstance the commission was convinced or reasonably persuaded by the recommendation of the Public Works Standing Committee.

**Dr ARMITAGE:** Can we take it then that the budget papers are wrong?

**The Hon. D.J. Hopgood:** Yes.

**Dr ARMITAGE:** I find it amazing that the Minister is not worried about the fact that the budget papers indicate that the Government intends to spend $1 million on a helipad that has been proven and admitted to be not supported by proposed usage. If that mistake is contained in the budget papers, one can only view with some degree of scepticism the other figures that have been presented to us.

I refer to page 9 of the blue book; I note that the 1991-92 preliminary budget allocation for Noarlunga health services has been increased by 51 per cent over the actual payment in 1990-91. Will the services provided to the community by the Noarlunga Hospital increase by a concomitant 51 per cent, and will the Minister reconcile the removal of $200 000 from the budget for surgical services at the Southern Districts War Memorial Hospital with his letter of 27 March 1990 to the Chief Executive of the board of that hospital which states:

> I am pleased to assure your board of directors and members of your staff that the Health Commission has no plans to change the role of the Southern Districts War Memorial Hospital once the Noarlunga Hospital is commissioned.

**The Hon. D.J. Hopgood:** First, with the extra money at Noarlunga we will buy some extra beds, which will be installed considerably later in the financial year; and, secondly, there is day surgery. I cannot predict at this stage for the honourable member how well used the day surgery facility will be. We know that there has been a significant upsurge in day surgery in all of our hospitals. It has been responsible, for the most part, for our being able to do more surgical procedures in the past 12 months than we did in the previous 12 months—and quite possibly more than in any 12 months in the history of public hospitals in this State.

So, when the honourable member asks, in effect, 'Will the southern districts be getting a service that is concomitant with this expenditure?' it depends a bit on how well the people in the southern districts are prepared to identify with their local hospital and how well the doctors themselves are prepared to use the day surgery suite that will be at the hospital. In 12 months we will have a fair idea.

I do not have immediately before me details of the activity levels at this stage for Noarlunga which, of course, has only been going for a short time. As far as the southern district are concerned, it is true that there has been some

evolution of thinking about the role of the Southern Districts War Memorial Hospital as part of the overall plan for the delivery of health services in the south. There have been considerable changes in the way in which the hospital operates. I have already referred to same-day surgery. We cannot rule out the possibility that at some time in the near future the Repatriation Hospital will become part of the State system. Indeed, the Noarlunga Hospital is there; it is only operating and we are stoking up as time goes along. I think it is reasonable in those circumstances that we should just step back a little and see how Southern Districts fits into the overall scheme. It has an important future in the scheme. However, one cannot do highly acute surgery everywhere and it may be that its future is other than in the acute surgery areas. All I can say is that what we wrote to Southern Districts at the time was our knowledge of our intentions. These intentions evolved, and we hope that we can involve the local people in that evolution.

**Dr ARMITAGE:** I would have thought that the type of operations being done at the Southern Districts War Memorial Hospital, such as hernia and varicose vein operations, hardly falls into the category of acute surgery. I think there has been some degree of misunderstanding, shall we say, about the role of the Southern Districts War Memorial Hospital. However, given that I am still interested in what faith members of the staff and the boards of hospitals can have in letters from the Minister and given that, clearly, the situation for the hospital is now totally different from that referred to by the Minister in March 1990.

**The Hon. D.J. Hopgood:** It is not totally different, but we want to involve the hospital in a close look at what its future should be and how it appropriately fits into the network down there. For example, the honourable member may be interested to know that less than 20 per cent of medical patients from the Willunga local government area were admitted to the Southern Districts War Memorial Hospital. Indeed, 60 per cent of all surgical patients in the southern districts came from the City of Noarlunga and from farther north. So, a large number of those people either elect, because it is their choice to go to hospital outside the area, or have to go anyway, because there are procedures—as the honourable member says—that are more highly acute than those provided at McLaren Vale, or ever will be provided at McLaren Vale, even if we proceed along the path that I referred to in my letter from which the honourable member has quoted. I think it is reasonable to step back a little to reconsider how this hospital fits into the total scheme.

**Dr ARMITAGE:** Without asking a question, I draw the Committee's attention to the blue book, page 29, indicating that the average adjusted cost per admission for the Southern Districts Hospital is $300 cheaper than Noarlunga.

**The Hon. D.J. Hopgood:** Noarlunga is hardly out of the womb. It is hardly a fair comparison.

**Dr ARMITAGE:** My third question relates to the blue book, page 16, under Grants to Health Agencies? The preliminary budget allocation for the Daw Park Hospice, according to this line, is $785 300. It is noted in the Program Estimates, page 38, under services for the terminally ill, as having a bed capacity of 15. I have recently been contacted by one of the general practitioners in that area, Dr Don Pearce, who has indicated that he has twice within the past few weeks been unable to get a patient into the Daw Park Hospice. On further inquiry he has been told that until very recently only 12 of the 15 beds have been opened. He was also told that another bed was opened in the immediate past with AIDS funding money. He was further told that there had never been 15 out of 15 beds operative at the Daw Park Hospice because of a shortage of funds. Dr Pearce indicates that he was also told there is a waiting list of 20 people to get into the hospice. This has led to both of his most recent patients whom he has attempted to get into the Daw Park Hospice dying in less than optimal surroundings in general wards in general hospitals. Will the Minister undertake to provide funding to open all 15 beds at the Daw Park Hospice?

**The Hon. D.J. Hopgood:** I will ask Dr Blaikie to answer that in some detail, but I would make a couple of points. First, there is some flexibility between Daw Park and the Repatriation Hospital. That sometimes means that some hospice patients can be accommodated in the Repatriation Hospital until such time as capacity is available in Daw House. I know that from personal experience. That gives us some flexibility.

Secondly, not everybody who dies will die in a hospice, and that will be with us for some time. This Parliament has set up a select committee to look, among other things, at hospice services to determine how we can better deliver those services. I am sure that honourable members will await with interest the results of that select committee. I will ask Dr Blaikie to address the specific point that the honourable member has raised.

**Dr Blaikie:** The budget allocation to the Daw Park Hospice this year has increased by 18.7 per cent. That is an indication of the Health Commission's knowledge of some of the matters that the member for Adelaide has raised. The Daw Park Hospice is a joint venture, commissioned in 1988, between the Repatriation General Hospital, the Commonwealth and State Governments. It has been wonderfully successful. That, I think, is an indication of the difficulties that some people are having in being admitted. It is not the only hospice in South Australia. Indeed, expenditure on hospice and palliative care services has been significant in the last few years. I am sure that members are aware of other developments as well. As regards Daw Park, additional AIDS money has been provided and at any one time 13 of the 15 beds have generally been open. We hope that the additional money provided this year will allow another bed to be opened.

**Mr HOLLOWAY:** My question relates to page 45 of the Program Estimates which deals with the role of the Public and Environmental Health Services in the State's health system. The member for Coles recently made a statement to the effect that Public and Environmental Health Services had been downgraded. She also claimed that the Public and Environmental Health Division had over 200 staff in 1987, but that there are now only 130. Does the Minister agree with those statements?

**The Hon. D.J. Hopgood:** I certainly agree with the member for Coles that Public and Environmental Health services has a very important role to play. Even if one were to be so ill advised as to do away with the South Australian Health Commission, Public and Environmental Health Services would still need somewhere else to reside. It would have to be a discrete unit providing the important service that it provides.

However, I have got to say that the figures that were quoted by the member for Coles in the House ignore the fact that there have been transfers of some of the functions from public and environmental health to other areas, in particular, occupational health, safety and welfare. A number of officers who previously worked for the Health Commission in that capacity indeed have gone in that direction.

If I can summarise what I am saying: the figures before me indicate that 64 employees have been transferred to other agencies. That does not mean that the function is not

still being carried out. The function is still being carried out by Government, but through a different agency, and possibly under the aegis of a different Minister. For example, in 1987-88, 5.8 staff were transferred to the Health Development Foundation, 6.1 staff were transferred to the Policy and Planning Division of the Central Office of the Health Commission, and 4.5 staff were transferred to the Public Information Unit.

In 1989-90, 33.6 staff from the division were transferred as follows: 20.6 to the STD clinic, 8.5 health surveyors went straight to country hospitals, 1.5 went to the South Australian Institute of Technology and three went to local government. On 30 June last year, the figure of 133 staff was further reduced by the transfer of 14 staff to the Department of Labour. So, when we look at the extent to which there has been some streamlining and saving in this area, let us bear in mind that those functions have not necessarily disappeared. In many cases they are being delivered through a different agency or under the aegis of a different Minister.

**Mr HOLLOWAY:** My second question relates to the Central Office of the South Australian Health Commission. I refer to the statements on pages 46 and 47 of the Program Estimates, which indicate that savings will be achieved by the reallocation of funds to high priority initiatives within the health system. As the Minister has just informed the Committee of the true position in relation to public and environmental health, will the Minister comment on the Leader of the Opposition's claim, as reported in the *Advertiser* of 3 September, that the Health Commission has between 500 and 600 employees?

**The Hon. D.J. Hopgood:** I gave the Leader a gentle serve—and all my serves are gentle—in the House a week or so ago, so I will not go into too much rhetoric here. However, I think it is fairly important that the Committee have the figures, because there has been a degree of confusion in the minds of some people as to just how many people are involved. According to statement 14 *(a)* of the blue book, which members have in front of them, there is a total of 342 employees. However, four of those are grant funded; they are not paid for by the commission. So, that leaves 338 employees of Central Office—a far cry from 500, 800 or 900, as quoted from time to time.

The 338 people include, as I indicated in response to the honourable member's previous statement, the 106 members of the Public and Environmental Health Division, who have that very vital role to play. If we subtract them, that leaves 232 employees. That is the health bureaucracy, if you like, the Central Office staff, and they are the people who have the responsibility for the support of the 26 000 people employed in more than 200 hospitals and health centres throughout the State. Without going into too much detail, I point out that these people are responsible for allocating funds and monitoring expenditure, for planning and coordinating a diverse range of health services, collecting and analysing financial work force activity data, for policy development, human resources management and industrial relations, managing a major capital works program, intergovernmental relationships—and, being half smart, not only making sure that the blue book is correct but making sure we have got one.

**Mr HOLLOWAY:** I refer to Estimates of Payments, 'Program 1—Services for the Aged and Disabled'. Is the Minister aware of the Funding Action Group for the Disabled and Mr John Reedman, spokesman for this group? The group has written to me and, I believe, to other members concerning the acute need of 31 severely disabled people who live with their families. I understand the group has made submissions for support services to provide respite and ongoing accommodation support. Will the Minister say how the Government intends addressing the problem of families who support severely disabled relatives at home?

**The Hon. D.J. Hopgood:** Yes, I am aware of this group. Since Mr Reedman has been mentioned by name I recall that he once worked for me in the office of the Minister of Education. He was not a political appointee but a public servant who was the Chief Executive Officer of the committee that recommended to me grants for non-government schools, the so-called Cooke or Medlin committee as it was known in those days. Mr Reedman and I have a rather long association. I might ask Colleen Johnson, Executive Director, Community Services Division, to comment, but first I would like to say something in general about disability services. Why is it that in recent times disability services have come on to the agenda in a way that perhaps they were not around back in 1973, that *annus mirabilis* when it seemed anything was possible and any demands from the community could be funded by the Government and so on? Why has this happened at a time when Governments are somewhat trapped in their capacity to do all that they would like to do?

First, if we look at disability generally—not only intellectual disability but disability and those who have multiple disabilities—we can say that more youngsters born with disabilities or having acquired a disability in childhood are surviving into adulthood. Previously many of them died. That generates that demand. Secondly, there is a changed appreciation of the way in which these people are able to live out their lives. That has come about partly as a result of better medical treatment but not only because of that, because we now understand that far more people are able to lead independent or semi-independent lives in the community if they are given the opportunity to do so. Once people understand that this is possible, quite naturally and for the very best of intentions, they ask that this should happen. And why should it not happen?

The capacity of Governments to be able to respond to what seems to be at present a demand almost falling out of the trees for at least the two reasons I have indicated and possibly more—a better appreciation of the rights of the disabled and all those sorts of things—unfortunately is limited. The honourable member will know that last year some additional moneys were funded to put into this area, and those additional funds are still built into the base of the area. However, it is still not enough. Recently we took a decision that was somewhat controversial at the time—I guess it still is—that some of the savings from the devolution of beds from Hillcrest Hospital would go to disability. That was controversial because people in mental health said, 'You are pinching money from us and giving it to disability.'

I think it is the function of the Government and the commission to make decisions like that and say, 'We put priority in an area because there is a need in the area.' Unfortunately, it is not possible to dig out all the money that we want to go to the disabled straight away, and the devolution of those beds and the savings will be realised only over at least a 12 month period or beyond. I can give a commitment that that money will go to the disabled. Whether the people who are subject to the specific submission to which the member refers or to which Mr Reedman refers in his letter will be the first recipients of those funds is not for me to say now. Colleen Johnson might be able to give us a better handle on that. I would say that it is up to groups like the Intellectual Disability Services Council (IDSC). We do not need extra inquiries or anything like that but we do need to determine just who should get the immediate priority, and that will be based on those who

have the greatest need. Perhaps Colleen Johnson might like to add briefly to what I have said.

**Ms Johnson:** Currently the State Government expends through the Health Commission $122 million a year on the provision of services to people with disability. In addition to that amount the Commonwealth, through the Department of Community Services and Health, expends an additional $34 million primarily through non-government organisations. In addition, we have the Home and Community Care Program, which operates through the Department for Family and Community Services. There have been considerable developments in the service provision for people with disability over the past few years and considerable new moneys. I would mention just a few of those. Since the 1987-88 financial year an additional $2.12 million has been expended through the Intellectual Disability Services Council for the provision of an additional 71 supported accommodation places.

In the same period, since the 1987-88 financial year, funding provided by and through IDSC for non-government organisations has increased from $1.3 million per year to $4.5 million per year. In the 1990-91 financial year the Health Commission made available an additional $1 million for the creation of a community support scheme. We were fortunate in being able to attract matching HACC money in respect of that $1 million, and this has meant a new scheme with an annual allocation of $2.6 million. In this current financial year we are able to provide an additional $400 000 for that scheme and, if we are again successful in matching that money with Commonwealth money through the HACC program, it will mean an additional $1 million for the community support scheme.

The Julia Farr Centre has done considerable work in the past couple of years in looking at new directions, and it has been able to provide additional respite services and accommodation support for people who are already living in the community or who wish to relocate from the Julia Farr Centre to accommodation within the community. We have provided additional funds over the past several financial years for the DPE scheme, and in the 1989-90 financial year an additional $740 000 was provided for equipment. In the 1990-91 financial year we provided $100 000 for a deaf/blind service, and we were able to look at support for the disability award. In addition, there is new Commonwealth money and we are also looking at the development of new services through efficiencies and the direction of money. As the Minister said, that is not to say that we do not have considerable outstanding demands in the disability area—we certainly do.

We have a large number of people who are not able to realise their potential as members of the community and who require a great deal of additional support. The Commonwealth-State Disability Agreement, which this State has recently entered into, will provide additional Commonwealth funds for disability in this State. However, it is expected that a considerable amount of those new moneys will be required to support the existing operations of services now funded by the Commonwealth Government. The Minister has already mentioned that funds will be made available from the relocation of beds from Hillcrest Hospital, and that will provide a significant increase in services in this area.

**Mr OSWALD:** I refer to page 9 of the blue book under 'Recognised Hospitals and Associated Services Teaching'. Under the preliminary budget allocation for the Queen Elizabeth Hospital the Minister would no doubt be aware that the 17 bed rehabilitation unit, which serves the western suburbs, is closing because of budgetary constraints. Originally, the unit had 23 beds, but cuts were made at the beginning of the year, which meant that six beds were lost, leaving 17 beds, and appropriate alternative facilities are not available. Will the Minister explain or indicate how the rehabilitation of patients in the western suburbs will be addressed following the closure of that unit?

**The ACTING CHAIRMAN:** The Deputy Premier would be aware of the Chair's interest in this particular question.

**The Hon. D.J. Hopgood:** Indeed, Sir, and the Chair would recall that I answered a question on this issue in the House only a week ago. I am not sure that I can say very much more than what I said then: that we see it as appropriate that rehabilitation of this kind not be carried out, for the most part, in a high cost acute hospital. Some of the patients who may have occupied those beds will occupy general beds elsewhere in the hospital, but we also look to St Margaret's Hospital, a combination of the Royal District Nursing Society, Domiciliary Care, and possibly some other initiatives yet to emerge, largely in order to take up the challenge of that class of patient. Perhaps one of the other officers would like to add something over and above that.

**Dr Blaikie:** St Margaret's Hospital in particular will be able to take up some of the demand in that area. It is a recognised, fully Health Commission-funded hospital of 48 beds. Currently, 60 per cent of the patients admitted to St Margaret's Hospital come from the western regions of Adelaide, 82 per cent of patients are over 65 years of age, and, currently about 40 per cent of patients at that hospital are from the Royal Adelaide Hospital, and 40 per cent are from the Queen Elizabeth Hospital. Therefore, those two hospitals are already using St Margaret's Hospital as a convalescent rehabilitation hospital.

It is fair to say that, once the Queen Elizabeth Hospital rehabilitation ward closes, it does not mean that no rehabilitation will occur there. There will still be rehabilitation in the general medical ward, but I think that, increasingly, St Margaret's Hospital will take a very active role in rehabilitation in the western suburbs. That decision, which has been jointly agreed between the Queen Elizabeth Hospital and St Margaret's Hospital, is one that I applaud.

**Mr OSWALD:** As a supplementary question, what is the average bed occupancy at St Margaret's Hospital?

**Dr Blaikie:** The figure is about 80 per cent with an average length of stay of about 15 days.

**Mr OSWALD:** So it is pretty full?

**Dr Blaikie:** Yes, we want it to be full, and it is, but that is turning around. The patients do not stay there forever.

**An honourable member:** So, there is no room.

**The ACTING CHAIRMAN:** Order! The questions will be asked one at a time. The member for Morphett has the floor.

**Dr Blaikie:** I think I have said all that I can.

**Mr OSWALD:** I refer to page 43 of the Program Estimates and 'Health Worker Training and Education'. A Specific Target/Objectives for 1991-92 is as follows:

> Continue review of allied health professional undergraduate clinical education.

When will the Minister make the final decision as to whether or not adequate funding will be provided for physiotherapy training in South Australia, given that, first, a July 1991 occupational therapy staffing survey which looked at the ratio of total beds for occupational therapy staff in South Australian hospitals in comparison with interstate hospitals indicates that we are much worse off; and, secondly, a 1986 survey indicated that there was a shortfall in occupational therapy services of 80.9 full-time equivalent staff, which is yet unaddressed? Will the Minister give a guarantee that

vitally important allied health professionals will be supplied in adequate numbers and with adequate training?

I will briefly explain my question and refer honourable members to comparable statistics. The ratio of beds to staff in the Royal North Shore Hospital in New South Wales is 47:1; Westmead Hospital in New South Wales, 36:1; Concord Hospital in Sydney, 31:1; St Vincent's Hospital in Melbourne, 31:1; and a list of Western Australian hospitals runs at 33:1; while in South Australia the figure for Flinders Medical Centre is 68:1; the Queen Elizabeth Hospital, 62:1; and the Royal Adelaide Hospital, 155:1.

**The Hon. D.J. Hopgood:** This touches on a broader issue: whether the State ought to be taking up funding, which has always traditionally been seen as a Commonwealth responsibility. It is true that all States do that and, in some areas, some States make a greater effort whilst others make a lesser effort. Traditionally, it is true that some other States have allocated more funding to this area than we have, just as, if we look at Government overall, we have allocated more funding to other areas. The way that it comes out in the wash is about equal across the various States. It is not simply a matter of South Australia saying, 'Yes, we do not spend as much in this area as perhaps Victoria does, so we will have to make it up.' We must look at the overall area, otherwise it seems to me that we are sitting ducks, not only for reductions in overall Commonwealth funding but regarding administrative decisions taken by the universities which, for the most part, are recipients of Commonwealth funding.

The Federal Government could say, 'Yes, we can cut back in that area and put some pressure on the State Government so that it will make it up'. I suppose that that is a slightly cynical interpretation of what could happen in other circumstances in the future. I am not saying that that is what has happened here, but I can say that the total budget of the University of South Australia has increased, we are told, by 0.3 per cent in real terms from 1989-90 to 1990-91. At this stage we do not have the details of the 1991-92 budget position—after all, it is not one of our units; it is a university. So, it was not an overall reduction in Commonwealth funding. Instead, the university adopted a stage plan to bring the school budget in line with notional income under what is termed the relative funding model.

As a result the School of Physiotherapy is required to reduce the number of clinical supervisors, and the school, not being able to obtain any more funding from the university, came to the Health Commission and said, 'We want you to fund six positions to supervise clinical payments at an estimated cost of $250 000 per annum.' We do not have those sorts of funds available. We have agreed to fund one full-time position at the Royal Adelaide Hospital from 1 January 1992 and, in the interim, a group of senior physiotherapists from major hospitals and from the School of Physiotherapy has been established to determine the average patient case load by student physiotherapists, and discussions between the University of South Australia and the SA Health Commission are continuing.

We are not unaware of the problem, and we do not lack sympathy for the overall position of the profession and its training, but the State cannot put itself in the position of immediately picking up the tab every time the university decides to change its funding arrangements in relation to what is traditionally Commonwealth funding. Where would that end? It would never end.

**Mr OSWALD:** On a point of clarification, the question was: when will the Minister make a final decision? I gather that he is really saying to me that, with the funding province that he has, no decision will be made.

**The Hon. D.J. Hopgood:** We made then a decision for one, and a group has been established to look at patient case loads. I imagine that it will report to us in about a month, and we may then be in a position to make a further decision, but the further decision could well be not to allocate any more funding.

**Mr OSWALD:** I refer to page 34 of the Program Estimates and the commentary on major resource variations, which indicates that the funds provided from confiscated assets were not included in the base. What were the funds provided from confiscated assets?

**Mr Davidge:** The value of the reduction in confiscated asset funding is $114 000. We have not allowed for a range of confiscated assets in the current year's estimates, because we do not know what that will be. That money comes from the sale of assets confiscated as a result of illegal activities and is used to provide additional funding for the Drug and Alcohol Services Council in the provision of its services.

**The Hon. D.J. Hopgood:** We will obtain further information later in the day.

**Mr QUIRKE:** Will the Minister or officials from the Health Commission give further information on the mammography unit, which I understand is now up and running? It has been put to me that the target for this unit is females from the age of 40 to 50 years. I understand that the the unit is to operate out of the major teaching hospitals. A few matters of concern have been raised about the involvement of radiologists in the reading of the material. How does the mammography unit function?

**The Hon. D.J. Hopgood:** Screening is available for women over 40 years, but it is specifically targeted at women in the age range of 50 to 69 years, with screening occurring at two yearly intervals. The honourable member has not specifically asked about it, so I will not go into country screening at the moment. In relation to the second part of the honourable member's question, I am joined at the table by Dr Kerry Kirke, the Executive Director of the Public and Environmental Health Division who diverted our attention a short time ago, and I ask him to comment.

**Additional Departmental Adviser:**

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

**Dr Kirke:** The issue of radiologists and screening of mammography films is a vexed question, because a publicly-funded screening program is quite different from private radiology. As the screening program develops, various patterns of reading have had to be developed. As it grows, more radiologists will be involved. Currently, negotiations are going on between the director of the screening project and the radiologist in the city.

**Mr QUIRKE:** It has been put to me that the strategy of the unit is now being determined by a committee and not by radiologists. I understand that radiological trained persons and analysts do the reading so that anybody who has a screening can be assured that it has been done by people at the cutting edge of medical analysis on this issue.

**Dr Kirke:** The issue of non-radiologist readers of mammography films has been raised nationally as there are sometimes difficulties in having radiologists in sufficient numbers with the experience to read screening films. The issue has not been resolved finally but I can say categorically in this State at this time all screening films are being read by fully-trained radiologists.

**The ACTING CHAIRMAN:** Is there a difficulty in obtaining radiologists for the Health Commission?

**Dr Kirke:** A number of radiologists are in private practice. There may be confusion between radiologists and radiog-

raphers. Radiographers are in short supply across the country. As the mammography screening program develops, we anticipate difficulty in attracting radiographers who are the people who take the X-rays. Radiologists are medical specialists trained in the reading of X-rays. We do not think there will be a shortage of them, although attracting those people into the public screening program might be difficult.

**Mr QUIRKE:** How big is the unit and what costs are associated with it?

**Dr Kirke:** It is a developing program and has been in existent only since 1 October last year. It is expanding rapidly. We started with an objective this financial year of screening around 30 000 women, having screened about 15 000 last year. Our eventual aim is to screen about 65 000 women a year in four or five years. The costs are escalating as the program grows. In the first instance, the Commonwealth has given us unmatched funds with which to develop the program. The second and third phases of the national screening program will be on a matched basis. We anticipate the contributions from the Commonwealth being about $1.6 million for the first phase and about $2.3 million each for the second and third phases. This is the proportion of the $64 million to which the Prime Minister alluded in March last year.

**Mr QUIRKE:** Finally, I understand that a committee determines the policy with regard to this issue. What is the committee membership and what is their medical training, if any?

**Dr Kirke:** We may have to take the question on notice. There are several committees including a national committee that decides national policy because, after all, that is part of a national program. During the pilot phase of our State program, which ran in 1989 and 1990, finishing at the end of September last year, we had a program advisory committee. I cannot recall the names of those involved. Radiologists were well represented on that committee. We plan to form a program advisory committee for the development of the fully fledged mature program, and we certainly intend to have a radiologist on the committee.

**Mr S.J. BAKER:** I refer to page 26 of the blue book where it refers to patient accounts compensable. The outstanding balance and compensable accounts as at 30 June 1991 was $7 427 004 and the percentage of outstandings greater than 60 days was 73 per cent. Outstandings greater than the 60 days constitute 60 per cent of total receipts for 1990-91. I am interested in specific measures that the Minister will be taking to decrease the percentage of outstandings that roll over greater than the 60 days.

**Mr Davidge:** The outstanding balance on compensable accounts decreased during the year from $7.768 million to $7.427 million. Taking into account fee and price increases during the year, that is a significant achievement in terms of reducing the overall outstanding balance. I do not have the figures relating to the percentage of accounts outstanding for 60 days or more in terms of how they compare with last year's figures, but they always comprise a high percentage of the total outstanding balance purely because of their nature and the fact that they are associated with workers compensation claims and other compensable items for which an immediate resolution is not possible. So, the hospitals face additional difficulties with respect to the very quick collection of those accounts.

**Mr S.J. BAKER:** As a supplementary question, is it fair to assume that WorkCover and SGIC are the two major agencies responsible for these outstanding accounts?

**Mr Davidge:** Yes.

**Mr S.J. BAKER:** Will the Minister provide details of the outstanding accounts by these agencies and can a further breakdown of outstanding accounts greater than 60 days, 120 days and six months be provided to indicate the real waiting time?

**The Hon. D.J. Hopgood:** I undertake to obtain what information I can, but I may need some indulgence from the Committee with respect to the date of 4 October, as this information is fairly detailed and will require a great deal of extraction. We could provide samples. There is nothing unusual about these figures. A figure in one column may indicate what is anticipated but the final settlement would be in the hands of the courts.

**Mr S.J. BAKER:** On page 33 of the Program Estimates it is indicated that in 1991-92 the commission intends to further develop and expand services provided by Alfreda Rehabilitation and McWork at the Lyell McEwin Health Service on a commercialised basis. Does this mean that organisations such as McWork will have to pay sales tax and other imposts suffered by private sector rehabilitative services, and are they meant to be truly competitive? Will those services be subject to the normal costs of other rehabilitation services?' For example, will the service contracted to WorkCover have the same level of costs and imposts placed upon them, and will they attempt to compete on a commercial basis?

**Dr Blaikie:** To the best of my knowledge, they will not. They are not a company but merely a component within an organisation: in the case of Alfreda, the Queen Elizabeth Hospital and, in the case of McWork, the Lyell McEwin Health Service. Both those bodies provide services for injured workers on a commercial basis. Patients are referred to them by WorkCover and other areas. Notwithstanding that they may or may not have to pay sales tax, they have been very successful. For instance, in Alfreda's case, income of over $1 million was generated last year over and above the base year before the commercialisation venture began. In the past, that money has been used for new equipment and services and it will also be used for a major upgrading of Alfreda.

**Mr S.J. BAKER:** As a further supplementary, the Committee has been told that organisations attached to public hospitals are using those facilities to commercial advantage and, in fact, competing unfairly with private providers. Is that a reasonable summation of the situation?

**The Hon. D.J. Hopgood:** The honourable member uses the pejorative term. I would prefer to say that they may not have to play to quite the same rules as would private enterprise deliverers of these services. The commission is happy to have the amount of $1.138 million for 1991. In 1991, McWork achieved a profit of $116 000 which has been retained by the Lyell McEwin Health Service for its use at the discretion of the board of directors for the sorts of indications that the Acting Chairman has already mentioned. Non-compensable patients will continue to be treated at no charge.

**Mr S.J. BAKER:** Regarding the AMCWC campus (page 29 of the Program Estimates) renovations were carried out recently to the Gilbert building to allow administrative and financial departments to be accommodated in that building prior to their eventual move to the Angas building. When the tendering process for the renovation of the Angas building was found to be out of kilter with these plans, the administrative and financial services were moved to the Florence Knight building. How much money was spent on salaries and wages, capital input and any other expenditure to renovate the Gilbert building, which was used in the short term and which is to be demolished? In other words, this building was temporarily upgraded at some considera-

ble cost to accommodate administrative staff, but that upgrading appears to have been a waste of money.

**Dr Jelly:** As I understand it, the definitive move for this project is to the Angas building. There will be no future move to the Florence Knight building, which is to be replaced by the new AMCWC building. I do not have at my fingertips the cost of salaries and wages used to achieve this move. This part of the total AMCWC project is being funded by moneys from the AMCWC.

**Mr S.J. BAKER:** Because someone did not line up properly the movement into the Angas building it seems that considerable money was wasted on temporary upgrading of the Gilbert building.

**Dr Jelly:** The temporary upgrading of the Gilbert building enabled the amalgamation to be achieved earlier, so that savings with respect to the amalgamation process in terms of salaries, etc have been achieved already. To do this, certain functions of both the Queen Victoria Hospital and the Children's Hospital had to be brought together. The Angas Building has to be refurbished before the move into it in a definitive way.

**The Hon. D.J. Hopgood:** In any event, I am not sure that the Committee quite picked up the earlier point that Dr Jelly made. My advice is that none of those moneys in terms of upgrading were Health Commission moneys at all, or came out of this budget. They were applied by the hospital from funds that it has available to it from other sources. The honourable member would be aware that, given the affection with which the hospital is received by South Australians, there are those other funds available. I do not think it is for me to tell the hospital how to use its own money.

**Mr S.J. BAKER:** I get concerned when the Minister says, 'It is other people's money and what they do with it is of no concern to anyone but the body itself,' given that we are well aware of the scarcity of funds for charitable purposes and, indeed, for the health budget. My question goes back to the principle of whether it be public funds in terms of either taxpayers' dollars or money donated and held in trust: given that these administrative units are now stuck in the Florence Nightingale Building and that the Gilbert Building had to be temporarily upgraded, what was the cost of that temporary upgrading as an interim measure?

**The Hon. D.J. Hopgood:** First, there is always a problem when one is moving into a new development as to what standard of comfort and convenience one provides for the people in the old one. The old one may be falling down and it will be another two years before one is in a position to provide the new facilities: does one allow those people to continue to live in squalor or does one undertake limited upgrading, which provides for some reasonable occupational health, safety and welfare and all those sorts of things?

Secondly, I am not saying that people should not be concerned about the way in which the hospital spends its own money. I am saying that as Minister it does not seem to me that I should direct the hospital as to how it spends the money it gets other than that which it receives from my budget. As to the question of whether we can talk about public funds having been involved in the sense that there were officers who were paid from public funds who had to spend at least some of their time thinking about this and physically shifting things from point A to point B, I guess that we can try to get that information. It will be very difficult to determine what percentage of the Chief Executive Officer's salary was, in fact, devoted to that task. I imagine it would be a very small amount and notional in the extreme.

**Mr McKEE:** I refer to page 41 of the Program Estimates under the heading 'Delivery of health services for the general population', and refer the Minister to a report that I read in the *News* yesterday which states:

> Large numbers of South Australian doctors are likely to stop bulk billing pensioners, charge all patients a co-payment and increase fees overall.

Will the Minister comment on whether there will be any likely effect in the light of that report?

**The Hon. D.J. Hopgood:** Yes, I saw the article to which the honourable member refers. First, I have some considerable sympathy for the average suburban GP. It seems to me that, if we look at salaries generally available to medical graduates, we see that the average suburban GP has really not done all that well in the past 10 years compared with those people who go into specialties, including those going into surgical specialties. So, a lot of them are not doing anywhere near as well as a lot of people would perhaps conclude. Having said that, I would be very concerned if, first, as the article suggests, a number of people have already added the $3.50. I would be even more concerned if, should a little way along the track the Commonwealth makes the decision to introduce the $3.50 charge, another $3.50 is added—double-dipping. I do not think that that is on. I remind the Committee that the Commonwealth has not yet made the irrevocable decision to introduce the $3.50 charge. I hope it decides not to do so and walks right away from it. I think it was the wrong thing to announce in the first place. However, it is in the Commonwealth's hands and, as the honourable member knows, a committee of the Federal Labor Caucus is examining this matter. So, anyone who at this stage is adding this repayment of $3.50 to what they are charging patients across the counter is really jumping the gun.

Secondly, and in particular, I would be concerned if what anyone has in mind is that, should the decision be taken, another $3.50 would be added. I do not think that is on and I advise that medical practitioners should look very carefully at their practice in this respect.

**Mr McKEE:** I refer to page 35 of the 1991-92 Program Estimates, entitled 'Services for mental health': a number of references are made to the reorganisation of the mental health services and the establishment of a single mental health authority to direct and control mental health services. How will people with a mental illness benefit from the proposed reorganisation of mental health services in South Australia?

**The Hon. D.J. Hopgood:** First, the establishment of the single mental health authority will ensure that there is a clear focus of responsibility for the development of what needs to be both comprehensive and, I guess, coordinated mental health services throughout the State. The authority will have the task of relocating the beds from Hillcrest and developing community services for these people. I remind the Committee that, on the best advice we have, $7 million will be directed to new community mental health services, with savings of $3 million going to other Government priorities, including what was indicated earlier about people with serious disabilities. Indeed, we have a commitment to ensure that those 120 people occupying those acute beds at Hillcrest will be relocated in circumstances where the quality of the services provided are at least what they get at present, if not better—preferably better.

The new service also has the task of developing and planning for new services in the next 10 or 15 years. Things are changing quite considerably in the area of mental health. The honourable member will be well aware of the vast changes that have occurred in the treatment and care of people with mental illness over the past 20 or 25 years. We

can anticipate that there will be further changes and it is important that we be up with the best in the world in the care that we can provide to people with mental illness.

**Mr McKEE:** I thank the Minister for that answer because, as you know, Mr Acting Chairman, Hillcrest is in my electorate. The program 'Health worker training and education', on page 43, identifies difficulties in recruiting and retraining general practitioners in country areas. Will the Minister advise what progress has been made in the provision of medical practitioners to country areas?

**The Hon. D.J. Hopgood:** We have been considerably concerned about this for some time. There have been national conferences devoted to this particular area. Following the August 1990 visit of Dr Livingstone, Director of the University of Queensland's Medical Education Committee, the Health Commission supported a proposal that a training scheme, having both a city and a country focus, be established under the responsibility of the Country Health Services Division of the commission. The division is doing a number of things. Mr Ray Blight, who is the Director of that division, will provide more detail.

**Additional Departmental Adviser:**

Mr R. Blight, Executive Director, Country Health Services Division.

**Mr Blight:** The prime area of concern is the maintenance of procedural skills of GPs working in the smaller communities. So, one of the objectives of this proposal is to provide additional training in the areas of obstetrics, surgery and anaesthetics for practitioners who are prepared to practise in the country. Our initiatives in this area are in the hands of a Rural Practice Training Advisory Committee, which has representatives from the Rural Doctors Association, the Australian Medical Association, the College of General Practitioners, the Health Commission and our two universities. Their primary role over the next 12 months will be to oversee the preparation of a feasibility study on how we can provide this additional procedural skills training within South Australia's resources. That feasibility study will have to encompass issues such as supply.

This general thrust is consistent with a national thrust. Agreement has been reached with the College of General Practitioners for the creation of a new post-graduate qualification—Diploma of the Faculty of Australian Rural Medicine. Our efforts are concentrated on how we can meet the requirements of this new qualification in South Australia. In terms of progressing the feasibility study, we have recently appointed Dr David Gill, who in the past has been President of the AMA and currently is Chairman of the Ministerial Review of General Practice. He has been appointed as medical consultant to this training scheme. He is presently overseas on other business, but during that trip he will be looking at rural training schemes operating in the United Kingdom. We expect that with his advice the training advisory committee will be able to report by mid 1992 on an appropriate framework to be implemented to meet this objective of improved procedural training for rural general practitioners.

At this stage we expect the training program to be spread across two campuses. One will be metropolitan—at this stage the Modbury Hospital is the preferred location because it has a number of specialist training posts available—and the other will be a country location, which most likely will be Whyalla, because the Whyalla Hospital is our largest country hospital, it has a significant complement of specialists and it is fairly well placed to assist in this training effort.

**Dr ARMITAGE:** In a true bipartisan spirit, I and my Party support many of those initiatives. The appointment of Dr David Gill, and others like him, is to be applauded. I turn now to the Program Estimates, page 43, under the heading, 'Health worker training and education.' One of the 1991-92 specific targets mentioned is to 'provide training for Board members of rural health units.' How much money will be spent on this specific target, what form will the training take, and why will any money be spent on this, given that the Government's recently released green paper on regionalisation would see boards of rural health units disbanded?

**Mr Blight:** This initiative has been in the pipeline for some time. In the early days of the formation of the Country Health Services Division, we recognised that a number of board members were having difficulty in coming to grips with their responsibilities as board members in a business as complex as the provision of hospital and health services to rural communities. Through a number of consultation forums we held three or four years ago, the need for orientation training for board members was identified by country communities. As a division, we took it upon ourselves to look at the solutions that might be available.

Over the past 18 months we have had discussions with the Health Industry Development Council and agreed that there was merit in that body putting together a training program for board members, the focus being both metropolitan and country. Because of the country interest, my division contributed $17 000 to the preparation of a board director package, but more importantly to deliver that package to board members in the country. Over the past three or four months, therefore, a number of training sessions have been held in country centres to which members of boards of all units in that area have been invited. The sessions, which have generally run for a day, are supported with printed material and a video package.

The response has been very encouraging. I have not heard a single criticism from any of our boards about the program. On the contrary, the feedback has been very complimentary. In terms of its relevance to the future, we still have some way to go before the final form of area health sevices in country South Australia is resolved. It is clear that we still require decision-making bodies in the country. The proposal is for fewer than is presently the case. I continue to see a need for this type of training, but clearly to a smaller audience if the green paper proposals proceed.

**Dr ARMITAGE:** The green paper on regionalisation unequivocally states that boards will be disbanded. I am confident that I heard you say that you believed that ought not to be the case. Do you believe that having boards in the country is a good idea?

**Mr Blight:** The proposal is that area health boards will be responsible for managing services in country locations. The green paper proposes six, so there will be six boards of directors essentially taking the responsibility for resource allocation service development for a wider grouping of communities than individual boards do. We will still need skilled board members. With the expanded responsibilities, it is clear that we need very highly skilled board members in the country.

**Dr ARMITAGE:** I accept that. You do not think that it would have been more appropriate to spend taxpayers' money on the area health board members once they had been chosen rather than on everybody when clearly not everyone will be on the area boards?

**The Hon. D.J. Hopgood:** It seems to me that this is a worthwhile expenditure of money. First, the green paper is a green paper, and one cannot guarantee at this stage that

every aspect of it will be implemented. Even if it is, as Mr Blight has indicated, there will be a reduced demand for some very highly trained people. Secondly, there are other areas where some of this training can be very useful. For example, we have a Health and Social Welfare Council, and that is the subject of an assessment right now.

The assessment may be that we should extend that system to the whole of the State. As the honourable member would know, at this stage it operates only in four councils: the Riverland, Murray-Mallee, the south western and the north-western suburbs of metropolitan Adelaide. If we are to extend that, we will be looking to the same people to assist us in the membership of those councils as well. Of course, we cannot guarantee that everybody who is offered the course will take it. It may be that the number of trained people will closely match the demand that we are looking at even if the whole of the green paper is implemented.

**Dr ARMITAGE:** I make it clear, again without asking a question, that I am in favour of the training program. I think it is marvellous, provided the boards stay. I now refer the Committee to the Program Estimates, page 45, where the specific targets for 1991-92 indicate the implementation of new international radiation protection standards. That is a laudable aim that we support. Will the Minister undertake to provide adequate funding for the Radiation Control Committee, such that it can carry out its required work to the satisfaction of members of the committee, who have a statutory role under the Radiation Control Act, so that the members will not be forced to take steps such as resigning from the committee because they are anxious about the inability of the committee to monitor radiation protection standards?

**The Hon. D.J. Hopgood:** The honourable member is concerned in particular about a vacancy in the Public and Environmental Health Division, which we have advertised but I do not think we have filled at this stage. Perhaps Dr Kirke can further enlighten the Committee.

**Dr Kirke:** Yes, the position has been advertised. We have not had any applications yet, but hopefully we will have them in the near future.

**Dr ARMITAGE:** That, of course, has been a long-standing vacancy.

**Dr Kirke:** Yes, it is to replace a Mr John Gibb who transferred to north Queensland several months ago.

**Dr ARMITAGE:** So, during that time the Radiation Protection Committee has been unable to carry out its activities to its own satisfaction.

**The Hon. D.J. Hopgood:** It depends on whose satisfaction, of course.

**Dr ARMITAGE:** To its own satisfaction, I said, Minister.

**The Hon. D.J. Hopgood:** That is your judgment.

**Dr ARMITAGE:** I refer to the Program Estimates, page 45, and public and environmental health services. A specific target in 1990-91 was to establish a process for health risk assessments of contaminated land sites. A specific target for 1991-92 is to work actively with the health component of the MFP project. Will the Minister provide details of all health risk assessments undertaken on contaminated land within the MFP project site? I am happy for that information to be provided at some later stage.

**The Hon. D.J. Hopgood:** We will take that on notice.

**Mr HOLLOWAY:** In response to my previous question concerning assistance for families who care for severely disabled people the Minister and his departmental officers gave a considerable amount of detail on the funding issue. I note at page 33 of the Program Estimates, under the heading 'Services for the Aged and Disabled' the following:

Establishment of Community Support Incorporated for the support of people with disabilities in the community.

Will the Minister indicate what Community Support Incorporated actually does and how it helps people with disabilities to live in the community?

**The Hon. D.J. Hopgood:** It is a non-government organisation that has been created to arrange practical support for people within their own homes and in the community. It funds things like personal care, respite care, and practical and physical supports—and that might include things like home and garden maintenance. I guess the major gain for consumers is the flexibility of funding to enable care to be arranged for their individual needs. Something in excess of 500 consumers have been supported by this funding. Funds are expended on the basis of assessment by case managers of the designated specialist disability agencies. In 1991-92, $3 million is available to this program, which includes an additional $400 000 in State moneys. We are also seeing additional Home and Community Care funds, relating to the $400 000 and this could provide up to—and I stress 'up to'—an additional $600 000.

**Mr HOLLOWAY:** On page 41 of the Program Estimates reference is made to the implementation of new aerial medical service arrangements. Will the Minister briefly outline these new arrangements, and can he identify any efficiencies or advantages that have resulted from their introduction?

**The Hon. D.J. Hopgood:** I guess the honourable member is referring to the transfer from the St John Ambulance Service to the central section of the Royal Flying Doctor Service. I think in July 1990, two air ambulances and seven pilots were transferred. The new arrangement is that St John retains responsibility for tasking the aircraft, as they call it, and providing air attendance, and the Royal Flying Doctor Service manages and services the fleet and actually employs the pilots. This has given us access to an additional aircraft, which has been donated by the Royal Flying Doctor Service. It means we have more flexible use of aircraft resources, and I think also more effective use of pilots' time. So, this seems to be leading to an enhanced provision of services.

**Mr HOLLOWAY:** Finally, I ask a question in relation to my own electorate. The Minister would be aware that I have questioned him in the past on the future of the Repatriation General Hospital at Daw Park, and in particular I have raised the concerns of many veterans who live in my electorate, who fear that the transfer of the hospital to the State system might disadvantage them. What is the current state of negotiations with the Commonwealth and with the veterans' groups on these issues?

**The Hon. D.J. Hopgood:** I do not think there has been very much movement from when I last addressed the matter in the House. The general rules of the game, as indicated by the State Government, remain as they were: that, in the event of the veterans' hospital coming into our system, general access to comprehensive health and hospital services for veterans would have to continue at the level they have always enjoyed. The Commonwealth would have to give a guarantee that all funds would be transferred to the State and be indexed for inflation. The Commonwealth would have to complete the comprehensive upgrading of the physical facilities at Daw Park, before the date of transfer. The veterans' community, as represented by the RSL, would have to be satisfied that the arrangements, particularly those related to priority of access and quality of health care, had been satisfied; lastly, the staff of the hospital would have to be satisfied that their interests were adequately safeguarded. In March 1991, a joint information paper was put out by the Health Commission and the Department of Veterans' Affairs on the integration of the hospital, and negotiations are continuing.

**Mr HOLLOWAY:** Is there a timetable set in relation to negotiations or discussions?

**The Hon. D.J. Hopgood:** The Federal Minister has said June 1992. That is what the Commonwealth would like to see happen. I do not suppose that the State really has a timetable. What the State says is that we will fit into any timetable if those five conditions can be achieved.

**Dr Armitage:** If we get a good deal.

**The Hon. D.J. Hopgood:** Yes, precisely; I agree entirely with the honourable member.

**Mr OSWALD:** I return to the subject of mammography. There are a few areas here that should be explored as supplementary to the response given to one of the Government members earlier. The screening program in all public clinics available to screen is now booked out until the end of the year. That fact did not come out earlier this morning. In fact, they now have waiting listed beyond that. No further names are being taken at this time, I understand. So, really we have a mammography program that has come to a standstill, if one looks at it from the point of view of people trying to get on the program. Going on the information provided this morning, if the program screened only 15 000 women last year and has an expectation of screening 30 000 this year, how will this existing program cope with a 100 per cent increase, if it cannot accommodate the existing requirements?

**The Hon. D.J. Hopgood:** In brief, it is because we have not yet got the Commonwealth contribution, and the sooner we get it the better. The cost-sharing phase of the program goes from 1991-92 to 1993-94. The Commonwealth contribution in each of those three financial years is $1.6 million in this financial year, $2.3 million next financial year and $2.3 million again in 1993-94. We are pursuing a five-year implementation plan for a State-wide service, and this will increase screening and throughput to around 65 000 screenings annually by 1995-96. Our timetable is, this year, 35 000 capacity, though it may be that the throughput is only 30 000, for the reasons I have already indicated, and then in the following financial years, 45 000, 55 000, 60 000 and 65 000. Then, of course, there is that matter of the mobile service for country areas, which is another thing again. But that is basically the explanation: because we are awaiting the Commonwealth contribution.

**Mr OSWALD:** Is it guaranteed or are these hypothetical figures?

**The Hon. D.J. Hopgood:** They are guaranteed funds, but the cheque has not arrived.

**Mr OSWALD:** I refer to hospital enhancement booking lists on page 28 of the blue book. In the 1990-91, $4.798 million was cross shared between the State and the Commonwealth under the line 'Booking Lists'. It is indicated that these programs will be totally State funded in 1991-92. What was the specific effect on booking lists of the expenditure of $4.798 million, and what is the amount of a similar program funded totally by the State in 1991-92?

**The Hon. D.J. Hopgood:** I have already indicated and the member has taken this up—that we are already funding the hospital enhancement program. The problem is that it is difficult to translate a certain number of dollars expended on booking lists one or two financial years ago into an outcome in this or next financial year because of the changes in the way in which we deliver the services as more and more of the services are handled on a same-day basis and, therefore, the unit costs reduce. We should be able to do more. The honourable member has heard me in the House on that matter previously. Basically, we can say that from 1986-87 the funds devoted to this specific purpose went from $3.8 million in 1986-87 to $5 million, $4.9 million, $8.2 million, $8.7 million and in this financial year $9 million.

In this financial year the honourable member will look in vain for what we would call a Commonwealth list assistance program, and instead he will find a hospital enhancement program of $5.7 million and a metropolitan hospital funding packet of $3.3 million. All I can do is point to the track record over the past 12 months where same-day surgery has been quite efficacious in respect of increasing productivity. We imagine that that will continue. We could do a calculation on the back of an envelope for the honourable member that might be of some use, but I make the point that as the number of procedures done by same-day surgery increases, so we get that more cost-effective component. Just to complete what I am saying, in 1988-89 to 1990-91 the booking list procedures increased from 27 529 to 30 834, which is an overall increase of 3 305 procedures in that period.

**Mr OSWALD:** I refer to special benefit schemes and miscellaneous services and the line 'Equipment Schemes' on page 25 of the blue book. The Minister will recall the Opposition's highlighting dilemmas faced by people expected to pay for literally life-saving equipment as outpatients from public hospitals and, in particular, the question of throat suctions that came up in the past few weeks. I note that the total gross payment for equipment schemes in 1990-91 was $2.445 million and that administrative expenses amounted to $1.315 million. Does the Minister believe it is appropriate that people should be forced to pay for life-saving equipment when 53 per cent of the money expended on equipment schemes in 1990-91 went on administration and only 42 per cent on equipment? What does the Minister intend to do to make these schemes provide the necessary equipment and services rather than a heavy administrative bill?

**The Hon. D.J. Hopgood:** Before these figures are carved in stone, I will ask an officer to comment as I am sure it is wrong that 53 per cent of the total cost goes on administration. I will ask Dr Blaikie to comment.

**Dr Blaikie:** I will have to take that on notice, but I can be certain that that amount is not spent on administration as we understand that term. Domiciliary Care is one of the major providers of equipment. There will be expenditure of $5.2 million, of which $2.1 million will be for equipment under the HACC program and the Disabled Persons Equipment Scheme.

**Mr OSWALD:** Will the staff look at that question during the lunch break?

**The Hon. D.J. Hopgood:** Yes.

**Mr QUIRKE:** The program relating to acute hospital services on page 41 of the Program Estimates refers to transplantation programs. Will the Minister advise the Committee on the establishment of a bone marrow donor register in South Australia?

**The Hon. D.J. Hopgood:** I can, because I launched the register about two weeks ago. Already about 800 people have expressed interest in being bone marrow donors, and that number is probably more than the South Australian Red Cross can test in the first year. The State undertook negotiations with the Commonwealth and the Jane Fournier Foundation. The negotiations took longer than we had originally expected, and that is an example of what can sometimes be the complexity of tied funding or tied grant arrangements with the Commonwealth.

Fortunately, we were able to negotiate a level of funding that the Red Cross needed to establish the register and, when Brian Howe agreed to match the Fournier Foundation funding of $50 000 in the first year, that was a bonus. Basically, we are looking at a State contribution of $55 000

in the 1990-91 financial year, and a Commonwealth contribution of $105 000. That Commonwealth and State funding has been secured for the next few years.

**The ACTING CHAIRMAN:** Can the Minister indicate to the Committee whether there is, as I understand it, an age limit of 50 years for registering for a bone marrow transplant?

**The Hon. D.J. Hopgood:** For the most part, we are talking about children suffering from leukaemia, but we will have to find out whether there is a specific limitation of 50 years of age.

**Mr QUIRKE:** Although I have not been able to find any reference in the Program Estimates to the hyperbaric chamber, I understand that it was recently used to treat a number of workers who inhaled toxic gas during an industrial accident. Does the Minister have details on the operation of the hyperbaric chamber at the Royal Adelaide Hospital?

**The Hon. D.J. Hopgood:** Yes, I do. The honourable member will remember very well the collapse of the Victorian division of the National Safety Council of Australia in March 1989. At that time Cabinet approved an additional allocation of $214 000 to the Royal Adelaide Hospital to allow the chamber to continue to operate. It is the only fixed facility of its type in the State, and it is being used progressively for the treatment of a range of conditions and anaerobic infections such as gas gangrene, burns and carbon monoxide poisoning, as well as what most people associate the chamber with, that is, the treatment of divers for decompression sickness, or the bends, as it is called.

Of the 40 or so workers who inhaled carbon monoxide during the industrial accident at Raptis in July of this year, 22 were treated in the chamber or through the Police Department's transportable chamber. In fact, divers suffering from the bends now comprise only a small proportion of those treated, and the service is essential for the occupational health and safety of the divers. Of course, it is also available for other purposes.

I think that, in light of the incident at Raptis, there has been some concern on the part of the diving community that perhaps the service will not be available to them. I can give them a guarantee. It is not a service that is overused. Obviously, it is used in emergencies and, fortunately, those emergencies do not arise very often. I think that perhaps the diving community are seeing to it that their number of misadventures are reduced as time goes on, and long may that continue.

**Mr QUIRKE:** On page 37 of the Program Estimates, under 'Services for Aborigines', there is a reference to the National Aboriginal Health Strategy. Can the Minister advise the Committee on its progress?

**The Hon. D.J. Hopgood:** It was endorsed in June 1990, and the development of the strategy began in 1988. I think it has made a significant contribution to the improvement of health services in South Australia. There have been a number of major programs, some of which are substance abuse, environmental health and antenatal care. During 1989-90 and 1990-91 the commission allocated nearly $600 000 on a one-off basis and made a recurrent commitment of just over $1 million to the national strategy initiatives. In 1991-92 it will allocate an additional $585 000 and raise its recurrent commitment to nearly $1.5 million. This will provide funding for things such as support for Aboriginal communities and Aboriginal health services in health promotion, research program evaluation, and in-service training of Aboriginal health workers. There is to be capital support for an Aboriginal substance abuse rehabilitation program at Murray Bridge, and there will also be increased primary health services for Riverland Aborignal communities.

**Mr Blight:** It is probably worth noting that the years ahead offer the greatest opportunity for additional funding for this very important program area. The next step by the Aboriginals and Torres Strait Islander Commission towards determining priorities for the millions of dollars of national funding that will be available is to ask each Australian State to put forward its views on what initiatives should be taken.

The South Australian reponse to that request has been multi-faceted, perhaps recognising that there is no one solution to the continuing problems of Aboriginal health. Accordingly, our response has covered a range of areas including further policy and program developments. It is very clear that we still have incomplete knowledge as to effective solutions in many of these health problem areas. So, additional staff will be committed to that, primarily through the recently formed Aboriginal Health Council and its Secretariat. As the Minister mentioned, we are also preposing a range of initiatives in the primary health care area. As to environmental health, we believe that, through the UPK initiative in the homelands, we as a State are somewhat in the vanguard of understanding and responding to environmental health issues.

In the short term, our efforts will be more likely directed to evaluating the effectiveness of these programs. In the area of employment and training there will be a whole range of initiatives and, finally, there will be an increased focus on the collection and analysis of data relating to the effectiveness of Aboriginal health programs.

**The Hon. D.J. Hopgood:** Mr Acting Chairman, in relation to your question about age limitation on bone marrow donations, I misunderstood you. I thought you were referring to the recipients rather than the donors. I have no information on the recipients, but I assume that there is no age limit. As to the donors, the age group limitation is 15 years and above and 50 years and below.

**The ACTING CHAIRMAN:** I thank the Minister and the Committee.

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

**Membership:**

**Mr M.J. Evans** substituted for Mr Holloway.

**The Hon. D.J. Hopgood:** The member for Morphett asked a question which assumed a split between administration expenses and the amount spent on equipment in the area of disability. We indicated that we would get the information as soon as possible after lunch. We have some information which may be of assistance to the Committee and I ask Mr Davidge to comment.

**Mr Davidge:** The comment made prior to lunch related to equipment schemes (on page 25 of the blue book), in particular to a sum recorded under administration expenses. That amount has been incorrectly coded and in fact is equipment and should have been shown in the document as such. The only administration expense of the two schemes is the $85 000 salary cost shown. The two schemes, which make up the $2.4 million, are the disabled persons equipment scheme and equipment under the HACC (Home and Community Care) program.

**Dr ARMITAGE:** We have asked about 10 questions and found two mistakes. It hard for the Opposition to question budget estimates when the figures with which we are provided are incorrect.

**The Hon. D.J. Hopgood:** Surely that is the answer the Opposition hoped to get.

**Dr ARMITAGE:** The people of South Australia would assume that the figures presented to the Parliament were correct. That is a reasonable assumption in a democratic society, but clearly that is not the case. I refer to page 28 of the blue book, the line 'Red Cross Blood Transfusion Service—Bone Marrow Register'. Prior to lunch the Minister announced that within the past couple of weeks he had agreed that State money be put into the bone marrow register, yet we note that $30 000 was for salaries and wages for 1990-91. How was this money spent? The money was provided only a couple of weeks ago yet $30 000 is shown as salaries and wages.

**The Hon. D.J. Hopgood:** We will get back to the honourable member on that point.

**Dr ARMITAGE:** I refer to page 45 of the Program Estimates, the line 'Public and Environmental Health'. One of the specific targets is the development of poisons and therapeutic substance legislation. The Minister may realise that there has been publicity, in which I and others have been involved, about the recent case of a 15 year old boy being blinded by an explosion potentially caused by the spontaneous combustion of yellow phosphorous.

A dispute exists about whether it might have been red phosphorous, but that is immaterial, because yellow phosphorous is presently under the control of the Drugs Act, which has been superseded by the Controlled Substances Act, under which yellow phosphorous and large numbers of other poisons are listed under schedule 7 'Poisons'. Although some sections of the Controlled Substances Act were proclaimed in 1984, the repeal of the relevant section of the Drugs Act was not proclaimed. Hence, will the Minister indicate when the regulatory powers under the Controlled Substances Act will be established to enable more meaningful penalties to be applied for the sale of yellow phosphorous in this case, indeed all schedule 7 poisons and others, to people under 18 years of age?

**The Hon. D.J. Hopgood:** We will take that question on notice.

**Dr ARMITAGE:** I refer to page 32 of the blue book. Does 'total employees' relate to the number of employees who are off work on workers compensation from each category and, if so, will the Minister supply a list of those workers and categorise their illnesses and other relevant information, such as for how long they have been off work, when they are expected to return and so on? Further, will the Minister supply figures on the number of redeployees from any category employed by the South Australian Health Commission?

**The Hon. D.J. Hopgood:** The second part of the first question requires an amount of detail and I will bring back a reply. The honourable member asked for clarification, and I ask Mr Davidge to comment.

**Mr Davidge:** The numbers quoted are the numbers in those categories on workers compensation.

**Dr ARMITAGE:** Will the Minister supply a list of workers in those categories?

**The Hon. D.J. Hopgood:** I will ask Mr Case to answer the second question regarding deployees.

**Additional Departmental Adviser:**

Mr P. Case, Executive Director, Human Resources Division.

**Mr Case:** The commission is continuing its dual role in the area of redeployment by taking direct responsibility for the displacement of detached staff and coordinating the placement of excess staff. The commission has some 59 redeployees and work injured employees listed for placement. In 1990-91; 38 permanent and temporary placements were made for people from that group.

**Mr McKEE:** I refer to page 45 of the Program Estimates. Under '1991-92 Specific Targets and Objectives' we see a line relating to the ongoing evaluation of the Port Pirie lead decontamination program. I ask the question in the absence of the member for Stuart and in light of Port Pirie being my home city. I understand that the members for Morphett and Albert Park have also had more than a passing interest in Port Pirie.

**The Hon. D.J. Hopgood:** The program was approved by Cabinet in December 1983. There has been a substantial reduction in blood lead levels of children in the area. It is currently undergoing a major evaluation to advise on the future of the program beyond 1994. It has its momentum to that point. The program has been with the South Australian Health Commission since November 1990, having previously been part of the Department of Industry, Trade and Technology. About 70 per cent of the total program budget is expended by SACON in decontaminating houses. There is little I can add except to say that we are doing this evaluation and the program will go at least to that point. What its future will be will depend on the current evaluation.

**Mr McKEE:** In the budget summary the Minister refers to the expenditure of $1.56 million on interpreter services in hospitals and community health services. Given the number of migrants in South Australia, what is the range of languages services available in the health system?

**The Hon. D.J. Hopgood:** The number of migrants whose first language is not English has grown. One of our concerns is that many people in older age tend to revert to their first language. This has created a problem, because that is the time at which there is a necessity for them to interact with our health system. There is now a greater proportion of health workers with skills in languages other than English than there has ever been, but the number of people who do not speak English being admitted to hospitals is also greater for the reasons I have indicated. We are targeting the professions to try to do what we can to ensure that more facilities are made available for people who do not have English as their first language. For example, a nurse currently located at Port Adelaide Community Health Service seeks to contact all refugees settling in the State to assess their health needs and refer them to private and public services. A Vietnamese midwife and other health professionals speaking the Vietnamese language are located in the western suburbs offering antenatal and primary health care to Vietnamese people, who comprise our largest group of non-English speaking migrants. During the past 12 months, a pilot program of Indo-Chinese access to medical care has been established in the northern suburbs.

The Government has increased language resources from just over $1 million at the beginning of the last financial year to the current allocation of over $1.5 million. Obviously, this will help us to overcome this considerable problem, but we will keep the matter under consideration to determine how we can continue to chip away at it. Areas such as dental services and CAFHS have been given some resources to see what can be done in their area of service responsibility.

**Mr McKEE:** Under the heading 'Services for families, adolescents and children' on page 40 of the Program Estimates reference is made to the Second Story's involvement in cooperative projects with city based services. What projects have been undertaken recently by the Second Story?

**The Hon. D.J. Hopgood:** The Second Story was relocated some time ago and recently I officially opened its new premises, which are conveniently located not too far from its original site in the city. Amongst the sorts of programs on which the honourable member wants advice are the Cautionary Diversion Program, which develops links between the South Australian Police Department and youth workers to target at risk young people, particularly Aborigines; the $30 000 Child Protection Pilot Project funded by the Save the Children Fund for at risk children and adolescents; a $26 000 outreach project called the Health Advocacy Pilot Project, which will target, in particular, homeless young people and which relates to the Burdekin initiative projects; and the Rundle Mall Pilot Project, which is a short-term project funded by the Rundle Mall Management Committee and which targets various groups of young people who are causing problems in the mall area. The official opening of the Second Story Centre in Hyde Street was on 25 July this year and the relocation resulted in recurrent savings of approximate $50 000, which has been redirected towards further program development.

**Mr S.J. BAKER:** With reference to the establishment of regional health service organisations and the issue of regionalisation as explained in the green paper, what will be the cost of implementation of the recommendations of the green paper?

**The Hon. D.J. Hopgood:** That is very difficult to say. It may be that full implementation of the green paper recommendations, if they were to go ahead, would involve substantial savings, because there would be a very drastic reduction in the number of employers in the public health system in this State. Chief executive officers and directors of nursing would not be employed by an individual board but by the area health board, and that which may achieve considerable savings. There may be even greater savings in the metropolitan area. So, it would be difficult at this stage and quite misleading to say that the setting up of an area health structure would cost a certain amount without at the same time giving an indication of the savings that would offset the cost. My staff is working on this matter at present. Should there be any indication that this sort of structure will be substantially more expensive than the current one, that would be a good reason for the green paper never becoming white.

**Mr S.J. BAKER:** Have moneys been allocated to the Murray Bridge Hospital board to purchase a home for the Chief Executive Officer of the future Regional Health Organisation, despite the fact that the green paper has not become white?

**Mr Blight:** No funds have been allocated to the Murray Bridge Hospital board for the purchase of a residence for the Chief Executive Officer or anybody else. In the past, there have been a number of precedents where we have provided funds to hospital boards for the purchase of residences for chief executive officers. In trying to attract high quality managers into the country, housing accommodation is an issue. It is difficult to expect people to sell their home either in a metropolitan or country area to take up a posting in another part of the country where real estate values might be hard to cash back in when it comes time to move on. So, over the years we have provided funding assistance for a number of our regional centres and some other locations.

I have received a communication from the Chairman of the Murray Bridge Hospital Board requesting that consideration be given to the provision of funds. A decision has not been made; no funds have yet been allocated. However, I think it is worth recognising that the Murray-Mallee Hospital and, in particular, the Murray Bridge Hospital have been very effective in demonstrating the value of cooperative arrangements between small, isolated country hospitals. The Murray-Mallee Hospital based at Murray Bridge is where our first voluntary regional health association was put in place, and it has delivered a lot of benefits at no additional cost to the combined Murray-Mallee community as a result of the cooperation between these boards.

**The Hon. D.J. Hopgood:** In global terms, the whole lesson of history has been that, if anything, the tide has been in the other direction. The most numerous group in the system is the nurses and they no longer live in.

**Mr S.J. BAKER:** I thank the Minister for that extra piece of information. The Minister would be well aware that the CEO of Murray Bridge Hospital already has a residence. So, there has been no suggestion that any extra money will be allocated for additional housing at Murray Bridge for any executive officer of the region or for an executive officer of the hospital? Will the Minister confirm that?

**Mr Blight:** Yes, there has been a suggestion. The Murray Bridge Hospital Board has requested funding assistance from the Health Commission, saying that it believes that this is a priority.

**Mr S.J. BAKER:** But there has been no decision?

**Mr Blight:** No, no funds have been allocated.

**Mr S.J. BAKER:** On page 46 of the Program Estimates, under the heading 'Development and control of health services', the 1991-92 specific targets indicate a continuation with the review of the aims, objectives and administration of the hospital coordinating and clinical programs. I am assuming that this is the well-known Booz, Allan and Hamilton review. Is the Minister aware of inaccuracies in data collection and of comparisons between unlike hospitals which potentially invalidate findings of the review?

**The Hon. D.J. Hopgood:** I invite Dr Blaikie to address himself to that question.

**Dr Blaikie:** They are not the same thing at all. The review of clinical program committees arose from the John Uhrig review of metropolitan hospitals a few of years ago. John Uhrig was a very notable industrialist and believed that to maintain what he called a 'system culture' in the health system it was desirable that all hospitals in the metropolitan area come under the one board of directors or one board of management. He maintained that funding would be provided not on an institutional basis—that is, hospital by hospital—but on a clinical program basis—ophthalmology services, orthopaedic services and so forth. The Health Commission has not been able to institute that because, as the honourable member is aware, the Government did not go ahead with that recommendation for a single metropolitan-wide board. However, the commission has established a number of clinical program committees. I can provide the details if the honourable member wishes, but I will not bore the Committee.

However, in a number of areas, major clinicians, senior nursing people and, in certain cases, administrative people do coordinate the provision of clinical services across Adelaide. I think that the Renal Services Committee is the most long standing of those committees. However, there are others relating to diabetes, hospice care, paediatrics and obstetrics, neo-natal services, accident emergency services and so on.

The honourable member's question relating to the validation of data is a matter for Booz Allan, of course, who are independent management consultants contracted by the individual hospitals, not by the South Australian Health Commission. I had a close involvement with the Royal Adelaide review and was on the selection panel for the consultants and, indeed, sat in on some of the strategic

meetings. Questions rose from time to time on the validity of the data, but nothing of any consequence. Like the Health Commission, Booz Allan makes mistakes every now and again. However, like the Health Commission, the end result is a fairly good health system and a fairly good consultancy from Booz Allan. The honourable member may be interested to know that Booz Allan has already identified $4.5 million of savings at the Royal Adelaide which has been accepted by the board and by the unions as being appropriate. It has by no means finished the review.

**Mr S.J. BAKER:** The board of the Royal Adelaide Hospital, of its own volition—according to information given to the Committee—contracted with Booz Allan to review its performance?

**Dr Blaikie:** That is correct.

**Mr S.J. BAKER:** Who provided the money for that review?

**The Hon. D.J. Hopgood:** The hospital.

**Mr S.J. BAKER:** It came out of the hospital's budget on the assumption that there would be some savings?

**The Hon. D.J. Hopgood:** That is right.

**Mr S.J. BAKER:** In the process of evaluating the services and the comparisons with the performance of other hospitals, you are not aware of any inaccuracies that enter into those performance indicators and assessments? In fact, they are deemed to be of a high quality?

**The Hon. D.J. Hopgood:** Two things could happen that could modify the outcome. First, yes, occasionally a costing could be wrong. One would hope that it would not be wrong by very much, but it is possible. I do not know of any to date. Secondly, some savings that are identified may not be realised, for whatever reason—it could be industrial intransigence or whatever. I am not aware of any serious problems there, although I think one of the areas of savings perhaps has not proceeded as quickly as it might have, and I refer to porters and orderlies, because of some degree of industrial concern. Those two things are always possible. At this stage, to the extent that there has been any of that, my mail indicates that it has been minimal.

**Mr HAMILTON:** This question may come as some surprise to the Minister. Will the Minister advise what is the current situation in relation to regulations for dental technicians? I understand that this matter has been going on for many years. I also understand that the previous member for Price, George Whitten, raised this matter and that subsequently it has been addressed on many occasions. As the Minister would be aware through his office, I have repeatedly tried to get some resolution of this problem. Whilst I am not offering that as a criticism, I understand that there is some considerable frustration and complexity in this area. Will the Minister give an update of the latest situation and say when it is likely that these regulations will be forthcoming?

**Dr Blaikie:** I do not know whether I have all the details. It is a long time since I have practised as a dentist—indeed, four years. I think the honourable member is not referring to clinical dental technicians. I think he will remember, as do I, the history of the battle fought by clinical technicians for a long time to achieve registration of clinical practice. Indeed, by way of almost a grandparent clause, the first group of clinical dental technicians was allowed to practise. It was the view of the dental profession at that time that they should not be allowed to practise but, if they were to be allowed, it should be limited to one intake. I am aware—and only remotely aware—that there has been agitation for further groups, that there has been some examination—and I stand to be corrected—and that further clinical dental technicians have been registered. Other than that, I would have to take the precise details on notice.

**Mr HAMILTON:** I would appreciate it if the Minister would undertake to provide those details by 4 October. I refer now to page 41 of the 1990-91 specific targets and objectives of the Program Estimates, which makes reference to the proposed upgrading and refurbishment of the Royal Adelaide and the Queen Elizabeth Hospitals. Will the Minister advise what specific upgrading and refurbishment has taken place at the Queen Elizabeth Hospital; and, secondly, will the Minister further advise, under the 1991-92 specific targets and objectives, what is intended regarding replacement of patient care systems hardware at QEH and its continuing redevelopment of stage 1? I would welcome that information as my interest in that establishment is well known.

**The Hon. D.J. Hopgood:** The Queen Elizabeth Hospital stage 1 redevelopment includes the upgrading of the kitchen, installation of a central plating system and a major redevelopment of the maternity building. The honourable member will be aware of the central plating system and kitchen upgrade. The maternity building includes work on the redevelopment of a 20-bed gynaecology and oncology ward on the first floor, a 20-bed postnatal/antenatal ward on the second floor, a 20-bed postnatal/antenatal ward and neonatal nursery on the third floor; service upgrade of the fourth floor; a six-room delivery suite, Caesarian theatre, and two birthing suites on the fifth floor, and two day surgery theatres on the sixth floor. We are talking of a total cost of $13.945 million. Expenditure to 30 June of this year was $8.4 million. The whole project was originally timed to be completed by November 1992, and one would imagine that timetable will be adhered to without too much trouble.

I have some information for the honourable member on the RAH ward redevelopment stage 1. The first stage involves minor works to free areas to allow future stages of the work to proceed. Then there is the establishment of a day angiography service in association with a cardio-vascular investigation unit; the upgrade of the cardio-thoracic surgical suite and wards; and the relocation of the waste compaction unit and linen handling facilities. The total cost of all this is $4.5 million and it is timed to commence in March 1992. The centralised plating system and refurbishment of the kitchen is almost finished. The expenditure to 30 June this year was just over $3 million in an estimated total cost of $4.6 million.

**Mr Davidge:** In 1991-92 there will be expenditure of approximately $1.5 million which will go towards replacing the Queen Elizabeth Hospital's main computer. On that computer are the bulk of the patient care systems at the hospital. The computer being replaced is seven years old. The expenditure will mean a significant upgrade to the future capacity at QEH.

**Mr HAMILTON:** The Minister will be aware of correspondence I have forwarded to him in relation to a particular circumstance at that hospital in which a constituent's appointment was not recognised. How many complaints have been received by the Health Commission and Mr Pickering's office about problems associated with the computer system or systems at the Queen Elizabeth Hospital? I understand that it may be difficult for the Minister to obtain that information readily, but, if he has not got the information, I ask that it be taken on notice.

**The Hon. D.J. Hopgood:** We will certainly get that information. I must take the question on notice now.

**Mr HAMILTON:** The Minister may recall that in April this year I wrote to him on behalf of the Spastic Centre's

Western Region Parent/Client Consultative Committee, as follows:

I have been approached by a group of parents who make up the Spastic Centre's Western Region Parent/Client Consultative Committee. In their correspondence . . . the parents voice their concerns at the lack of services/therapy available for adult clients.

Minister, I would certainly appreciate your response to the matters raised in the attached letter . . . particularly regarding the request for a grant of $770 000 to cater for 200 adults.

The Minister in his response indicated:

I note the concerns of the parents for therapy services for their sons and daughters. Certainly my information is that this is a significant need not only for this group of clients but for many other people with severe levels of disability. Although funding cannot be made available at this stage, it will be considered in the 1991-92 budget process.

Hence my question to the Minister.

**Ms Johnson:** We were talking earlier about considerable need in the disability area. While we have made great gains in the last few years, we still have a long way to go. The demands for expanded services in disability relate to supported accommodation, home and community support, employment and skills training opportunities and therapy services. There is no doubt that all of those services are required. In this financial year the expansion funds that have been made available relate only to home support. There is no additional money this financial year for therapy services. Certainly the requirements in that area are known and acknowledged along with other service requirements in the area of disability.

**Mr BLACKER:** I seek information in relation to the redevelopment of the Port Lincoln Hospital. I notice that the blue book records that there has been a reduction in the bed capacity from 72 to 61. Also, to my knowledge, some redevelopment work is being planned. What stage has been reached in the planning or redevelopment? When will physical work commence and when is it expected to be completed? Secondly, what will be the bed numbers of the redeveloped hospital, and will geriatric patients be accommodated within those facilities?

**Mr Blight:** The Port Lincoln Hospital redevelopment will now proceed essentially in two stages. The first stage will involve redevelopment of the kitchen and laundry areas. The second stage will be the more extensive redevelopment of the ward areas so as to provide a more efficient and functional layout and lead to further efficiencies in nurse staffing of the ward areas. As regards clinical service areas, the theatre block will remain on the first floor, but there will be further improvements in the day surgery suite, upgrading of the casualty and radiology section, and so on.

In terms of the function of the Port Lincoln Hospital, it is proposed that its in-patient capacity be dedicated to acute services. On the existing Port Lincoln campus there is an old building which has been used for geriatric accommodation for many years. In recent times the occupancy of that geriatric wing has reduced substantially. My most recent knowledge of approximately three months ago is that the number of true nursing home type patients in that area was two. There are still some rehabilitation patients being accommodated there.

In terms of planning for the future, as there is a 40-bed nursing home in Port Lincoln itself and as there is substantial spare bed capacity in the smaller hospitals in nearby towns, it seemed sensible to redevelop Port Lincoln Hospital as an acute base hospital providing an expansion in specialist services at the same time. So, in the ward redevelopment there will be no geriatric ward as such, although from time to time there will still be long-stay acute patients accommodated within that main area. I might say that in the redesign for the Port Lincoln Hospital there will be no special patient areas. For example, the dedicated children's ward that is in the existing facility will not be provided. It will simply be general accommodation and it will be used depending on patient load and patient priorities.

In terms of funding for the project, the first substantial sum of money, of the order of $1.8 million, will be provided in 1992-93. It will be spent in that year. The year 1993-94 will see an expansion to around $3 million. The project will be completed in the 1994-95 financial year, with final expenditure in that year in the order of $6.6 million. That will leave Port Lincoln Hospital as a modern, efficient basic hospital for lower Eyre Peninsula.

**Mr BLACKER:** By way of a supplementary question: does that increase the bed number back to the original figure of 70 or 72?

**Mr Blight:** My recollection is that the planned bed capacity is 70 beds. I am not aware of the figure of 61 beds. I will have to check that out. I understand that it is planned to have 70 beds dedicated to acute care.

**Mr BLACKER:** The 61 beds is a new figure to me, too. I am wondering whether this can be checked out. I notice in the entire listing it is the only hospital showing a reduction of 11 beds. Is that accurate?

**Mr Blight:** I will certainly follow up the matter.

**Mr OSWALD:** I refer to the South Australian Health Commission blue book, page 1. What are the South Australian Health Commission deposit accounts that are listed on that page? Will the Minister clarify the utilisation of those funds? In particular, are any of those funds used in speculation on the money market?

**The Hon. D.J. Hopgood:** I am sure the answer to the second question is no. However, I will ask Mr Davidge to address himself to the question.

**Mr Davidge:** The deposit accounts referred to are deposit accounts that we operate through Treasury. The Health Commission has no Treasury function as such. All Treasury functions are performed by the South Australian Government Financing Authority on behalf of the Government. So, these moneys are on deposit with Treasury and available for Treasury use, and it invests as appropriate.

**Mr OSWALD:** I ask a supplementary question. How are the funds accumulated? I am not absolutely sure where these funds come from. How do we accumulate in this case $3 million as a surplus over the course of time?

**Mr Davidge:** It is a difference between the funding that is provided versus the money that we spend. At any particular point of time there might be a discrepancy between that; so we start off the year with an opening balance in a deposit account and then as we receive funding and make payments from that deposit account the balance in the account varies.

**Mr OSWALD:** If a hospital needed an injection of funds to help it out during a budgetary period, is that the fund it would go to?

**Mr Davidge:** No it is not. It is purely a bank account balance.

**Mr OSWALD:** I refer to page six of the blue book and to 'Recognised Hospitals and Associated Services Teaching Hospitals'. The allocation for the 1990-91 budgetary period for the Royal Adelaide Hospital is $167.7 million. Was any part of the Royal Adelaide Hospital utilised in setting up the field hospital for the Adelaide Grand Prix in 1990, or in any previous years?

**Dr Jelly:** The Royal Adelaide Hospital does set up a facility at the Grand Prix, staffed by people from intensive care and from other specialties. The building that they provide the service in is a transportable building that was donated by some firm, some years ago. My understanding

is that the Grand Prix committee recompensed the Royal Adelaide Hospital for the costs associated with providing that service.

**Mr OSWALD:** At page 47 of the Program Estimates, under Support Services, issues and trends indicate a need to provide training and coordination to ensure an appropriate counter disaster response within the health system. Given the susceptibility of Adelaide to earthquake faults, and particularly remembering that the Flinders Medical Centre is sited on an earthquake fault line, will the Minister tell us what might be an appropriate counter disaster response if there was a major earthquake with direct disastrous consequences for Flinders Medical Centre and, in particular, where would the immediate and medium term people requiring hospitalisation be treated?

**Dr Jelly:** As controller of the health, medical and ambulance functional service within the Disaster Plan, it would be a matter of assessing that situation when it occurred. Flinders Medical Centre, I understand, was built with significant earthquake reinforcing, so one would hope that damage would be limited—but one can never guarantee that and it depends on intensity. Simply put, it would be a matter of our identifying what resources remained available to us and using them to the best advantage. That would include, if a state of disaster had been declared, under the State Disaster Act, private facilities as well as public facilities.

**Mr QUIRKE:** Returning to the matter of mammography screening, which I was exploring this morning. On page 39 of the Program Estimates under the Services for Women program reference is made to the introduction of a rural mobile mammography service and to increasing current breast X-ray screening from 15 000 to 35 000 per year over three to five years. Will the Minister provide details of funding for these services and, in particular, quantify the extent of the services that will be supplied to rural South Australia?

**The Hon. D.J. Hopgood:** I referred to this obliquely this morning, without giving any details, assuming that someone might get around to asking the question this afternoon. The mammography trailer for country services is to be delivered at the end of this calendar year. The Commonwealth has contributed $400 000, and screening in country areas will commence in January 1992. The mammography equipment is not easily transportable, so the unit will be housed in a 40 foot semitrailer, to be relocated by prime mover at certain predetermined intervals.

In general, the mobile service will be sited at major regional centres only, but screening will be available to all eligible women within a defined catchment area. The planning document and itinerary for this service will be released shortly, and I think I have mentioned in the House previously that Port Lincoln has been selected as the first site for the trailer. We are concerned about country women having access to your service. The mobile trailer will have an annual through-put of about 10 000 screens. Women attending the mobile unit who have screen detected abnormalities that persist after mammographic workup will be required to come to Adelaide for more detailed investigation.

**Mr QUIRKE:** It follows that this service obviously needs to be well publicised in rural areas. How is the commission going about that task and what measures will it put in train to ensure that rural people know of these service?

**The Hon. D.J. Hopgood:** I will ask Dr Kirke to respond.

**Dr Kirke:** Rural women are clamouring for this service. The CWA, the Women's Agricultural Bureau and other clubs are very much up to speed and have been looking for this service for some time. We are in communication with them. The Lions Club has already donated considerable funds to help us establish the country service. I do not think we will have any trouble finding 10 000 women wanting to be screened in the first year.

**Mr QUIRKE:** Page 38 of the Program Estimates refers to the management of terminal illness, and there is specific reference to the commissioning of hospice beds at the Lyell McEwin Health Service. Will the Minister provide details of initiatives in this vitally important area of palliative care for the terminally ill and, in particular, those services available in the northern areas of metropolitan Adelaide?

**The Hon. D.J. Hopgood:** The honourable member does well to ask about the northern areas bec, as he would know, when this Government came to power in 1982, the only palliative care service funded by the commission—at $20 000 a year was the Southern Hospice Association. Generally, services in the northern areas lagged somewhat. However, the position in the north has improved considerably and services are now vailable at Modbury and Lyell McEwin. A six bed dedicated hospice was established at Modbury in May 1990, and a further six bed hospice unit was provided at the Lyell McEwin Health Service in December 1990.

As I said earlier, my select committee is further examining these provisions and may want to make some recommendations to the Assembly when eventually it reports. Apart from the services I have indicated and the ongoing Daw House Hospice, more than $250 000 is provided to Southern Cross Homes with a contribution to the hospice unit at the Philip Kennedy Centre and a little less than $250 000 goes to Calvary Hospital for the Mary Potter Hospice.

The south, the centre, the north-west and the north are provided with some beds, and almost certainly over the next few years more will come. I should also indicate that there is at least one private hospice service operating and, as is appropriate for a private service, it is not a recipient of Government funds.

**Dr ARMITAGE:** I refer to page 3 of the blue book which indicates that the 1991-92 expected receipts from the sale of land and buildings is up 307 per cent from the previous year and, given that the previous year's actual receipts were about $3.5 million (despite a budgeted figure of $14.7 million), does the Minister believe that $16.745 million is an achieveable figure in this economic climate and does that money include the $7 million ostensibly to be raised by the sale of the Queen Victoria Maternity Hospital building? Assuming that the Hillcrest devolution is not far enough down the track for the potential sale of Hillcrest land to be included in that figure, can the Minister tell us what is the expected price for the sale of the land at Hillcrest when it is eventually sold?

**The Hon. D.J. Hopgood:** The $16.745 million is made up in respect of sales as follows:

| | |
|---|---|
| Hampstead Centre | $5.646 million |
| Hillcrest Hospital | $4.4 million |
| Moorcroft House, St Corantyns | $3.6 million |
| Glenside Hospital | $1.327 million |
| Newton Lodge, Newton | $.7 million |
| Northcote House | $.46 million |

As the honourable member implies in his question, budgeting for some of these is as difficult as any sort of budget one can bring down because there may be good reasons why one delays the sale of a property for some time; for example, the state of the market and all those sorts of things. Mr Davidge might like to comment further.

**Mr Davidge:** It is fair to say that there is obviously some uncertainty associated with the achievement of that estimate, but there is no doubt that the properties identified there are surplus to requirements. We believe that in the

second half of this financial year there are greater prospects for property sales. Whilst I would not be 100 per cent confident that we can make the $16.745 million, it does reflect a realistic assessment of the properties that can be made available for sale this year.

**The Hon. D.J. Hopgood:** It is worth pointing out that for one or two of the sales the purchaser will be the Urban Lands Trust. In effect, what is happening is that an off-budget area of Government is purchasing from an on-budget area and, in those circumstances, the thing is a little more predictable than when one is simply selling to a private individual.

**Dr ARMITAGE:** I seek clarification about the difference between the $14.7 million budgeted for last year and the $3.6 million achieved. Was that because properties put up for sale did not reach the reserve? The commission achieved only 25 per cent of the total budgeted figure.

**Mr Davidge:** The specific answer is that certain properties were not put to market and a sale achieved, rather than our not getting what we expected for those properties.

**The Hon. D.J. Hopgood:** Some of the properties are included this year.

**Mr Davidge:** As to the Queen Victoria Hospital—

**Dr ARMITAGE:** Is it on the list?

**Mr Davidge:** No.

**Dr ARMITAGE:** At page 38 of the Program Estimates one of the specific targets in 1991-92 is:

> Appoint a medical director to Northern Hospice Care Service including Lyell McEwin and Modbury Hospice Services.

That was a 1990-91 specific objective in last year's Program Estimates. Does the Minister believe that this target will be met this year, or will it flow over again?

**The Hon. D.J. Hopgood:** I hope not. I ask Dr Blaikie to comment.

**Dr Blaikie:** The difficulty has been finding an appropriate appointee. The position has been advertised on two occasions but there has been no person to appoint. In the meantime, interim arrangements are in place at Modbury and Lyell McEwin. The plan is to have one medical director straddling both northern hospice services. The arrangements made are quite appropriate and involve experienced general practitioners or hospital-based doctors. The joint northern hospice intends to advertise again at the beginning of next year or the end of this year, when it believes that more suitable candidates may be available.

**Dr ARMITAGE:** I recently visited the Modbury Hospice Service and I in no way denigrate the service provided—I believe it is marvellous. I was asking whether it was achievable this year. I refer to page 16 of the blue book relating to grants to health agencies under the line 'Family Planning Association'. The preliminary budget allocation for 1991-92 is down 13 per cent over actual payments for 1990-91. I declare an interest in the Family Planning Association, having spent many clinics there in the past. Knowing the excellent preventive work that it does, and given the dilemmas faced by the Government in honouring its promise to maintain the same services at the ANCWC as is now present at the Queen Victoria Hospital, specifically with regard to the termination of pregnancy services, is it wise to cut the Family Planning Association grant by 13 per cent in real terms? It seems like cutting off your nose to spite your face.

**The Hon. D.J. Hopgood:** I can only echo the sentiments expressed about the work done by the Family Planning Association. Ms Johnson has more detailed information.

**Ms Johnson:** The budget allocations are not always as they seem. The Family Planning Association has had no reduction in budget this financial year. The gross payments for the 1990-91 financial year were $614 000, and the budget for this year is $529 000. However, in the 1990-91 financial year the Family Planning Association received one-off funding for several items. It was, as I said, one-off funding and understood to be that. It included the following: $56 000 for AIDS funding; $17 000 for safe sex funding; $2 500 for general insurance; and $30 000 for a new switchboard. With those items deducted, the budget for the Family Planning Association last year has been maintained, and it received the full inflation allowance of 3.6 per cent.

**Dr ARMITAGE:** I assume that its service provision will not be affected at all?

**Ms Johnson:** That is correct.

**Mr McKEE:** I refer to the 1991-92 specific targets/objectives on page 45 of the Program Estimates and the indication that the Government will undertake a review of the microbiological status of ready-to-eat foods. Am I correct in assuming that that is take-away foods from outlets such as hamburger and pizza chains?

**The Hon. D.J. Hopgood:** I will ask Dr Kirke to enlighten us.

**Dr Kirke:** Ready-to-eat foods include such things as pizzas, which are made up of all sorts of bits and pieces and put together in one place. We are doing a special review of the bacteriological content of such foods.

**Mr McKEE:** How long will the review take?

**Dr Kirke:** Most of this year before we get the results because we want to do it seasonally, similar to the market basket survey.

**Mr HAMILTON:** I refer to page 35 of the Program Estimates. Under 'Services for Mental Health' it is stated:

> Establish a single mental health authority to direct and control mental health services . . . Develop strategies for increasing the availability of community mental health services.

Will the Minister elaborate on the intention in this area?

**The Hon. D.J. Hopgood:** I mentioned earlier the setting up of the South Australian Mental Health Service. To give the Committee an idea of the very broad spectrum of people that we are using, the board members are as follows: Mr Reg Perkins (Chairman), ex Chairman Glenside Board; Professor Ross Kalucy (Deputy Chairman), representing the three universities; Ms Yvette Amer, ex member of Hillcrest Board; Dr David Ash, representing medical staff; Mr Peter Bicknell, ex member Strategic Planning Authority; Mr Greg Box; Ms Dolly Costello, ex member Glenside Board; Ms Liz Dalston, representing consumers; Ms Mary-Louise Hribal, the solicitor; Mr Colin Parkin, representing nursing staff; Mr Don Sandford, representing staff other than medical or nursing; and Ms Irene Towler, representing consumers. I ask Colleen Johnson to briefly expand further.

**Ms Johnson:** The devolution of the 120 beds from Hillcrest Hospital will allow the development of $7 million-worth of additional community-based services for people with mental illness. As part of the devolution planning process, some months ago a group looked at the general shape of community services and what might be required in the community. As part of that exercise, the work of Professor Gavin Andrews was used as a basis, and he argues that some 70 staff are required in the community per 200 000 population. This is the model on which we have been working.

This will mean that over time we will see the development per 200 000 people of teams of service providers. It will look something like the following: 20 or so staff to provide crisis services; 12 staff for mobile community services (people who will intervene with difficult clients or those who may be causing some problems for a short time); 10 or so staff for general services, which includes assessment, treatment and counselling and support; 10 staff for living skills services rehabilitation, vocational training, skills develop-

ment and educational programs; 14 staff for supported accommodation and general community support services; and, an additional two staff for counselling and support and educational services, most likely provided through non-government organisations. Our model will allow several crisis teams and mobile intervention teams throughout the metropolitan and country areas. This will provide across South Australia almost 500 people based in the community.

**Mr HAMILTON:** I refer to 1991-92 specific targets/objectives on page 45 of the Program Estimates, as follows:

Undertake further injury prevention initiatives in relation to dog bites, swimming pool fencing, fork-lift and truck injuries.

What is the extent of these problems and what sort of preventive measures are contemplated by the Health Commission?

**The Hon. D.J. Hopgood:** We have an injury surveillance and control unit in the Public and Environmental Health Division. It monitors data from accident and emergency departments of hospitals and works with a range of agencies such as Foundation SA, the Department of Public and Consumer Affairs and local government to reduce identified hazards. The unit is small and its promotional activities include a regular bulletin highlighting identified hazards. Some of the contentious issues raised publicly recently have included amusement devices, bunk beds and dog bites.

I will not say anything further about dog bites, because that subject has been pretty thoroughly canvassed in the press. In relation to bunk beds, the commission has demonstrated the commercial feasibility of a safer bunk bed design in collaboration with a South Australian manufacturer, and prepared the initial draft of what is being proposed will form the national uniform standard for the manufacture of bunk beds. Obviously, this is very important in terms of the safety of children and others. I know that if I have a choice of sleeping in a bunk bed, I always climb up to the top.

In relation to codes of practice for amusement devices, we have looked at dodgem cars and paddle boats. There has been some concern about the adequacy of procedures for inspection and certification of large mechanical rides, and these have been conveyed to the Department of Public and Consumer Affairs. As these sorts of rides, such as ferris wheels, are popular at the show, it is important that we maintain proper surveillance.

**Mr S.J. BAKER:** With respect to the closure of the Hillcrest Hospital, what estimates are currently available of the number of people within the community who have been looked after by parents but who are now requiring separate or assisted accommodation? I understand that 1 200 to 2 000 people in the intellectually disabled category require accommodation and that the closure of Hillcrest will set that program back by at least five years.

**The Hon. D.J. Hopgood:** I am not trying to be pedantic, but it is important to distinguish between mental health and intellectual disability. Workers in the field do so, because we have been criticised by people who say we will be transferring some resources currently in mental health into the area of intellectual disability. I will ask Colleen Johnson to supply the details, but it may be necessary to take part of that question on notice.

**Ms Johnson:** There have been comments in the community to the effect that the closure of Hillcrest will place extra demand on community services, and I think it is important to set the record straight. Currently, many people with mental illness who live in the community require assistance of several kinds from time to time, such as assistance with employment, personal care, cooking or shopping. The relocation of the Hillcrest beds will not increase that demand because not one bed will be closed as part of the relocation process. Currently, there are 120 beds at the Hillcrest Hospital, and we will still have 120 beds after its closure, but they will hopefully be closer to where people live because they will be relocated to several sites around Adelaide. So, there will not be an increased number of people living in the community.

However, that relocation will free up money so that we can provide $7 million of additional community support services for those people already living in the community, many of whom are receiving very little support at present. The relocation will also assist in terms of community service provision in general disability, because there will be some freeing up of funds from the Hillcrest relocation which can be diverted to other disability services such as brain injury, intellectual disability, autism and so on.

So, we can look forward to alleviation of community problems and certainly not to adding to them. In terms of the actual number of people with a mental illness requiring accommodation support, we have attempted to gather that data in the Health Commission. We are trying to get better at it, but our figures are only preliminary. I am happy to provide the information that we have, but I hope that within a year or two we will be able to provide more reliable figures.

**Mr S.J. BAKER:** I assume that the commission's best estimate will be provided. At least five people in my electorate have told me that they have brought up a child who has severe disabilities, often both physical and intellectual and occasionally mental—sometimes the barriers are hard to distinguish—but they are at the stage where they no longer have the capacity to look after those children who are now adults or adolescents. As the Minister said earlier, more of these children are surviving birth and this is placing enormous strain on parents, who are tremendously frustrated. Where will the 120 beds be located? Will they be located in hostels or boarding house accommodation, because the member for Unley has commented on one of the boarding houses that is located in the street in which he lives.

**Ms Johnson:** The 120 beds will be placed in hospitals. Negotiations with the various hospitals are continuing. There are 60 acute beds at Hillcrest Hospital; at this stage it appears that 20 of those will be relocated to the Lyell McEwin Hospital, 20 to the Queen Elizabeth Hospital and the remaining 20 to the southern suburbs. It is unclear at the moment whether those 20 beds in the southern suburbs will be relocated to the Repatriation General Hospital, the Flinders Medical Centre or the Noarlunga Hospital: negotiations are continuing. A further 10 secure beds will be transferred from Hillcrest Hospital to Glenside Hospital, and the remaining 50 beds, which are long-stay beds, will also go to Glenside Hospital. So, of the 120 beds, 60 will go to general hospitals and 60 to Glenside Hospital. None of those beds will be placed in hostels or any form of community accommodation.

**Mr S.J. BAKER:** As a supplementary question, I understand that a number of houses have been built specifically for people with intellectual and physical disabilities. Will the Minister provide brief details on the programs in place for this year and on funding and staff involved?

**The Hon. D.J. Hopgood:** We answered that question in global terms this morning, but we will provide more detailed information.

**Mr S.J. BAKER:** Will the Minister say what he believes to be an appropriate number of reserve ambulances to ensure an adequate counter disaster response not only for those people immediately affected but also for those who may need emergency ambulance transport coincidentally to

any disaster? Will he ensure that St John Ambulance is given funds to enable it to provide the appropriate number of reserve ambulances?

**Dr Jelly:** By definition, a disaster means that normal resources are stretched beyond normal limits. However, in the case of a disaster in which there is a significant number of casualties who need to be moved, the disaster plan provides for the use of alternative vehicles for the less seriously injured, reserving the St John ambulance or other ambulance services for those who really need that sort of service. I think it would be inappropriate to provide excess ambulances in the case of a disaster. The last time we were stretched to that limit was during the Ash Wednesday bushfires in 1983, when St John Ambulance was not stretched beyond its normal operational capacity.

**Mr S.J. BAKER:** Supplementary to that, at that stage St John had a number of reserve ambulances; has that number been maintained, or has it fallen dramatically?

**Dr Jelly:** I am not sure what the honourable member means by reserve ambulances. At that time the service ran more clinic cars than it runs now. They were used for some transport purposes on that day, as I understand it.

**Mr S.J. BAKER:** So, there would have been a natural reservoir of ambulances that could have been thrown in in an emergency?

**Dr Jelly:** Yes, and the St John Ambulance Operations Branch, as it is now termed, also has a system whereby it can use private vehicles of a station wagon nature in the event of an emergency.

**Mr S.J. BAKER:** As a supplementary question, will the Minister provide details of how many fully equipped reserve ambulances can be called in in the event of an emergency, because I understand that we do not have that capacity any more and if we were to have another emergency like Ash Wednesday we would not be able to provide the same level of service?

**The Hon. D.J. Hopgood:** Yes, provided that we understand that we are using the same language.

**Dr Jelly:** It would be a matter of identifying how many ambulances the service has not necessarily reserve ambulances.

**Mr HAMILTON:** I congratulate the Deputy Leader and the Deputy Premier on this initiative in publicising that people smoke filthy, disgusting things called cigarettes. I say this as a reformed smoker and I condemn those purveyors of death. In last Saturday's *Advertiser*, the National Heart Foundation warned that passive smoking causes 10 times more deaths from heart disease and lung cancer and that more people will die from passive smoking. The foundation spokesperson also indicated that compounds in sidestream smoke were up to 100 times more toxic than the smoke inhaled by smokers. What is the Government doing to promote no smoking in public places?

**The Hon. D.J. Hopgood:** Sidestream effects of smoking are of considerable concern. I guess that is particularly so following the ruling of the national tribunal which, of course, opens up the possibility for litigation against an owner of any public place where smoking is going on. That is particularly so where the person may have a contractual arrangement or may be in a master and servant relationship with the owner of those premises.

Of course, part of the concern here is that where the smoke drifts from the end of the cigarette, it is not subject to filtration of any sort. Smoke that is exhaled by a smoker has been filtered twice—by the filter in the cigarette and by the lungs of the smoker. That does not occur in relation to the smoke that drifts from the end of the cigarette. That is one of the things we have incorporated in our propaganda material that we have tried to circulate, particularly following the Justice Morling decision to which I referred earlier.

For example, there is a working smoke-free resource kit, which has been developed and launched. It provides employers with information and assistance to develop and implement workplace bans cooperatively with employees. This was a project undertaken by the Health Commission and the Occupational Health and Safety Commission. A number of guidelines have been promulgated. The Hospitality Industry Smoking Policy Committee was set up in May 1990, on which all relevant industry associations, trade unions and health organisations are represented. It launched its voluntary code of practice on smoke-free dining on 7 February 1991 and, so far, more than 170 hotels, restaurant, motel and licensed club operators have adopted that code. Finally, of course, we take whatever advantage we can of the World No Tobacco Day, which occurs on 31 May.

**Mr HAMILTON:** As a supplementary question, in my forthcoming newsletter to my electorate, I have made mention of the fact that these kits are available. I take it that they are available to any member of the public and not necessarily just to the business sector?

**The Hon. D.J. Hopgood:** Yes.

**Mr HAMILTON:** On page 45 of the Program Estimates reference is made to the assessment of the health impact of blue-green algal blooms. Will the Minister provide additional information about the extent of this problem? I understand that this would also be associated with the red tides, which have manifested themselves not only in the Port River but also in the West Lakes waterway. I am particularly interested in what the Health Commission intends to do in terms of assessing the health impact.

**The Hon. D.J. Hopgood:** It is perhaps fortunate for the Committee that this question was not asked earlier in the day, because I think I might have been tempted to spread myself a little on this one, having had the opportunity to become reasonably well informed. I will be brief, but before I answer the question, so that it can be included in the record at this stage, I refer to a question that was asked this morning about confiscated assets. They are in relation to convictions that occur in the South Australian courts following drug offences where it is demonstrated that these assets were obtained from profits from drugs and they may include land sales, house sales and repossession of motor vehicles.

The blue-green algae is a different organism from the red tide. The red tide seems to have become a worldwide phenomena in recent times. On the other hand, the blue-green algae, at least in one of its manifestations, was reported from Lake Alexandrina as early as the second half of last century. Therefore, it is not necessarily related to very intensive activities that have occurred in recent times, although it may date from European settlement. At this stage a good deal of research is being undertaken. We do not have the sort of answer that we require that will enable us effectively to control it under all circumstances in very large bodies of water. One can control it in very small bodies of water, but the effect of that is to change drastically the environment in a way that one might find quite unreasonable. For example, in a small reservoir copper sulphate can be used to control it. Of course, the effect of that is that there may be fewer, if any, fish left in the reservoir. That does not matter if it is a reservoir, but if it is a large body of water where there may even be a commercial fishery, one may think twice about that sort of management.

The other aspect is the development of an early warning system so that people who draw water from the lake or lakes know when there may be some danger. We have tried

to ensure, with the cooperation of the E&WS Department, that alternative and safe water supplies are available. We have also done a survey through local GPs in the Strathalbyn and Langhorne Creek, area and we are not aware of anyone reporting directly to those medical services sickness as a result of having drunk the water. That does not mean that it has not happened or that it might not happen at some time in the future.

**Mr HAMILTON:** What programs or expenditure of additional moneys will occur at the Alfreda Rehabilitation Centre?

**The Hon. D.J. Hopgood:** I have a little bit of information on that. It has been involved in occupational rehabilitation for the past 10 years. It generated additional revenue of $1.1 million in 1991. In fact, I think we gave that figure earlier today. It is proposed to use the surplus and further revenue to provide new facilities, including a new gymnasium, a physiotherapy treatment facility and an undercroft car park as well as upgraded reception and administration areas.

**Dr ARMITAGE:** Given that the questioning on this line is about to finish, I indicate that I have many more questions and will put them on notice. I thank the members of the commission and the Minister for their candour.

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

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Family and Community Services,
$185 462 000

**The Chairman:**
Mr M.J. Evans

**Members:**
Mr S.J. Baker
Mr K.C. Hamilton
Mrs D.C. Kotz
Mr C.D.T. McKee
Mr J.K.G. Oswald
Mr J.A. Quirke

**Witness:**
The Hon. D.J. Hopgood, Minister of Family and Community Services.

**Departmental Advisers:**
Ms Suzanne Vardon, Chief Executive Officer, Department for Family and Community Services.
Mr Graham Boxhall, Director, Administration and Finance.
Ms Anne Howe, Executive Director, Operations.
Mr Andrew Hall, Director, Family and Community Development Unit.
Mr Ken Teo, Manager, Juvenile Justice Unit.
Mr Rene Bos, Manager, Financial Services.
Ms Joy Wundersitz, Senior Researcher, Program Planning Division.

**The CHAIRMAN:** I declare the proposed payments open for examination.

**Mr OSWALD:** My first question relates to page 51 of the Program Estimates under 'Offender services'. In yesterday's *Advertiser* the Attorney-General attacked the Children's Court over its lenient sentencing policies. In his attack he said that in appropriate cases the court should use its new powers to sentence offenders to up to two years detention. The Attorney-General also said that the court should act quickly and decisively to provide a greater deterrent, pointing out that the changes to the law in January allow the Children's Court to impose community service orders as specific penalties for crimes. He was critical of the court for not deciding whether to use them or not. Is the Minister aware that community service orders are not used more often not because of the court but because procedures within his department have made them too cumbersome to obtain? No sentence can be handed down without first obtaining a compulsory assessment panel report and it takes six weeks for a report to be prepared by the department, making immediate action by the court impossible. That means that a serious offender must be released again while the assessment is done, allowing the juvenile the chance to reoffend. Does the Minister propose to rectify this FACS procedure?

**The Hon. D.J. Hopgood:** I think that I should ask Mr Ken Teo, the Manager of our Juvenile Justice Unit, to comment on the way that we approach this matter. We are in fact very keen on these orders and would like to see the courts impose more of them. I will ask Mr Teo to explain how we approach our responsibilities in this respect.

**Mr Teo:** Prior to the amendments to the CSO, which were proclaimed on 24 May this year, a small number of community work options were available. Part of that was because the courts had to record a conviction on an offender before a community work option could be imposed. Since 24 May there has been an increase in the numbers of community service orders. In some cases it is true that assessment panels take six weeks to report. A child who is appearing before the court would be assessed for the offence and the assessment would take account of a whole range of programs that the child may be asked to undertake. If a community service order is one of the options, it is brought up as one of the considerations for the panel. The length of time is not because of the community service order: it is the time for the assessment to take place.

The court can now impose a community service order through contacting the department, but, we would need some time to inform the court as to whether a placement is available. However, in many cases that have occurred since 24 May, community service orders have been imposed through assessment reports. There are two ways of doing that. The majority of cases that have happened thus far have been through a system of panels. If a child were in custody, assessment panels by and large take only 14 days to report. However, if a child were in the community—on bail from the court—and had what we call a day assessment, it could take from four to six weeks.

**Mr OSWALD:** If a placement is not available, the recommendation that comes from your department to the bench would be that a community service order not be granted. On that assumption, if there is no placement available, the CSO will not be put in place. Also, we have the six weeks delay in getting the paper work done by your department. It has been put to me by the bench that the Attorney-General's criticism yesterday was quite unfounded. The bench could cooperate and get these children through very quickly, except for this problem of having to wait in some cases, as you have agreed, for six weeks for the community service order paper work to be arranged or for the department to get the wherewithal back before the bench. Indeed, therein lie many of the problems associated with the turnover of children. It is one thing to allow the Attorney-General to criticise the judiciary when the problem is within the department.

**Mr Teo:** We can now furnish every community service order that is imposed by the courts. In the metropolitan area we have two community service centres. For example,

in the Elizabeth area we have a placement at Salisbury which has just cleaned 120 STA buses of graffiti in the last three months, ending in late August. That program can take numerous kids, because we have a supervisor with additional contract assistants. It is a work orientation project. If you have a CSO on a one to one basis, it is more intensive and hence more difficult. That applies mainly in the country. In the metropolitan area we can process all the community service orders that the court wants us to do. Basically, we have excess capacity in our community service orders now.

**The Hon. D.J. Hopgood:** I think I should ask the Chief Executive Officer to comment briefly on the claimed delays in assessment.

**Ms Vardon:** Not all the assessments take six weeks. Some of them are done quite quickly. We are conscious that there is a delay. One of the reasons for restructuring our department was that we gave an undertaking to ourselves and to the Government to supervise all orders and provide all assessments rapidly. After 1 October, when our restructuring is in, we will be guaranteeing that there will be no delays by us in getting these assessment reports done for the court.

**Additional Departmental Adviser:**

Mr R. Leahy, Manager, Home and Community Care Support Unit.

**Mr OSWALD:** My next question also relates to the assessment panel reports and to a comment reported in the *Advertiser* yesterday made by the Attorney-General when he attacked magistrates and judges for the leniency of sentences. It has been put to me that the recommendations of an assessment panel report play a pivotal role in the conduct of a case before the court and the penalty handed down by the bench. In view of this, how can the Children's Court act as a deterrent to juvenile re-offenders if the Department for Family and Community Services persists in recommending bonds with supervision to chronic recidivists, some of whom are known to be involved in the theft of motor vehicles to the extent of tens of thousands of dollars as well as breaking and entering and other serious offences?

**The Hon. D.J. Hopgood:** I find that a little strange, because there was a well publicised case recently involving a persistent offender, where the clear advice from the Department for Family and Community Services was that there should be custody, and the judge in his wisdom decided that that should not be the way to proceed. So, let us not run away with the idea that it is always the Department for Family and Community Services that is pleading to the Children's Court that there be bonds, with or without supervision. That is just one case. I suppose we could get some details for the honourable member concerning the way in which some of these things have gone but, generally speaking, it is up to the court itself concerning the nature of the penalty. The department can only advise.

**Mr OSWALD:** I ask a supplementary question. I think the Minister is very much out of touch and that he should go and acquaint himself with some of his own departmental documents that go to the court. I will not read any out to the Committee, in case it identifies children, but I have knowledge of many files that involve cases of multiple convictions for stealing and driving motor vehicles, larceny, breaking and entering, and other offences, and recommendations from the department going back to the court for another bond or supervision. On the one hand, one branch of Government is criticising the bench for their inactivity while, on the other side, the department is continuing to put recommendations for bonds with supervision for known recidivists who walk straight of the court and steal another motor vehicle. That is on the record. I will not reproduce the details here, but the Minister knows as well as I do that what I am saying is perfectly correct.

**The Hon. D.J. Hopgood:** The honourable member can say what he likes, but the fact of the matter is the judge can do what he likes. It is not an instruction to the judge, and the legislation makes that perfectly clear. In 20 per cent of all cases, as I understand it, the judge does not follow the advice of the department. In some of those cases it may well be that the department is recommending a bond and the judge goes for custody, while in some cases it may be the other way around. However, 20 per cent is a reasonably high percentage as these things go, which I think bears out what I have been saying, that the judge is completely unfettered by the legislation.

**Mr OSWALD:** For my last question, can I pick up that statement by the Minister that the judge can do what he likes? One of the complaints about the Children's Court is that the Department for Family and Community Services administratively has penalties changed that have been handed down by magistrates, that the department uses section 44 of the Children's Protection and Young Offenders Act as a cheap bail application. There have been occasions where a magistrate in his judgment has considered that a detention sentence is appropriate for an offence and where the Department for Family and Community Services has had the child back in the court the same afternoon for reconsideration by the judge, resulting in the release of that child. In view of these complaints, why does the Department for Family and Community Services use section 44 to circumvent the considered decisions of magistrates who are trying to protect the public by implementing deterrence for the 200-odd serious juvenile delinquents who are constantly being recycled through the court on cases of breaking, entering, larceny and car theft?

**Mr Teo:** Section 44 of the Act refers to reconsiderations before the court. I cannot comment on the example given, but certainly, in relation to reconsiderations, in a custody case, if a child wanted to have a reconsideration, the department would contact the child's lawyers. In the case that the member refers to, where in fact the department has taken the case to court, I would say in the majority of cases like that there would be a solicitor representing the child in court and so in a sense the department would be facilitating an application by the child for reconsideration, rather than the department's reconsideration. Once again, I cannot comment on the individual case that the member brought up, but there are some cases where assessments to the court demonstrate that a judgment in a sense goes against the sorts of things that have been discussed by the panel, etc., and there might be some grounds to put before the court in terms of reconsideration, in which case the department would put that to the court for reconsideration.

**Ms Vardon:** I point out that the reconsideration is done by another judge and this other judge is still the one to make the decision. It is not the department that makes any of these decisions.

**Mr OSWALD:** My question to the Minister is: what is actually happening? The Minister said initially that the judge or the bench can do what it likes. What is happening here is that the magistrate makes a decision, based on doing what he likes, the department disagrees with that decision, it goes up to the judge, it is overruled and the child is sent back out into the street again.

**The Hon. D.J. Hopgood:** What is this 'having it overruled' business? It is a matter for the second judge, who is also completedly unfettered—QED.

**Mr HAMILTON:** Turning now to some of the positive things that I believe the Government has addressed in terms of welfare services, I refer to page 55 of the Program Estimates and to the following comments under issues and trends:

The HACC program is under review as a result of renegotiated financial arrangements between the Commonwealth and the State. Policy and functional reviews are therefore planned or are in train.

The increasing numbers of aged and 'old-old' people in the community as well as an increasing number of trauma-damaged young people are placing increased demand on service providers.

The community services sector review requires close examination of the nature of the partnership between non-government and Government health and welfare services.

Clarification of the respective roles and responsibilities and the cost-effectiveness of the strategies will be addressed.

Further, under '1990-91 Specific Targets/Objectives', it says:

New HACC service initiatives are under preparation. Dementia respite, dementia brokerage, continence education, specialised food services and home support programs are in various stages of development.

Service standards for the HACC program have been prepared and are in the process of implementation.

I am aware of a number of meetings that have been held around the metropolitan area to address these problems. Will the Minister give us an update on the outcome of those meetings?

**The Hon. D.J. Hopgood:** I ask Bob Leahy to comment on this, because it requires some degree of detail.

**Mr Leahy:** In relation to the public forums, first of all, information is given to the service providers, consumers and others, who attend those meetings to hear from Government officials what aspects have been considered by the Federal and State Government negotiators looking at the issue of health care funding for the aged. Advice has been given as a result of those meetings, through the Minister to the Department of the Premier and Cabinet, and that represented the views at the national heads of Government meeting. The results of the Ministers' meeting in Sydney two weeks ago were basically a general agreement on the new program structure for health and aged care funding based around five different programs, including hospital-based health services, a primary health care program and a separate aged care program. Those positions that the Ministers of Health and Welfare discussed in Sydney will be put to the heads of Government meeting to be held in Perth in November. At this stage the outcome has not been decided and I am not aware that a State position has been adopted. The Minister might like to comment.

**The Hon. D.J. Hopgood:** There is no agreement as yet on funding arrangements and only the Prime Minister, the Treasurer and the State Premier can agree on funding arrangements (I guess that that is their bailiwick) and until such time as that happens the exact nature and shape of these sorts of programs in the future remains a little clouded.

**Mr HAMILTON:** As to support for the accommodation assistance program in this difficult economic climate, can the Minister advise what steps the Government is taking to ensure that the needs of homeless young people continue to be met? Can the Minister indicate the amount of money allocated to those programs? As most members would agree, this is one of the more critical issues that need to be addressed.

**The Hon. D.J. Hopgood:** The honourable member will be aware that the SAAP program was initiated as a result of Brian Burdekin's first report, which has been further reviewed. The review of the programs that arose out of the Burdekin report was further conducted by Burdekin when he came to Adelaide and had hearings. I appeared in evidence in those hearings and, despite his quite critical comments about some aspects of the programs in the Eastern States, Commissioner Burdekin was pleased with what has been achieved here. We can take some comfort from that.

We are talking about a target population aged between 12 and 25 years and a total of $4.7 million was allocated to the youth supported accommodation programs in 1990-91. It funded 30 agencies to ensure that a total of more than 350 beds through about 90 outlets were available at any one time. These can range from short-term emergency accommodation to the provision of outreach support to assist young people in learning to live in independent accommodation.

It is important that we are responsive to the sort of changing needs that this unfortunate group tend to have. Some of the more recent developments include the designation of resources to meet the special needs of young people homeless for the very first time. the establishment of a new service for homeless young women and children, the development of what is called a brokerage program, which will enable services to be flexible and cost effective in response to these needs, and the establishment of a parent/adolescent reconciliation service. As I said earlier, Brian Burdekin identified our progress in these sorts of areas to be well ahead of most if not all other States.

**Mr HAMILTON:** Can the Minister advise what the Government has done in response to the recession as it relates to services for homeless adults in the inner-city area of Adelaide?

**The Hon. D.J. Hopgood:** For a start, meal services have been funded to be increased from six to seven days a week at the Hutt Street Day Centre and the Westcare Day Centre. They average 120 clients a day in the former and 70 a day in the latter. Government officers have also worked in cooperation with the St Vincent de Paul night shelter to redevelop and restructure the service. Funding will be increased from 1 October and this will enable the agency to improve the level of service provided to the residents.

In April this year we funded a social work service to operate from St Vincent de Paul, and this has resulted in stable accommodation with support where appropriate. This year the Government also funded four housing support workers, two at the Wright Court Day Centre, one at Westcare and one at Hutt Street. They have assisted a number of clients and placed over 70 homeless men in stable accommodation.

I can give a number of other pieces of information that should be briefly mentioned. One is the Aboriginal Sobriety Group working with other agencies to establish a night shelter for single Aboriginal people. It will have a 12-bed capacity and is expected to be operational by the new calendar year. The Salvation Army's William Booth residential program will increase the number of homeless men it supports in the medium term accommodation by 20 by making special arrangements with private landlords. In all, the Government provides about $1.8 million to inner-city services for homeless men and women and a total of 30.5 funded staff actually work in the area.

**Mr OSWALD:** As to 'Offender services' at page 51, concern has been expressed about the time it takes the department to prepare reports and present itself before the court. Why does the Minister accept the present situation where it can take up to 12 months to get a child before the Children's Court after the child has been reported for a serious offence? Why does it take the department three weeks to process an 'in need of care' order through the Children's Court when it takes only two or three days interstate?

**The Hon. D.J. Hopgood:** I will ask Mr Teo to respond to that. However, I make the point that it is not easy to get any case heard quickly before any court. I only have to refer to what occurs in the courts generally in this State to know that the court lists are long. That was another of the issues behind one of the strongest statements that the Attorney-General made a few days ago about the productivity of the profession from which he comes. I point out that it is the police who take the offenders to court. Mr Teo may want to add further comment.

**Mr Teo:** I believe that 12 months would involve an extreme case. Many cases involve delays in the court system. Where a child is apprehended for an offence and arrested, the child immediately goes to the court the next day. What happens to the child subsequently is dependent on the courts through adjournments and the like. Where a child is reported it takes about 21 days before the summons is issued for the child to appear and, following that, it is dependent on the court system.

**Ms Vardon:** As to 'in need of care' cases, sometimes it does take a long time to get a child before the court, but that is because we do not take it lightly. We can get an interim order at the next opportunity when we are concerned about a child. Sometimes cases are contested and it takes a while to get them through. The law in South Australia is somewhat more restrictive—and that is appropriate—than in other States and I would not necessarily like to see a situation where we could get an in need of care application dealt with quickly. It could be that we need a longer period to consider the application.

**Mr OSWALD:** Still on the subject of offender services, what is FACS doing to counter the high level of truancy from schools by juveniles who have been through the Children's Court and refuse to attend school? Does the department have any idea how many children are involved? I am referring to children who have offended, are in placement and then fail to attend school and roam the streets. Not every parent or foster parent who has one of these children rings up the department and says that the child is not at school. Certainly the schools would have some idea if the child is not turning up every day.

**Mr Teo:** We certainly do not have the figures to hand. With regard to children in community residential care, we have school programs which encourage children to go to school. We certainly cannot provide figures.

**Mr OSWALD:** Will they be available at a later date or do you not have them.

**Ms Vardon:** It would be difficult to give a fixed number because it can sometimes take four to six weeks for a child to get back to school. All children who have been before the courts have the opportunity to be involved in the tripartite program that we have developed over time with the Education and Health Departments to get behaviour disturbed and truanting children back to school. It has a high success rate, and many of the 1 000 children who go through it each year are known to us. It is an excellent project for those children. Mr Teo said that we can get the children who come into our care back to school. Certainly, those in secure care go to school. We have residential care workers who pay great attention to children who are in care to ensure that they get to school. Not every child in foster care gets to school, but it is the responsibility of the case worker to ensure that they go to school if possible. Perhaps we could provide a fixed monthly figure or something similar.

**The Hon. D.J. Hopgood:** We will get what we can.

**Mr OSWALD:** The basis of my question was a survey that I did involving a number of women who foster these children. The common thread is that the department has no idea of the number of children in their care who do not go to school each day. The women suggested that I visit schools in the northern suburbs to get some indication of the numbers. We may have to take the survey further and go to the schools to get a handle on how many children are roaming the streets whilst the authorities think that they are at school.

My third question relates to offender services. This afternoon I have referred to the pivotal role which FACS plays in handling the less than 200 serious juvenile offenders causing most of the trouble in Adelaide. They are constantly recycled through the Children's Court. Even the Senior Judge has admitted publicly that the system has failed. As an acknowledgment of the collapse of the juvenile justice system and the statistics that show that for the quarter ended March 1991 juveniles are responsible for nearly half the offences cleared as a percentage of all offences cleared, and acknowledging the role that the Minister and FACS are supposed to play in handling the 200 or so children who are constantly recycled through the courts and continue to seriously re-offend, will the Minister accept responsibility for the failure of his department in this area and resign?

**The Hon. D.J. Hopgood:** Let us not play games: we are here on serious business. How often do I have to say that, if the Senior Judge of the Children's Court wants more children locked up, it is in his hands to do so. He can hand them over to us for custodial placement and we will perform our responsible task in that respect. It is a bit much when people who have a solution in their hands but who for some reason refuse to operate on that solution try to handball the blame, if such is appropriate, elsewhere. Of course the system is not in collapse. The vast majority of youngsters are dealt with by the system once and that is it. That is an index of the success of the system. There is a small core of persistent offenders, and the Attorney-General has already made clear what the Government thinks about that. The House has set up a select committee that may want to draw its own conclusions about this matter and may well do so. It is not easy.

Somebody drew up for me recently a list of eight persistent offenders, seven of whom were young Aborigines. This nation has just been through an exercise after which we have been told by judges, journalists, politicians and opinion makers generally that wherever possible Aborigines should not be locked up because they hang themselves. There is a dilemma here for people involved in juvenile justice generally whether they be judges, social workers or whoever. On the one hand the imperatives of deterrence suggest that some of these youngsters should be placed in custodial care; on the other hand, a recent national royal commission came down with the very strong recommendation that, wherever possible, we avoid locking up Aboriginal people. It is not an easy dilemma to resolve.

**Mr OSWALD:** It was not my choice of words but rather the Senior Judge himself saying that the system had collapsed. I put that on the record.

**The Hon. D.J. Hopgood:** I find that a strange judgment in itself.

**Mr OSWALD:** Read the *Advertiser.*

**The Hon. D.J. Hopgood:** I have read it, and I still find it strange.

**Mr QUIRKE:** I refer to family law decisions. I have had some constituents complain to me about the income of a wife, husband or *de facto* partner being taken into consideration in assessing the non-custodial parent's contribution towards the support of children of a former marriage. Will the Minister explain the process in such cases?

**The Hon. D.J. Hopgood:** After determining the proper financial needs of the children, the Family Court considers the financial capacity of the parents to contribute towards those needs. The court then takes into consideration the total income of the respective household of each party in order to determine what is necessary for the parent to support himself or herself, including his or her reasonable share of the household expenses. That is how the system works. Did the honourable member want a more detailed explanation?

**Mr QUIRKE:** In the instance of which I am aware, a family has been awarded custody of a child and one parent was the natural parent of the child. As a result of the breakdown of a relationship many years earlier, the non-custodial parent was made to pay an amount towards the welfare, education and other expenses to the custodial parent for the child. In this particular instance, it was put to me that the income of the custodial parent's spouse and the non-custodial parent's spouse are taken into account in determining any future order for maintenance on whatever level. Is that how the process works?

**Mr Boxhall:** It is difficult to give a general answer to that question because the Family Court takes each circumstance into account. I have heard of cases where the income of the custodial parent's spouse is not taken into account. That is one source of complaint that we get from some non-custodial parents who might complain that the income of a custodial parent's spouse is not taken into account. Again, that is a matter for the court, and increasingly the situation is affected by the child support agency's formula.

**The Hon. D.J. Hopgood:** In any event, if we are interested in some changes all we can look at is advocacy, because it is actually a Commonwealth jurisdiction. I believe that the Minister for Social Security has announced some reforms to provide a simpler system. We will provide further information if we can.

**Mr QUIRKE:** Does that mean that the income of a custodial parent's spouse is not taken into account in the current situation?

**Mr Boxhall:** My understanding is that it is not necessarily taken into account.

**Mr QUIRKE:** If a non-custodial parent wishes to change the amount of maintenance assessed to be paid under the child support formula, that parent would incur considerable expense in applying to the Family Court for a review. A moment ago the Minister alluded to a possible new formula. Will he provide the Committee with further information?

**The Hon. D.J. Hopgood:** It is more a matter of an appeal process. The suggestion is that either parent will have access to an appeal process within the child support agency. That process would not involve legal representation, no costs would be involved and the right of appeal to the Family Court would be retained. The Minister for Social Security feels that this would be a better way to approach this difficult problem.

**Mr QUIRKE:** What is the continuing role of the department in family maintenance matters?

**The Hon. D.J. Hopgood:** It continues to provide services to custodial parents in relation to maintenance. The department is dealing with children whose parents separated before 1 October 1989 or who were born before 1 October 1989 if their parents did not live together. Assistance is also provided to people seeking increased rates of maintenance for children, collecting maintenance payments from non-custodial parents and disbursing them to custodial parents, such payments being disbursed on the next working day after receipt.

The child support agency within the Australian Taxation Office assesses maintenance by means of an administrative formula under the Child Support Assessment Act in cases where the parents separated on or after 1 October 1989 and children born on or after 1 October 1989 if the parents did not live together. The Commonwealth expects the department to retain its current involvement in collecting and enforcing maintenance liabilities because the child support agency to which I have referred is still not able to extend its services and the department still has about 5 000 current maintenance accounts.

**Mr QUIRKE:** In 1991 family maintenance services increased from a proposed amount of $1.8 million to actual expenditure of $2 million. Given the proposed transfer of functions to the child support agency, will the Minister explain the reason for this increased expenditure?

**The Hon. D.J. Hopgood:** The transfer to which I referred has not occurred as quickly as anticipated and there are more social security beneficiaries in the present economic climate.

**Mr S.J. BAKER:** The statistics on page 51 of the Program Estimates indicate a deterioration in the effect of the INC program with an increase from 3 per cent to 20 per cent of placements terminated because of reoffending and being placed in detention. The table on page 65 shows that in 1989-90 the figure was 3 per cent, in 1990-91 it was 15 per cent, and the target for 1991-92 is 20 per cent. This trend suggests that the INC program as a mediating process is somehow breaking down.

The INC guidelines provide that long-term support placements offered to offenders are of three to six months duration and are available only if the child is under threat of incarceration. It has been put to me by INC parents that this period is inadequate and that it should be the same as other INC placements, that is, up to 12 months, to avoid the young offender being moved away regularly after he or she has settled into a compatible INC family. Will the Minister consider changing the guidelines?

**Ms Vardon:** Are you talking about young people who are not offenders but who are adolescents at risk?

**Mr S.J. BAKER:** No, they are offenders, and that is why they are part of the INC program. They are put into the program to receive stable parenting and discipline, and the whole process breaks down because it is not possible to establish a long-term relationship with the new parents.

**Ms Howe:** They are two quite separate programs. The reason for constraint with offenders is that a court order is issued as an alternative to detention. So, to extend the program beyond the period of the court order would be similar to arbitrarily extending their time in gaol. There is a lot of coercion about what may occur with these kids in the program, because if they fail to stay and fulfil their obligations the alternative is to go back to court and to be locked up.

The other program to which the honourable member is referring relates to children under the care of the Minister or the department. That care can be extended for as long as required. Quite often, if those two things come together—that is, the child is on a detention order and is under the guardianship of the Minister and is in the care of the department—there will be an extension. It is problematic for the INC program given that it is a court-ordered program.

**Mr S.J. BAKER:** If that evidence suggests that being passed around from one parent to another or to a guardian or foster parent is not in the best interests of the juvenile concerned, I would have thought that if FACS believed that the program had worth and if a successful relationship had

been built up it would not suddenly say, 'The courts were going to give us only three months, and that's it' and then they can wander on to the next one. I would have thought that the department would try to change the rules or fight for a longer term relationship. I find it quite fascinating that suddenly the courts are again at fault and the department is blameless.

My question really relates to whether the department would consider changing the rules or at least, in its interrelationship with the courts, suggest changes. If legislative change is necessary, the department should look at that process. It may well be that that is not appropriate, but I would have thought that commonsense suggests that, if a successful parenting process is going on and if the kids have had a fairly rough life, shipping them off to someone else does not do anyone much good.

**Ms Howe:** There is a constraint in that it is a sentence to a placement. The program has been very successful for 10 years. Many children went home following the detention in the community with an INC family. The difference over that period is that fewer and fewer children are able to return home. If that is the case, and they are uncared for in the sense that they do not have a home, we can then take out a care order to give us the capacity and the right to intervene in their life. In those cases, we can extend programs and placements. We are also aware of the changing nature of the situation.

The INC program is relatively costly compared with, say, a foster program, and that reflects the nature of the difficulty of the children. We are about to introduce a program that will reduce the cost but provide more compensation than is presently available for difficult adolescents. It will also enable family placement to continue for more than 12 months—for two years if that is required. We are attempting to change the system at the moment to take care of the problems that the honourable member has described.

**Mr S.J. BAKER:** I refer now to psychiatrically disturbed victims of domestic violence. What happens to those people who are currently excluded from women's shelters?

**The Hon. D.J. Hopgood:** I will ask Andrew Hall, the Director of the Family and Community Development Unit, to answer that question.

**Mr Hall:** A number of women have been excluded from some women's shelter services in South Australia. The Supported Accommodation Assistance Program (SAAP)—which is a joint Commonwealth-State program—has as one of its guidelines that it is inclined to provide treatment type services. The issues to which the honourable member refers require mental health or psychiatric type treatment, which is specifically excluded under SAAP. Not being content with that, we have established a group to look at training for shelter workers to work with these people to stabilise their behaviour whilst they receive, on an out-patient basis, psychiatric or mental health services.

Training program, that will include speakers from around Australia will to be conducted very soon at Port Lincoln. A group has been established with the Health Commission to look at how we might provide these services through women's shelters on an out-reach basis and how we might train the workers in those shelters so that they can manage the behaviour and assist in the overall treatment program. This group will also look at access to mental health facilities and services for women who are totally unable to be accommodated in women's shelters.

**Mr S.J. BAKER:** So, you are telling the Committee that, if a woman who has been assaulted, for example by her husband, becomes disturbed as a result of that and goes to a women's shelter, she is turned away. She then goes home, but she has available to her an outreach service. Women would be those most affected. How does that woman remove herself from the violent situation? Is there another supported accommodation service involved?

**Mr Hall:** No, there is no other supported accommodation service. The reason a number of these women are unable to go to existing shelters is that often the shelters are very crowded, there are children around, and other people are at risk from their behaviour. Our approach has been to train shelter staff in how to manage disturbed behaviour so that the women can stay there and not be a risk or danger to others. At the same time, they are assisted in getting access to out-patient or community mental health services so that they can stay in the shelter and still receive treatment.

**Mr S.J. BAKER:** However, they are currently turned away. Are you saying that you are going to train shelter workers to be paramedics, psychiatrists, psychologists or whatever, to assist in this process? That raises some questions about the quality of the shelter workers and their capacity to achieve those lofty heights. I have considerable doubts about whether that is possible. What other support services are provided for these women at the moment?

**Mr Hall:** I know that there have been cases where women have been turned away, but I am not sure that the problem is of the magnitude that the honourable member suggests. Some people have been turned away and we look to the mental health services to accommodate them if their behaviour is so disturbed that they require in-patient medical or psychiatric treatment.

**Ms Vardon:** In the short term—we do not have a long-term answer yet—Crisis Care, in the middle of the night, has picked up the tab for many of these women for some days in private accommodation, whether it be a boarding house or a hotel, while we look for alternative placement for them. However, the problem is very real and they are sometimes very difficult to place. We need supervised hostels strongly supported by the health system, and that is what we are trying to negotiate.

**Mr S.J. BAKER:** On pages 51 and 63 of the Program Estimates, reference is made to Aboriginal youth development. Last year only $6 000 was spent and this year it is proposed that $73 000 be spent, and there is no staff line. The department's objectives list specific strategies to deal with the difficulties encountered by many Aboriginal youths. What are those strategies and where can the staff component be found in the budget lines?

**The Hon. D.J. Hopgood:** There are a number of strategies and I will run through them very quickly. The Aboriginal staffing numbers increased from 48 in 1989-90 to 57; Mr George Tongeri was appointed as the independent complaints officer for young people in secure care; the Aboriginal family care project has been built up in a new program that has been started at Coober Pedy; various aspects of the Muirhead report have been implemented; and Aboriginal youth affairs committees have been set up in 22 country locations for recreation and support of young people and grants of $4 000 have been given to each community. In part, that explains the increase.

**Ms Vardon:** The actual under-expenditure on that item related to anti-petrol sniffing money. That is money we get from DAS to combat petrol sniffing. As I said, we have been supporting and have in place a couple of anti-petrol sniffing projects on the lands. We are not totally happy that they have all been successful. So, last year, the Regional Director refused to spend the money, which was a pretty sensible thing to do. She called for an evaluation and the results, when they came forward, were not satisfactory in any way. We found another area in which to spend the anti-

petrol sniffing money. In fact, we spent it at Fregon, where we appointed a youth worker.

We are trying a new technique to combat petrol sniffing. There was a time when it seemed that one had to sniff petrol to get onto one of the good programs. It was almost an incentive to sniff, and if one did so one could join a horse riding program, or whatever. We are trying a new system at Fregon where we have a youth worker who develops programs for all the kids. We believe they are working quite well. They do not have to be sniffers to get onto it. It is another form of anti-petrol sniffing, but it is not directed at sniffers. We are trying to dissuade sniffers from doing it. The incentive is that if they do not sniff they can go on that program. It is a better way of delivering these things.

**Mr S.J. BAKER:** On a point of clarification as regards staff numbers, you mentioned two personnel: a youth worker and a director, I think. Are they catered for elsewhere in the estimates?

**Ms Vardon:** Yes. You will find them under 'Adolescent Support'.

**Mr Boxhall:** Most of our services to Aboriginal people are now not designated as specific sub-programs: they are mainstreamed into the other programs. This was a special program for petrol sniffing that remained. The line above 'Aboriginal Youth Development' is 'Adolescent Support', which involves over $5 million.

**Ms Vardon:** You will also find that the 22 Aboriginal youth committees have been a great success. A lot of youth work has been developed through the Aboriginal communities themselves. The money comes under family and community welfare development grants.

**Mr McKEE:** I have two questions in relation to the financial support area and emergency financial assistance. The first question is of a general nature and the second is about the specific amount. The program of financial support indicates that actual expenditure last year on emergency financial assistance and financial counselling was lower than budgeted, but increased expenditure is proposed for this financial year. Will the Minister outline what is being done by the department to help people in financial distress?

**The Hon. D.J. Hopgood:** We have to remember that there is a dual role here. On the one hand, the Commonwealth handles what are sometimes called transfer payments—social security payments—where there is a responsibility to ensure that all Australians have an adequate income to meet essential living needs. However, the State Government has an important role to play through its policies and services in housing, transport, water resources, health and the family and community areas. We are endeavouring to expand and clarify our role in emergency financial assistance and in the financial counselling area.

Emergency financial help is provided to assist people with limited financial resources who cannot obtain basic necessities, such as food, because of an unexpected crisis. I should make clear that it is the Commonwealth's job to ensure that, barring unexpected crises, people have sufficient sustenance to maintain a reasonable lifestyle. Our EFA is normally a once only cash payment for that reason. It is most often used where a small cash payment can avert a larger problem, where doing something about financial difficulties or where the lack of some financial solace addressed to financial difficulties may precipitate a family background. Although the Program Estimates shows a slight reduction in expenditure against budget last year, this reflects lower salary and administrative costs incurred in providing the direct assistance. The payments were 44 per cent higher than originally budgeted. As a result of a conscious strategy by the department, there was a relatively small reduction in the number of EFA applications approved, enabling larger amounts to be paid to those people needing that level of assistance. Some 86 per cent of all successful applicants received assistance to buy food.

**Mr McKEE:** On that same subject, in 1990-91 emergency financial assistance expenditure is indicated at $3 174 000. How much of that expenditure goes on costs to administer the scheme?

**Mr Boxhall:** Perhaps I could work back the other way. The amount of direct payments for emergency financial assistance was $1.82 million. The rest was for running the scheme. We were able to contain administrative costs on the scheme last year.

**The Hon. D.J. Hopgood:** It is worth making the point that people who are involved in the administration of the scheme do other things. We cannot regard their total salary as being devoted to the administration of the scheme, because they may be in other areas of responsibility for the department as well.

**Mr McKEE:** My third question relates to electricity concessions. It is noted that the department conducts audit checks by matching the names of pensioners receiving the concessions against their fringe benefit entitlements as recorded by the Department of Social Security. How frequently are those audit checks conducted and what impact have they had on expenditure?

**Mr Boxhall:** We carry out that check four times a year. Sometimes we put primary emphasis into processing new applications that come in, but normally it is every quarter or close to it. In the 1990-91 financial year a saving of nearly $290 000 was realised as a result of those audit checks. Since they came in three or four years ago, $1.2 million has been saved.

**Mr OSWALD:** I refer to pages 51 and 65 of the Program Estimates, 'Offender Services'. Foster parents claim that supervision of children by the Department for Family and Community Services, after they have been through the court and placed in their care, is virtually non-existent. To use their words, as a result of a survey of those women that was carried out, it is a joke. The Minister is aware that I raised this matter in the House some weeks ago and he responded by means of a ministerial statement. In that statement of two weeks ago, the Minister referred to more resources being put into this area, yet the Program Estimates (page 51) under 'Offender Services' shows no increase in staff or resources. From where in the budget is the Minister getting the additional staff and money required to give increased attention to these children in order to support the commitment that he gave in his ministerial statement?

**The Hon. D.J. Hopgood:** This relates to restructuring. The honourable member will be aware that the restructuring which I announced in May—a complete reorganisation of the department—means a 36 per cent increase in staff involved in delivering services to the public through a 40 per cent decrease in management and consultant staff. There have been two years of planning, detailed reviews of productivity and full support by the Government's central agencies to ensure that this would proceed without significant disruption.

The Chief Executive Officer has previously commented about the additional resources that will be available in another area into which we shall be able to move. I think the date given at that time for the full effects of the restructuring was 1 October. For example, the department will be able to serve 1 200 extra statutory cases such as child abuse and juvenile offenders, and that represents something like a $3 million increase in productivity. As a result of that

enormous increase in field staff, these things have been made possible. As to where one points to it in the papers, I am looking to my officers for a more detailed explanation.

**Mr Boxhall:** When these estimate documents were prepared, the exact proportion to be spent this year in various programs could not be adequately determined, and so we thought it was best to keep it on the same basis as last year, to enable an initial comparison. As the restructure takes place during the year we will be able to more closely identify what the resources will be.

**Mr OSWALD:** My final question in relation to the offender services line is: will the Government provide the Opposition with a copy of the report entitled 'The net widening effect of aid panels and screening panels in the South Australian juvenile justice system', referred to in the Program Estimates? Obviously, the Minister would not have one with him now, but we would appreciate a copy of it.

**The Hon. D.J. Hopgood:** We will provide that.

**Mr OSWALD:** I will be happy to pass it on to the select committee, because I think it could be of interest to them. Supplementary to that question: one of the 1991-92 targets/objectives is to maintain and improve the performance of panelists in the new structure for field services. What is the Department for Family and Community Services position as regards the Attorney-General's green paper on juvenile justice, which floats the idea of abolition of panels, and this is also supported by the Senior Judge of the Children's Court, Judge Newman?

**Ms Vardon:** The position of the department—which I might say still needs to be considered with the Minister—is as follows. In relation to recidivists, the panels do not deal with recidivists. The panels are in fact part of the process that clears out of the system people who come one or two times. Our position is that it is unnecessary to fiddle with the panels, except that we believe there needs to be more victim involvement in the panels. We agree with the proposals that are before the Parliament, that parents should be made to go to those panels, that attendance by parents should almost be compulsory.

So, we believe there should be some sharpening of the panels. But given that they deal with the 87 per cent of the young people who hardly ever re-offend, our position is that it is silly to tinker with that system, because we do not want a whole lot of those kids coming before the court system, as that would simply clog it up. Our position is that, clearly, the recidivist program area needs sharpening up and we believe that is something that has to be dealt with by the select committee and other people. We do not agree with the Chief Judge.

**Mr OSWALD:** My third question relates to page 35 of the Estimates of Payments, although this probably could come in anywhere. It relates to the Minister's role as the landlord at the Brighton-Glenelg Community Centre. The Minister may recall that last year I asked him questions about the future of the centre, and he informed me that the property was for sale and that that would be some time off in the future. Since then a Government working party has been formed to negotiate its disposal.

It goes without saying that it is of great concern to the local community centre that its security of tenure has suddenly become very tenuous. They thought that they had several years but have now been informed that that is not the case—particularly now that SACON has become involved. Will the Minister provide the Committee with details of the time constraints in relation to disposal of the property? Will he say why no-one from the management committee was invited to participate in the discussions? Also, by what criteria did the Government decide that the site was under-utilised, when between 1 200 and 1 500 people a week, from 50 different groups, use the centre? Does the Government see the centre surviving if it is broken up and the user groups dispersed to different locations around the western suburbs?

**The Hon. D.J. Hopgood:** First of all, the title of the property is held by the Minister of Public Works. Most buildings on the site were erected in the 1930s. They are drab in appearance. They require continued and expensive maintenance. Blue asbestos has been located in the ceiling cavities of the community centre and SACON tradespeople have refused to enter the ceiling to carry out maintenance work until it is removed. So, that is one of the problems we have. Secondly, SACON has indicated a requirement to spend an estimated $560 000 on maintenance of the buildings, and continued deferral of maintenance will of course increase the estimated costs and exacerbate the existing problems.

The site was actually identified by the Department of Lands, in its audit of all Government properties, as being under-utilised, and by SACON, in its review of properties in the ownership of the Minister of Public Works, as not providing adequate return for its value. My department has found that most of the services that it has provided from the centre can be more appropriately located elsewhere, and we have been progressively relocating facilities from the site. There is a working party that is looking at these matters.

It is interesting to see that in fact there are representatives of the Patch Theatre and of the Brighton-Glenelg Community Centre. There is the community complex coordinator and there is a representative of the Brighton council. It is true that at this stage no-one has been appointed to represent the Montessori school nor has anyone been appointed as a consumer representative for adults or a consumer representative for children. It is also true that the Glenelg and Brighton councils have representation on it—over and above the earlier representative that I mentioned from the Brighton council. There is also a representative of my department and a representative of SACON.

I do not think that I can add too much more to what I told this Committee last year, except that there has been one particular matter that has been raised with me in the past day, and therefore almost certainly has been raised with the honourable member, and I refer to a letter from one of the user groups at the centre, claiming to have a 20-year lease on the property. I am advised that a check of the departmental records at this stage indicates that the department was prepared in 1983 to enter a 10-year lease, with right of renewal for a further 10 years, at a rent of $10 per annum, or as determined by the appropriate Minister. The committee at the time indicated that it was not prepared to enter such a lease, and in June-July 1984 agreement was reached for the centre to continue to provide rent-free use, but no actual tenure was ever arrived at.

**Mr OSWALD:** I ask a supplementary question. Is the Minister of Family and Community Services the signer of the original lease? Was the property leased from the Government, via the Minister as head of the department, or did it come in through SACON? We were a little confused intially in relation to the Minister's explanation as to where SACON started and finished and where the Minister started and finished.

**The Hon. D.J. Hopgood:** The land is owned by the Minister of Public Works. I call on Mr Boxhall to further explain.

**Mr Boxhall:** It is clear that the Minister of Public Works is the one now with the carriage of it. As the Minister just indicated, there is a form of agreement for and on behalf

of the then Director-General of Community Welfare and the President of Seaforth Community Centre. As has happened until these arrangements were clarified between SACON and Government departments over recent years, as the prime occupier of the site we were responsible for negotiating arrangements with other occupiers, and that is the basis of that form of agreement. There was no formal tenure or lease arrived at, because the earlier discussions fell through, because the committee did not like the proposals at that stage.

**Mr OSWALD:** In the future will the centre negotiate with the Minister of Family and Community Services or the Minister of Public Works as regards its future tenure?

**Mr Boxhall:** My understanding is that the Minister of Public Works has agreed to a joint SACON/Department for Family and Community Services project working on this and, presumably, ultimately that would report back, with my Minister apprised of the views of that working group, to the Minister of Public Works for final decision.

**Mr OSWALD:** Which Minister can we approach to ask for an extension so that the centre can be acknowledged as a useful part of the district and can stay?

**The Hon. D.J. Hopgood:** Either Minister.

**Mr HAMILTON:** In view of the anticipated 4 per cent growth in the older sector of the South Australian population and the increased number of younger people with disabilities, what provision has the Government made to meet the inevitable demand for support to stay at home?

**The Hon. D.J. Hopgood:** As much as anything we need to talk about the HACC program. I will not spend too much time on all the details, but I will certainly satisfy the honourable member. In 1985 funds totalling $13 million were provided for home support services and since that time the allocation of these groups with the HACC program has grown progressively to the present $41 million.

As the honourable member would know, we are dealing not only with older people but with younger disabled people because both groups are target groups for the receipt of these funds. This year's budget provides for $2.38 million to meet the impact of inflation on service delivery and the full implementation of initiatives begun in the past financial year.

In last year's budget new funds totalling $4.1 million were provided for a number of new initiatives. The community support scheme, to provide home support for young people with autism, behaviour disorder, brain injury, and intellectual and psychiatric disability was $2.6 million in a full year. Respite care for the carers of people suffering from dementia, with special service people of a non-English speaking background—and this Committee was talking about those problems earlier today—amounted to a figure close to $400 000. Also included is support for people with incontinence, and advocacy services to allow the users of HACC service to exercise their rights and grants to provide transport service.

Approval has also recently been given to a number of country domiciliary care services to provide aids and equipment to clients who receive basic maintenance and support services througth the HACC program. We are talking about $20 000, and the other point I should make is that negotiations are under way with the Commonwealth for an additional $1.86 million in funding.

Those funds will be used to provide home-based services for young people with a disability and their carers and to expand further domiciliary care for the elderly. Of course, the first half of that has had considerable mention in the Committee this morning under the health lines.

**Mr HAMILTON:** I do not know whether this issue comes under health or is covered by this portfolio (I suspect a combination of both), but in the past I have had parents coming to me concerned about their adult children with a mental disability. These people have had great difficulty in getting support from the department, because they do not fall into a particular category, when their children do not take their medication. What advice can the Minister give me and people in the community about how they handle those situations? I remember many years ago a lady from Woodville South who had a problem with her adult son, who eventually assaulted her when he did not take his medicine, telephoned me from outside the electorate subsequently pleading for information about where she should go on a Saturday night or in the early hours of Sunday morning to get assistance.

**The Hon. D.J. Hopgood:** The Management Assistance Panel is one area to which I would direct the honourable member. This morning under health we talked a good bit about the Intellectual Disability Service Council, which is the major area trying to sort out these matters. I will get more detailed information.

**Mr HAMILTON:** As to training and support for the non-government welfare sector, with increased demands again for welfare services from the community sector, what efforts have been made to ensure that non-government welfare agencies have the necessary supports to provide services to people who need them?

**The Hon. D.J. Hopgood:** This is an ongoing saga, I am afraid, and it is not easily resolved. Members will be aware that more than half the budget that comes through me as Minister of Family and Community Services goes not to direct services provided by the department but either on concessions, on the one hand, or, on the other hand, grants to the non-government welfare sector which, in turn, provides services that are conjugate with what Government provides.

There are a number of problems. The first is being able to continue this level of effort, given the sort of budgetary problems that Governments around this country are currently facing. The second problem is that increasingly people who work for these non-government welfare services are becoming as expensive as those who work for the Government. From the point of view of wage justice one can hardly complain about that.

Two major award decisions have been around for some time, one of which has been brought down in an interim form and one of which is pending, but they will increase considerably the cost to the non-welfare sector of employing people to provide these services. Together with SACOSS and the major players in the field, the Government has tried to get a review going of the whole area to determine what efficiencies can be adopted by these organisations and what other things can be done to try to ensure that these services can be continued without there being huge additional subventions of money that would not in the first instance go to improved service delivery but would go into the greater salary component that these services will have to meet.

That Community Services Sector review has been in progress for some months and is due to report before the end of this calendar year. We can look forward with a great deal of interest to see what will be resolved. Already there have been savings in some areas and altered administrative and service delivery arrangements that have helped a bit but we have quite a way to go. One wonders how adequately we will be able to deal with all these problems, given that the increased award provisions are certain to take effect.

**Mr HAMILTON:** I notice on page 51 that 'Aboriginal youth development' was underpaid by $65 000. Does that mean that Aboriginal youth missed out on some services as a consequence?

**The Hon. D.J. Hopgood:** Perhaps the honourable member was not present when the member for Mitcham asked this question, and I refer him to *Hansard* for the answer.

**Mr HAMILTON:** How does the budget support the effort of Meals on Wheels, one of the biggest voluntary based organisations in South Australia?

**The Hon. D.J. Hopgood:** Meals on Wheels is funded through the HACC program and the manager of the HACC unit, Bob Leahy, will respond to that question.

**Mr Leahy:** Meals on Wheels receives funding through the HACC program as a subsidy towards the cost of meals. The organisation was recently offered a grant of $250 000 to pilot a new form of food service preparation, which involves a combination of high technology to work with the skills of the existing volunteers to possibly do things more efficiently. Meals on Wheels is having problems in some areas with recruitment of volunteers and we hope that this pilot may assist in using the existing volunteers more effectively.

This is involved in the cook/chill technology, which apparently has been redefined and is now in use in airlines. The Government has provided in the budget this year additional funds to meet the cost of inflation, and a grant of about 4 per cent has been provided, which is just over $40 000. The organisation will receive additional funds to provide for the demands on services of about another 4 per cent, which will provide an increase in meals at any given time from 4 500 up to 4 700 per day. An allowance for 200 meals per day will be provided.

**The Hon. D.J. Hopgood:** I will refer briefly to the honourable member's previous question. I told him of some of the problems and the ways in which we were trying to address them. I did not tell him the good news, which is that in this area the SAAP scheme will increase its grant by about $810 000. It is not all problems and difficulties—there is some good news out there for these agencies providing these important services.

**Mr OSWALD:** I refer to page 55 of the Program Estimates at which it refers to the HACC scheme. How is it proposed that the dementia brokerage scheme will operate?

**The Hon. D.J. Hopgood:** I previously referred to it when I ran down a list of things that would be happening, but I did not give details. I will ask Mr Leahy to comment.

**Mr Leahy:** The concept of brokerage involves the negotiating of existing services to be brought in to provide the respite that the service aims to give or to buy it in when the service is not available or full. We have developed a number of areas where that method will be applied, including the southern area and the Southern Domiciliary Care Service. The statutory agency down there has been given a grant of approximately $130 000 to get it off the ground. We have given a grant to the Hills Community Health Service to provide that support and in the eastern region we have given a grant to Aged Cottage Homes, a non-government organisation with considerable experience in providing services for older people. Those services are now getting off the ground and they will be bringing in negotiating services with existing agencies or buying them in to provide the respite that carers of people with dementia at home look for.

**Mr OSWALD:** The Program Estimates also refer to an assessment of the role of local government in the service delivery. Will the Minister explain what he sees as the role of local government in the delivery of HACC services or is it telegraphing a change of role or emphasis down the track on the involvement of local government and HACC generally?

**The Hon. D.J. Hopgood:** Local government is already involved in the HACC program in a number of ways, including the provision of HomeAssist services involving 34 councils; providing day centre respite programs; providing a range of information, advocacy and referral services to older people through 27 jointly funded aged care or community care workers; assisting with local transport, through contribution to the costs of such services; and support for volunteers involved in the provision of services to the frail aged. HACC payments to councils last year totalled $1.77 million and councils contributed a further $600 000 to the delivery of support services.

The honourable member will be aware of what is called the 'memorandum of understanding, between the Premier and the Local Government Association and, in order to meet the requirements of such, officers of the HACC program and the LGA have been negotiating a new three-year agreement which strengthens the partnership between HACC and local government in the funding and delivery of HACC and related services.

I understand that there have been problems in Victoria between local government and the HACC program. We think that we are in a position to be able to avoid those problems. The Commissioner for the Ageing has been working with local government in the preparation of legislation for supported residential accommodation. It is true that we look to local government to have at least the level of involvement that it has currently in this range of services and there are some opportunities for innovative programs. For example, I know that for some years the city of Noarlunga has operated (we have not put funds into it but the Commonwealth may have, otherwise it is totally funded by rates) a new arrivals program where visitors go out to see people in new homes in the area, taking with them information about the area, facilities and so on. That is the sort of area in which local government can continue to play an expanded role and I expect it to do so.

**Mr OSWALD:** I refer to pages 60 and 61, relating to domestic violence services. One of the points mentioned at page 61 is to offer timely help of a preventative nature. How much of the $441 000 allocation has been earmarked for domestic violence in the ethnic communities and has the department ever considered promoting a counselling service for ethnic male perpetrators of domestic violence? The background to my question is that the proposition was put to me by ethnic shelter workers who claim that there are agencies to help non-ethnic males, but the ethnic males are ignored. This is inhibiting their working with abused ethnic women.

**The Hon. D.J. Hopgood:** The honourable member is perfectly correct. On the one hand, one could say that any service is available to any citizen. The problem with the multicultural community is the language barrier. Where there is no such barrier, these people are able to access the services. Where the language barrier exists, although we are trying to do what we can, a good deal more needs to be done to provide such services. I will take up the suggestion—if it has not already been taken up—at officer level as it sounds as if it came from within the system. We will see what we can do further to improve the service.

**Mr McKEE:** When will the proposed amendments to the Community Welfare Act and the Children's Protection and Young Offenders Act introduced last session be reintroduced?

**The Hon. D.J. Hopgood:** As soon as possible. As the honourable member knows, these two Bills were among the

slaughtered innocents of the last session, those that we did not get around to debating. Since that time a need has been seen for a number of further minor amendments to be added to the Bills. I assure honourable members that they do not unduly complicate the legislation. In those circumstances a good deal of redrafting has had to occur. The department is very keen for the amendments to be processed. I have indicated that as soon as I get them I shall process them. We expect that they will be dealt with expeditiously by the department.

**Mr McKEE:** The Government has announced that legislation for a Children's Interest Bureau Act will be tabled. When is that likely to be introduced?

**The Hon. D.J. Hopgood:** I would hope to be able to introduce this legislation before Christmas. I cannot give any more specific timetable than that, but I can be reasonably confident of introducing it before Christmas. Given the amount of legislation that we will have on the Notice Paper by then (and I speak as Leader of the House rather than as Minister of Family and Community Services), I anticipate that we will be debating the measure in the February to April part of the session.

**Mr McKEE:** It was indicated over 12 months ago that amendments would be introduced to the Adoption Act 1988 in relation to powers of veto for access to information about children adopted before the introduction of the existing Act. When are those amendments likely to be introduced?

**The Hon. D.J. Hopgood:** We have had to address a number of technical questions as to whether this power should lie in the Adoption Act or more generally in other legislation, such as the Guardianship Act, which might be a more appropriate vehicle. This matter is being considered at officer level and, as soon as agreement has been reached, appropriate amendments can be pursued. I suggest that this may be a matter for consideration in that portion of the session that falls early next year.

**Mr OSWALD:** My question relates in part to the question of the member for Gilles. It is a question on a subject which appeared in a Bill that was withdrawn, but I think the question is still applicable because it is part of on-going planning for the department. The Government is planning to disband the child protection panels. Will the Minister explain the structure to be set up to replace the panels; the membership and qualifications proposed in that replacement structure; the changed role; how the new system will speed up the processing of children's cases; and what, if any, additional costs will be associated with the new structure under the council? I think there has been a general inquiry from both sides of politics as to what is proposed so that constructive comment and discussion can occur.

**The Hon. D.J. Hopgood:** Some of these questions will have to be taken on notice, but Ms Vardon will answer the substantial part.

**Ms Vardon:** The replacement of the panels has given us a fair amount of concern. As we have said before, the panels were a very important procedure in the 1970s and perhaps in the early 1980s, but as notifications increased the panels became an inappropriate mechanism. They had about 12 or 15 functions, one of which was to receive notifications. Other functions included encouraging the community with knowledge about child abuse, getting agencies to work together, providing community education on how to care for children, and so on. The panels became overloaded in respect of their notification function. We were very concerned that the developmental function of getting agencies to work together was being put on the back burner.

Many of the developmental functions of the panels have been transferred to the South Australian Child Protection Council. One function that has not been referred to that council is the receiving of notifications, which remains a function of the department. It has been mooted that the developmental functions cannot stay at State-wide level, that they should be promulgated through regional committees of the South Australian council. Under the legislation, the council has the power to create such committees.

Regional committees do not suit everyone. A lot of people work together at district or local level, and we feel that the structure, rather than being too formal, might evolve from how human service agencies work together. For example, in Elizabeth there is a very good working relationship between the police, the Health Department and FACS, and we would look to that inter-agency group to do the developmental work. However, we would not take the entire northern region and expect the functions to be applied to the whole of that region; we would prefer that to be done locally.

The question of receiving notification and giving the department a review function is interesting because we believe that the whole of the system should be reviewed—not just the department but the police, health and so on. We need to have a way of checking that practice. At State-wide level, we have established an operational review group, chaired by Anne Howe, and it is proposed that instances of poor practice go through that group—one has already—and that it provide a critical policy review of all agencies involved. With respect to the individual case level—and, in a general sense, all cases—the department has built into itself some quite rigorous review systems with very strong quality assurance mechanisms; and we have introduced senior practitioners and supervisors at a very high level.

The unresolved political issue is whether or not every single case needs to go before an examining body external to the department. We do not believe that needs to be done. However, we believe that samples of cases should be critically reviewed by all parties and that that type of thing should be done at local or regional level. We would like to disconnect every single case from an external structure and have those external structures look at the broader issue. The actual cost of the changes, which is the question I hesitate to answer, I am not sure about. I think that most agencies involved in this process could absorb the costs of structured meetings. I do not see that as a major cost item.

**Mr OSWALD:** My next question relates to Crisis Care: a question which the Minister and the CEO would be aware that I raised in the House. What plans does the Government have to restrict Crisis Care to an evening only service, how will the branch and regional offices cope with any additional workload, and will additional staff be employed on branch switchboards or counters?

**The Hon. D.J. Hopgood:** I will ask the CEO to respond, because on the day on which the honourable member asked this question in the House this matter had been discussed in a forum at which the CEO was present. Indeed, that may well have been the source of the honourable member's question.

**Ms Vardon:** We thought that the honourable member's timing was impeccable because we had only just made the decision, which still has to be put before the Government, but the Minister has indicated some favour towards it. The whole department has been involved in a productivity review. No stone has been unturned; we have had a productivity team look at everything. Much to our delight, the Crisis Care service invited the productivity team in, but of course it would have examined that service anyway.

As part of the whole award restructuring process, we had to determine levels for every job. The new phrase on everyone's lips is the 'core business'. We had to determine each

agency's core business. We had to sharpen the focus of every agency and put the dollars where the core business was. It is very important for South Australia that Crisis Care provides an after hours service as its core business. However, we have had problems with the after hours service. We had a low response time to Elizabeth and Noarlunga, and we had complaints from foster parents that there were not enough people on duty at night to help them. So, we said that the after hours core business had to be sharpened up.

We did not have any extra dollars, so we said that if resources were to be made available to do this we would have to look to the daytime shifts to provide this sharper service at night. We have given the service the responsibility, in particular, to provide better care to foster parents and to work out how we can provide a service for Elizabeth and Noarlunga. We thought that these were honourable objectives. We then said that as an organisation we had a problem with the daytime service. We looked at the Crisis Care figures and found that most calls are received between 2 p.m. and 11 p.m. Quite a lot of the daytime calls come from people who use the Crisis Care number. We have undertaken to keep a 24-hour number and those calls will be answered by someone with appropriate skills. We are not quite sure how that will be accomplished, but we have three or four ideas at the moment and they will be referred to the local office.

It is our belief that we now have district officers with a capacity—with intake and assessment teams—to respond to people in crisis, and we believe that we have the necessary resources in the district offices. We are talking about quite a different configuration of social workers and community support workers than we had before. We believe that this is the best use of the dollars.

**Mr OSWALD:** You mentioned certain hours as being peak periods. What are they?

**Ms Vardon:** From 2 p.m. to 11 p.m. In fact, we will shore up the shift from 4 p.m. to 11 p.m., which is the busiest time of all.

**Mr OSWALD:** Will the Minister provide details of the Government's State concession card, which replaces the PHB card? What policy decisions will influence its use? I refer to page 58 of the Program Estimates, on which there is reference to a change in policy with regard to its use and those who can use it.

**The Hon. D.J. Hopgood:** It has generally been agreed amongst the States that since we do not want to get into the question of means testing, we should base our eligibility criteria on a person holding a Commonwealth issued pensioner health benefits card or benefit entitlement. In a small number of cases, a State concession card can be used. However, generally speaking, this system simplifies the State's administration of concessions, although it does not tie the State to Commonwealth decisions about eligibility for pensions and benefits.

A number of options is being examined by State welfare Ministers and, indeed, there was a discussion about the issue earlier this month. The options include transferring responsibility for care concessions (that is, income support related concessions) to the Commonwealth; the introduction of separate State-Territory concession systems that are not linked to Commonwealth health cards; development of a national concessions program jointly funded by State, Territory and Commonwealth Governments; and extension of Commonwealth and State-Territory concessions to all pensioners within the existing framework of responsibilities. It is expected that the last option would cost an additional $96 million in the provision of State-Territory concessions to those who are currently not eligible. So, the Ministers endorsed a proposal for further work on options three and four, and the development of a proposal that details a national concession system based on a set of care concessions and agreed cost sharing arrangements.

As a contingency measure, consideration has been given to a separate State concession card not linked to the Commonwealth card. This is the reference to a new State concession card. Because of the additional administrative complexities that I have explained, it is not our preferred option at this stage, but it will be further considered if any proposed national concession system is to South Australia's detriment. It is possible that this matter could be resolved at the meeting that the State Premiers and Treasurers will have with the Prime Minister and Federal Treasurer in November. It is my feeling that it may not be; that it may be further adjourned until next year.

**Mr QUIRKE:** I note that the cost of secure care staff has increased. Will the Minister tell the Committee what is being done to try to reduce the rate of offending in general crime prevention strategies?

**The Hon. D.J. Hopgood:** People talk about crime prevention strategies generally. We do what we can with our own family and community services crime prevention management plan. I mention the country Aboriginal youth team that was developed in response to a lack of recreational leisure activity for young people in the Port Augusta area. We have redirected resources to employ four young Aboriginal people to plan and develop a range of activities. The program also employs supervisors on a casual basis. Already 100 young people attend the program. It has attracted a lot of community support from human service agencies, the private sector, the army and the police. Preliminary data suggests that offending rates have declined since the program began but, of course, we will follow that up in more detail.

The Noarlunga office of the Family and Community Service Department has initiated two projects. The first of these entails using off-duty police personnel as intensive adolescent support workers with young people referred to them by the children's aid panels; and the second is a project targeted at high risk families through specific programs run by Child, Adolescent and Family Health Services Unit staff. It differs from the conventional programs in that it provides a high degree of personal and practical support to individual families to ensure their attendance, and this includes help with transport, child care and meals. There is a good deal of additional information I could give in relation to the crime prevention component, but I think perhaps I should simply make it generally available to the members of the Committee.

**Mr QUIRKE:** I note on page 65 of the Program Estimates reference to consideration of a report entitled 'The net-widening effect of aid panels and screening panels in the South Australian juvenile justice system'. What recommendations have resulted from that?

**The Hon. D.J. Hopgood:** The panels have been criticised on the ground that they widen the net of social control; that is, rather than dealing with offenders who would otherwise have been processed through the Children's Court, they are bringing into the official justice system those children who would previously have remained outside it. There has been a longitudinal analysis of the number of youths processed by the South Australian juvenile justice system over the past two decades or so.

It has indicated that some net widening occurred after the introduction, first, of the aid panels in 1972 and, secondly, of the screening panels in 1979. It has also indicated

that the period of active net widening was of relatively short duration, after which the numbers being brought into the system stabilised, and even showed some signs of decreasing. Thirdly, the long-term effects of net widening have persisted with the levels of processing at the end of the survey period remaining higher than at the beginning. So, in the light of that the department has collaborated with the Police Department to revise screening panel operations to ensure more youths are diverted to a formal police caution at this level, thereby considering some of the residual affects of net widening. Further examination of the issue will be dealt with as part of a departmental review of its contribution to the delivery of juvenile justice, and that will result in a submission to the select committee.

**Mr QUIRKE:** What is the department specifically doing to meet the crisis needs of people in rural areas?

**The Hon. D.J. Hopgood:** We are not alone in this in that some counselling services are made available through the Department of Agriculture. However, as far as we are concerned, a good deal of activity has taken place on the West Coast, particularly arising out of the very severe drought that the West Coast experienced a couple of years ago. Servicing areas out of Port Lincoln include Wudinna, Cowell, Cleve, Arno Bay, Elliston, Tumby Bay, Cummins, Darke Peak and surrounding areas. There is a financial counsellor and social worker averaging one day per week visiting rural areas, and travelling over 30 000 kilometres since February this year.

Currently, there are 33 customers from rural areas as part of a total case load of 49, which is pretty heavy. In total this year, 70 of the 100 customers have been from rural areas. There have been applications for money from various trust funds to assist. A lot of the time involves advocacy of customers in social security matters. He has recently been successful in a case where a family received $18 000 in back money as a result of a decision by the Administrative Appeals Tribunal. Imagine what effect that must have had on a farming family severely strapped for cash anyway. The social worker often accompanies the financial counsellor on the rural trips.

Without going into a lot of additional details, I can say that similar stories can be told in relation to the Kimba area and also the Ceduna Far West area. Monthly visits to Streaky Bay will commence in October 1991. Before the Committee runs away with the idea that perhaps we are dealing only with agriculturists here, I point out that a number of people in the fishing industry have also sought assistance and financial counselling. There are also some details that could be given in relation to the South-East, but I will not detain the Committee at this point.

**Mr OSWALD:** I refer to the Program Estimates, page 62. The Program Estimates acknowledges that several reports and surveys have been conducted into excessive abuse suffered by Aboriginal children in traditional and urban communities. This was mentioned in the 1990 objectives of the department, but for some reason it was deferred. As this serious problem has been around for many years, why was the study not completed in 1990-91, and why did the Minister again defer the study to 1991-92?

**Ms Vardon:** A report was brought down a couple of months ago from the Pitjanjatjara Women's Council. It is an excellent report on child abuse in Aboriginal communities. It took a long time to bring the report down, because it took a long time for the people doing the research to get to all the women on the lands. We are very happy with the report. It makes many suggestions as to how Aboriginal women in particular can take steps to reduce the abuse of Aboriginal children.

Following that report, it was decided that South Australia should host a national conference on child abuse in the Aboriginal community. The week after next 400 people, most of them Aboriginal, will be coming from all over Australia to talk about preventing abuse in Aboriginal communities. It is the first time the communities have got together. We did not feel we could rush any of that; it had to go at the pace at which people were ready to move. Therefore, there has been a bit of activity in the last few months.

**Mr OSWALD:** On page 60 of the Program Estimates there is a reference to a critical incident stress package and the psychological service that is provided. What is a critical incident stress package and what is the psychological service that is being provided?

**The Hon. D.J. Hopgood:** This is a difficult thing to precis. It may be of greater interest to the Committee if we were to make the report available. If the honourable member wants me to open it up, I am prepared to do so, but I think he might prefer to ask a few more questions.

**Mr OSWALD:** It is for my education and that of the Committee as to what the department is doing in this area.

**The Hon. D.J. Hopgood:** All right. We will get the report to the honourable member.

**Mr OSWALD:** The Program Estimates (page 62) 'Individual, family and community care and protection' refers to a 500 per cent increase in the number of reported cases of child abuse over four years followed by a two year reduction. It quotes 2 898 cases compared with 3 213 the previous year and 3 898 the year before that. We are pleased to see a drop and congratulate those involved in the department or other agencies who have brought about that downturn. So that we can get a better understanding of the reporting of abuse, does the department have any figures on how many cases eventually went to court and were proven and, if so, will the Minister make them available? It is one thing to say, for example, that nearly 4 000 cases of child abuse have been run around the media, but it would be interesting to know how many got to court as proven cases.

**The Hon. D.J. Hopgood:** We will try to get the details. The figures that I have relate to physical, sexual and emotional abuse and neglect. One would not normally expect neglect to finish up in the criminal court. Basically, we are dealing with sexual abuse, which usually goes to court. We do not have the details at the table, so we will have to try to get that information and report within the time frame that the Chairman announced this morning.

**Mr OSWALD:** The Program Estimates (page 50), under 'Welfare Practice', indicates that the number of full-time equivalents for 1990-91 totalled 108.4 and for 1991-92 will total 108.9. Page 48 indicates that the number of full-time equivalents has dropped. During the year we were told that the justification for the restructuring of many FACS offices would be an increase in the number of new workers on the front counters who were to be recruited and trained for this purpose. I was under the impression that they would be new staff coming in. This would free qualified social workers for field work. Does 'Counter Services' refer to counter staffing levels in regional branch offices or are they picked up under a budget line elsewhere?

To summarise the question: we understood that there would be new staff on the front counters. Where will they come from? Are they completely new staff being recruited into the department, which does not show up here in relation to counter services, or are they coming from elsewhere? What is happening in that part of the organisation?

**The Hon. D.J. Hopgood:** I ask the Executive Director, Operations, to respond.

**Ms Howe:** The joy of the restructure, I suppose, is that previously some 560 full-time equivalents were counted across the whole region and now what we have done is cash in some 60 of those positions and recreate 90 new positions, which are predominantly front counter service people. The reason that they do not appear in the budget papers in that form is because we are in the midst of putting this into place. We hope to have the process completed within the next couple of weeks. Thus, it is not possible for us to provide the comparison as between last year and this year along the lines of the restructure. As I said, there will be some 90.3 full-time equivalent new service provider positions and that will be funded out of the decrease in middle management and consultant positions. They will show in next year's budget papers.

**Mr OSWALD:** Is it possible for the Minister to provide the Opposition with the department's submission to the community services sector review?

**The Hon. D.J. Hopgood:** Both a formal submission and a number of contributions have been made along the line. The formal submission can certainly be made available.

**Mr OSWALD:** I ask the question because I would like to make a genuine contribution to the debate and it is necessary to know where the department is coming from. I refer to the Building Community Support program (page 56 of the Program Estimates) and to the reference to a large scale community education campaign that will be pursued on teenager/parent conflict and juvenile crime. Until the Government gets these areas under control, it is like putting the cart before the horse; nevertheless, what is the Minister proposing to include in this education program and where is the budget line for it, as there are nil dollars listed this year under 'Community Education' on page 45 of the Program Estimates? In essence, can we discuss details of the education program that the Minister is proposing?

**Ms Vardon:** Perhaps I can break it up into two parts, because there is the parent/adolescent area of concern for us and the area involving offenders. We spent quite a bit of money last year putting together a kit on helpful advice for parents whose children have run away. Lots of parents find it extremely difficult to manage teenagers—this is as old as the hills. I have trouble with my teenager. But there are families where the situation becomes impossible, and a fair amount of advice can be given as well as helpful information in literature, and we want to increase that.

We have looked at a model from Western Australia, which is particularly good and helpful for parents. We want to continue to put that out and we will be doing it with CAHFS and CAMHS and our colleagues in the health system. So, at that level these are pamphlets for when families need help, not just a general smattering of it. In the area of juvenile justice, of course, we will wait for the select committee to do a lot of work. However, there is some notion, which I think is coming through the Neighbourhood Watch committees and others, that everyone who offends is going to be 14, 15 or 16 years old. I have read quite a few of the minutes and recommendations from Neighbourhood Watch committees and I have a feeling that they are being flooded with 'moral panic'. I use those words carefully, because there is a fair amount of information to suggest that all young people are going to offend or to suggest that people should watch out for young people, and so on.

We do know certainly that young people offend and they do commit a fair slice of the offences, but not very many of the whole of the cohort of youth offend—I think it is about 4 per cent at most—and most of those do not offend again. One of our concerns is that from time to time the public needs better information than it is getting. So, we have asked our managers to target the Neighbourhood Watch committees and others, to give them better information. Most young people are fine young people. They have ordinary problems, like being unemployed and so on, but the notion that all youth is 'out to get you' is something that concerns us.

That is the sort of education we are talking about: getting the information about offending back into perspective in some places. This is in no way to decry the seriousness of the situation in relation to re-offenders. We are not trying to soften that at all, but as David Rathman said yesterday, many of the young people involved in car chases are Aboriginal youth, who have no chance of obtaining employment and so on. There is also the question of education about the conditions that those young people come from as well. We need to pay attention to that.

I might just put on the record that, in relation to one of the most recent car chases, six of the young people came from the one family. We are having a meeting with the whole of that family next week and I will be going to that. The family, of course, says, 'What can we do about these young people?' I think that is also part of the community education question and the matter of how we can work with them to change the conditions that make their kids think it is exciting to go and chase policemen. So we are looking at community development projects as well, and on a broader scale.

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

**Membership**

Mr S.G. Evans substituted for Mr S.J. Baker.

**Additional Departmental Adviser:**

Mr L. Powell, Commissioner for the Ageing.

**The Hon. D.J. Hopgood:** We tabled our strategies document, Family and Community Services, last year, and the Committee may be interested in this. It is available to all members of the Committee.

**Mr OSWALD:** Where have the geriatric assessment teams been established in country areas, and how successfuly are they operating?

**Mr Powell:** The Commonwealth provides funding for 17 geriatric assessment teams. From memory, the country locations are Whyalla, Mount Gambier, the Murray Mallee, centred in Murray Bridge, and the Eyre Peninsula. I would have to take on notice the location of the other geriatric assessment teams.

As to their effectiveness, the report that I have from agencies working in country areas is that the rural teams appear to work in a closer, more co-ordinated fashion than do the metropolitan teams, where they are collocated with domiciliary care services. The country teams bring together service providers, GPs and paramedical personnel in a closer working relationship than in the city. All the reports I have are that the effectiveness in the country is extensive.

**Mr OSWALD:** Will nursing homes in South Australia be exempt from the proposed legislation relating to the licensing of supported residential facilities?

**Mr Powell:** Yes. The working party that has been preparing the draft legislation for the licensing of supported residential facilities has had discussions with the industry bodies representing nursing homes, both private and not-for-profit, and the Commonwealth. At the moment the recommendation to the Government will be that those facil-

ities—nursing homes and hostels—that are covered by Commonwealth outcomes standards (monitoring) should be exempt from the proposed legislation.

**Mr OSWALD:** How many seniors cards have been issued? What is the estimate of the cost of the seniors card for 1991-92?

**The Hon. D.J. Hopgood:** We will take that question on notice. We may be able to give that information later in the evening rather than waiting until next week.

**Mr HAMILTON:** The department, as part of its social justice allocation for the students at risk with social behavioural problems program, received $200 000 and 10 positions. With the restructuring of the department, how will these positions and this money be targeted to the designated program?

**Ms Vardon:** There has been some concern that with our restructuring this $200 000 will be lost. The $200 000 was allocated to special social workers who worked with the schools. The roles that they performed will be undertaken by the youth teams, and we anticipate an overall increase in the amount for that program.

**Mr HAMILTON:** The Program Estimates (page 62) under '1991-92 Specific Targets and Objectives' states:

> An analysis will be undertaken of methods of intervention in cases of child abuse in the Aboriginal community.

Can the Minister enlarge on this program? How large is this problem? What methods will be used in this intervention program that is proposed under these objectives?

**Ms Vardon:** We have partly answered the question, but probably not totally. We cannot say exactly how big is the Aboriginal child abuse problem. We do not know whether it is the same as or different from that in other populations, but I have talked before about the study done on the Pitjantjatjara lands, which gave us a lot of information about the nature of abuse.

Aboriginal people perceive the abuse not as isolated within their own communities but as having been compounded by the external systems that have been part of their lives. Inevitably, to resolve child abuse in their communities we have to address also institutional abuse. Aboriginal family care projects around South Australia have been very successful in reducing abuse, and we hope to get some strategies from the Aboriginal conference on child protection that will be held in Adelaide in two weeks. We plan to have a major strategy developed in about a month as to how to tackle abuse in the community, but nobody knows the extent of it.

**Mr HAMILTON:** Under '1991-92 Specific Targets and Objectives' it further states:

> A policy on family violence will be developed in conjunction with the domestic violence preventative unit.

Can the Minister elaborate on what is intended in this area?

**Ms Vardon:** There has been an interesting division in family violence policy in South Australia, much of which is ideological. There are people who advocate specially identified child protection programs, and there are people who advocate domestic violence programs. They see the aetiology of the violence associated with adults and children as being somewhat different and we have to pay attention by keeping them separate.

It has been a concern to us that by keeping them separate we are not addressing what is happening in families. So we have to keep them together, while allowing the ideologues to maintain a separate interest. We identify and highlight violence in families and achieve a program to bring peace in families. That is easier said than done, but the elements of the program are to bring together core child protection and domestic violence issues and try to look at a new way of helping families as a whole, because while some families abuse only children and some abuse only adults, in many families violence affects both adults and children. So we want to look at peace and conflict resolution in families as a general principle.

**Mr HAMILTON:** What research has been carried out in recent years as to violence perpetrated on adults who then perpetrate that violence on children? How profound is that problem?

**The Hon. D.J. Hopgood:** It is certainly true to say in respect of child abuse areas that abusers are often the people who have been abused themselves in childhood, and that relates to sexual abuse as well as physical abuse. As to specific research, I will have to ask the CEO to comment.

**Ms Vardon:** The Minister has answered the question. As there is much research available, I am happy to give examples of it. No-one knows why some people who are abused are peaceful and others carry it through.

**Mrs KOTZ:** I refer to page 33 of the Program Estimates. The Commissioner for the Ageing provides an Ageline, which is an excellent litmus test of issues and concerns for the ageing community. Have there been any significant changes in issues raised over the past financial year compared with the previous year and are there any other new matters raised which are worthy of comment?

**The Hon. D.J. Hopgood:** Perhaps I will give some broad figures without getting into too much detail. I am advised that it has not changed much. The emphasis on various issues remains with accommodation, which tends to be the big one, and about 16.7 per cent of calls relate to accommodation, although services generally (we could break that down into smaller categories if we wanted to) comprise another 15 per cent, legal matters make up 10.6 per cent, financial 8.7 per cent and then we get into areas like pensions, benefits and concessions.

The reason these matters do not show up more is that the Commonwealth has the Department for Social Security. People understand how it operates and go directly to it if they have complaints. Those figures are similar to what I could have given the Committee 12 months ago. There does not appear to have been any particular shift. I will ask the Commissioner to comment on any new matters.

**Mr Powell:** The new matters that come to the Ageline often relate to new budget initiatives at Commonwealth or State level; for example, with last year's Federal budget announcement about deeming rates for pensioner incomes we had a significant increase or blip in inquiries about deeming and Ageline followed that up with financial institutions to monitor what products were being offered to pensioners.

There was a rapid change in the type of products and the extent of products being offered by banks, building societies and so on. It is that kind of *ad hoc* response that tends to produce special issues from time to time. Similarly, last year's Federal budget contained initiatives on pharmaceutical benefits requiring older people to pay a nominal sum for their pharmaceuticals and that also generated inquiries. During the year there have not been any ongoing new areas of demand, other than those mentioned by the Minister. I can provide a much more detailed breakdown of the nature of inquiries and the relative distribution.

**Mrs KOTZ:** That would be appreciated. At the end of page 33 of the Program Estimates reference is made to an allowance for the anticipated national wage increase of 2.5 per cent. However, there have been significant salary increases much greater than 2.5 per cent for non-nursing personnel in the area of domiciliary care, which will have to be borne by the health units involved. Will the Minister

advise the extent of increases in this area for the 1991-92 year and indicate whether adjustments have been made in budget estimates in 1991-92 to take into account the increases greater than 2.5 per cent?

**The Hon. D.J. Hopgood:** I can do nothing more than report on what I said at the commencement of examination of the health estimates at the beginning of the day. We have an inflationary component of the level indicated by the honourable member written into the global budget for the Health Commission. Over and above that, any award increases will have to be absorbed by the whole system and, for the most part, the way in which we operate that is to work out the budgets of the units and say, 'You are going to have to absorb that.' At this stage it is almost impossible to estimate exactly what that will entail.

On the other side, as I reported to the Committee this morning, the recurrent expenditure for the commission has increased in real terms in this budget so we have some capacity to absorb some of those things provided there is not a significant blowout in activity of the kind that will impinge on the budget. That is about as specific as we can be at this stage.

**Mrs KOTZ:** I refer to page 28 of the Program Estimates. If the Commonwealth Government moves progressively to provide untied grants for aged care, what guarantee will the State Government give to quarantine these funds for the correct purposes?

**The Hon. D.J. Hopgood:** Probably we will be required by the Commonwealth to do that if it moves to that area. Our problem as a Government—and I speak now not so much in the narrow portfolio sense as a Minister of Cabinet but as Deputy Premier—is that once we move from a tied grant area into financial assistance grants (FAGS), with tags or without tags, there is a sense in which the Commonwealth no longer quite owns that program in the sense that it once did. The traditional political audit or pressures that can be brought to bear on the Commonwealth to maintain its effort in that area tend to disappear and the problem the States then have is what guarantee there is that the same amount of money will automatically flow two or three years down the track to us through the FAGS system, through the normal taxation reimbursement system.

That is precisely what the States and the Commonwealth are grappling with right now. We are convinced of the sincerity of the Prime Minister's indication more than 12 months ago that he sincerely wants to rationalise in this area, having the Commonwealth doing more and the States doing more in this area but both doing less, but the States are understandably nervous about how the financial guarantees will be tied down.

**The CHAIRMAN:** As to the Retirement Villages Act and related legislation, I understand that there may be some review of that legislation at the moment and I am interested to see whether it relates to areas of ongoing management in villages, perhaps more than the initial questions that the Act initially picked up of the establishment, purchase and sale of units and the like, which was obviously the first area of attack.

There seem to be problems emerging now where conditions change from when residents first move into villages. The example I have had brought to my attention lately is one where, for example, there was a resident caretaker at the time of the opening of the village but now the management has discontinued that facility of a resident caretaker.

Weekly maintenance fees are set at one level when the village opens but at another level some years down the track when the village has been operating for a while and residents are clearly locked in. While these things can be done without any dishonest intent, because of changing circumstances to which management feels it has to respond, it is obviously the case that aged residents in these villages need certainty of tenure and conditions more than anything else—it is their most overriding concern. Would any amendments address the kinds of ongoing management problems to which I have alluded and what is the time line envisaged for it?

**The Hon. D.J. Hopgood:** The Commissioner and his people are working very hard on this legislation. You, Mr Chairman, may be aware of the discussion paper put out almost a year ago. The commission has been busy collating responses to that discussion paper. There are some controversial things in it, and there is a sense of feeling that nothing is easy in this area, the easy things having already been done. The legislation that looked at the caveat emptor is out of the way.

The sorts of issues that have been brought to our attention are such things as concerns about advertising material and presale undertakings given or understood to be given to prospective residents by the retiring village sales staff; poor communication between administering authorities and residents in some retirement villages; the absence, in some villages, of any mechanism for residents to exercise a role in the management of their community; the limited access available to residents of some villages to information, especially financial information about the management of funds which they have paid to the administering authority either as a loan or as recurrent maintenance fees; and concern about the role of trustees in some villages.

In addition, we have the matter to which you, Mr Chairman, have referred. Some of these matters can be easily tied up with respect to a village which opens following the passage of the legislation. If some of these matters are to be addressed with respect to existing villages by the legislation, there would have to be an element of retrospectivity in the legislation. I look forward to the enthusiasm with which members might want to approach the task, given that people are always a little nervous about some aspects of retrospectivity. I ask the Commissioner to give some indication of when we might be in a position of having something close to a simple Bill.

**Mr Powell:** My office has been convening a consulting group of residents, industry and regulatory interests following the release of last year's discussion paper. That group has now almost completed its work and will be submitting firm proposals to the Government possibly within the next six weeks to two months.

**Mr McKEE:** I refer to award restructuring. It was stated that by 1 October full implementation of award restructuring may be done. How is it proceeding and will it be achieved by 1 October?

**The Hon. D.J. Hopgood:** My officers are counting the days. They say that they will take a day off after 1 October and will be pleased to have it out of the way.

**Ms Vardon:** For the bulk of the department the award restructuring will be done, except for residential care and some other small units. The residential care people are being reviewed at the moment. We need to reshape the way that they deliver their services and need to get rid of a few lines of hierarchy and reshape their jobs. Until we finish the final reshaping of all residential care jobs, we will not be finished. We are 90 per cent finished along the hard track of award restructuring. We look forward to being finished by the end of this year.

**Mr OSWALD:** By the year 2000 one in four elderly people will be from non-English speaking backgrounds. What programs exist to train culturally and linguistically appropriate staff, and what programs does the Government have

to ensure more effective liaison and coordination with ethno-specific welfare agencies.

**Mr Powell:** To take the second part of the question first, the expansion of ethno-specific services for older people from non-English speaking backgrounds over the past five or six years has been quite extensive. In the nursing home area we have about seven nursing homes for specific ethnic groups. Similarly we have 12 hostels for ethno-specific groups. I will provide details for the honourable member on which groups are serviced by those facilities. There has also been a significant expansion of community based services, some funded through the HACC program for specific groups in which South Australia has taken a lead on the design of programs to meet those needs. The kind of program I have in mind is the ethnic link project, which assists older people from non-English speaking backgrounds to gain access to mainstream services through the provision of advocates and people to facilitate the connections.

We have the multicultural respite care program operating in the western suburbs under the aegis of Western Domiciliary Care, which provides respite services to people of non-English speaking backgrounds. We are about to launch a specific respite care program for people of multicultural background with dementia. The expansion of programs in all these areas to service the needs of non-English speaking backgrounds is well under way. They rely heavily on volunteer input, and many of the communities have shown a great deal of enthusiasm in picking up this challenge. There remains a problem in the hostel area with shortfalls between the funding provided to community groups by the Commonwealth Government for establishing hostels and the balance which community groups—in this case ethnic community groups—have to raise to get to the point of being able to start construction. We are aware of about six groups which have received a commitment of Commonwealth funding, but we are having a great deal of difficulty making up the balance to be able to start construction.

**Mr OSWALD:** What programs exist to train culturally linguistically appropriate staff?

**Mr Powell:** Programs are offered through the Office of Multicultural and Ethnic Affairs by way of cultural awareness training programs. The community based programs I have mentioned offer training to volunteers and other staff. In the nursing homes and hostels some of the ethnic communities have picked up the challenge of teaching basic language skills to Anglo-Australian staff working in those facilities, so that there is at least a basic level of communication on simple day to day phrases that Anglo-Australian staff can use in communicating with the ethnic residents. That is a good example of how communities have picked up the challenge and are actively involved in the administration of facilities for their older community members.

**Mr OSWALD:** Should the Government be more involved in classes for recently arrived non-English speaking elderly residents, or should we leave it to their own groups to take part in the training? Should there be greater Government input into classes for these people?

**The Hon. D.J. Hopgood:** I draw the parallel with the ethnic schools funded by the Minister of Education which tend to be run by the communities themselves, often on church properties on Saturday mornings and Sunday afternoons. I think they have provided a very effective program, and it is probably better that, wherever possible, the carriage of the program be in the hands of the multicultural group with the Government providing whatever sustenance is needed to make the program effective. That may not always be possible, in which case the Government may have to go to that next step. However, where it is possible, that is the way we should go.

**Mr OSWALD:** There are particular difficulties for aged persons who seek podiatary services in the northern suburbs. What plans does the Government have to rectify this problem?

**The Hon. D.J. Hopgood:** I will have to check with the Health Commission about that matter. I will take that question on notice and make sure the information is provided to the Committee.

**Mr OSWALD:** What developments have taken place in the provision of HACC transport services to the ethnic frail aged in the financial year just passed, and what provision has been made for the current financial year?

**Mr Leahy:** The HACC program has provided funds for a number of transport services, many of which are run by local government. We see it as the main carrier in respect of the local transport needs of frail aged people. Of course, people from ethnic backgrounds tend to do business outside those areas, and for that reason a number of years ago we funded a bus sponsored by the Ethnic Communities Council that was designed to provide transport for ethnic groups.

The bus is available on a very low contribution basis. Ethnic groups are required to provide their own driver, but the bus is available seven days a week. We make a small grant on a recurrent basis towards the operating cost of the bus and towards the cost of a person to coordinate the bookings and maintain the bus. It tends to be used mainly in the metropolitan area, and particularly in the western suburbs. A number of other small ethnic groups have received support from the HACC program for their own transport; for example, the Italian community in the east recently received assistance from us for a bus service which they use to transport frail aged people of Italian background to day programs.

**Mrs KOTZ:** I refer to page 29 of the Program Estimates. I think the Minister is probably aware of my interest in this specific area, but my question relates to the number of hospice beds in metropolitan Adelaide. Is the hospice movement currently coping with the demands for its services?

**The Hon. D.J. Hopgood:** If we had more beds they would almost certainly be filled, and as knowledge of the palliative care philosophy spreads we can expect greater demand. A couple of questions were asked this morning about difficulties that one GP had in referring one of his patients to the Daw Park hospice. No questions were raised in relation to the northern suburbs, although, as the honourable member would know, there is less provision at this stage in that area because of the relative youth of those programs. Almost certainly, in the next couple of budgets, we will be looking towards increasing the number of palliative care beds that are available in the northern suburbs. At this stage we are not overrun by demand, but perhaps not everyone understands that these services are available.

**Mrs KOTZ:** Under the program title 'Services for the aged and disabled' on page 33 of the Program Estimates, reference is made to the sharp increase in demand for home delivered and community-based services for the aged. The table indicates an increase in the number of client contacts by 18 domiciliary care services from 539 000 in 1988-89 to an estimated 715 000 in 1991-92. That represents a sharp increase of over 21 p c in just three years.

Page 28 of the Program Estimates indicates that the recurrent expenditure on domiciliary care services for 1990-91 was $24.2 million, which is $3.2 million over the budgeted figure of $21 million. However, there is no budget estimate in the Program Estimates for domiciliary care services for 1991-92 because of a change in presentation. Will the Min-

ister provide a comparable figure for domiciliary care services for 1991-92, and will he give the reasons for the overrun in domiciliary care services for 1990-91?

**The Hon. D.J. Hopgood:** We will obtain the specific figure requested by the honourable member from the officers of the Health Commission. The overrun is fairly easy to understand. There is a large movement towards out-of-hospital care, rehabilitation and convalescence. This movement is being actively encouraged by both Federal and State Governments as they seek to have more same day surgery and shorter stays in hospital, all of which means that the convalescent phase that used to occur in an acute bed hospital tends to occur outside that hospital, perhaps in some other sort of health unit but more likely at home with support.

To get the true picture we need to look at Royal District Nursing Society services as well as domiciliary care. The RDNS has considerably modified and streamlined its service provision in the past couple of years, and I think it is very productive indeed, as is domiciliary care. So, this increasing demand will continue, partly driven by the deliberate policy of governments to try to ensure that acute hospitals are for acute patients. The honourable member would probably be aware of one of the occasional papers brought down under the Macklin report to Brian Howe which indicated that, although the number of customers of public hospitals would increase between now and the end of the century, demand for acute beds would decline because of the increase in same day surgery, shorter stays in hospital and people recovering at home supported by these sorts of services. So, that demand will continue, and one could imagine a similar sort of increase in the next budget. However, we will obtain the specific figures for the honourable member.

**Mrs KOTZ:** Will the Minister provide a breakdown of the money spent on home support and rehabilitation services refered to on page 28 of the Program Estimates?

**The Hon. D.J. Hopgood:** Yes.

**Mr OSWALD:** What is the number of hospice beds in metropolitan Adelaide, and is the hospice movement generally coping with the demand for its services?

**The Hon. D.J. Hopgood:** That question was answered in part this morning, but I will provide the following details: there are six beds at Modbury, six at Lyell McEwin, 10 at the Philip Kennedy Centre, 15 at Daw House, and 17 at Mary Potter, making a total of 54 beds. There are also palliative care teams in the eastern, northern and western regions, and there is the southern community hospice team. Finally, I should mention that, although I am not in a position to give a lot of detail and although it is not strictly relevant to the budget, there is at least one private hospice agency operating in South Australia.

**Mr OSWALD:** What is the present status of the HACC program? What recommendations have been made regarding the program in South Australia as a result of recent consultations about HACC with aged care providers?

**The Hon. D.J. Hopgood:** Of course, this all relates to the exercise that was announced by the Commonwealth 12 months ago, and to which I have already referred. HACC is one of those programs that the Commonwealth funds through tied grants with a matching contribution having to be made by the States. We think we have had a pretty happy experience in respect of the HACC program.

I believe the unit is extremely well administered in South Australia and that we are the envy of other States for the way in which we have been able to interconnect with Commonwealth public servants to try to ensure that our priorities are not overly distorted by what the Commonwealth wants us to do. However, the honourable member will be aware that in some other States there has not been as a happy story as there might have been. There are demands in some quarters for HACC to be completely dismantled, for the money to be made available by way of a FAG—to use the acronym I mentioned earlier—and for the Commonwealth presence to be minimal, at the very best.

As part of the process, we have had a number of public meetings to test the water so far as our people—the consumers—are concerned. At the meeting I attended at Way Hall the message came through loud and clear that the consumers want HACC in something like its present form.

The State's position has to be partly informed by that, because that is what the people want. So, we have to justify moving away from it, if that is what we want to do. The other concern of central Government agencies is that, despite what I said earlier, moving to tax reimbursement grants may not be as disadvantageous as some people think, because there is some built-in advantage to South Australia because of the Grants Commission aspect of the whole thing—the fact that the Commonwealth Grants Commission looks at our lower taxation base and the fact that it means we should continue to do at least marginally better than a per capita grant would suggest. That has to be balanced against some of my fears about where we might go if the tied grant situation is lost and the Commonwealth loses its enthusiasm for moving in these areas at all.

There are two further aspects of the whole issue. First, the Ministers who are responsible for these programs got together. There is very little agreement between the States as to where it should go. It is quite clear that the Commonwealth Minister is committed to maintaining the program in something like its present form. However, none of the Ministers was in a position to commit their jurisdiction to a funding arrangement for the whole thing. So, it has been very much left to the Premiers, Treasurers and the Prime Minister and the Federal Treasurer to sort it out in November. My advice to the State Government has been that, whatever the financial arrangements might end up being, we cannot ignore what the consumers are telling us about their experience in respect of what they see as a very successful program. Their only concern is that they would like a little bit more of it. Mr Leahy may like to comment further.

**Mr Leahy:** I think that the Minister has summarised the situation. Consumer comments really have not changed. There has been some criticism of some of the complexities of the HACC program, and I think there is no doubt that it is one of the most complex inter-Government relationships that has been available. But, as the Minister indicated, for various reasons it has been more successful in this State. I think the consumers have seen its advantages and the outcomes for them have actually been valued. There has not been the same degree of tension in this State between Government departments and Government sectors, for example.

The Minister previously referred to the situation in Victoria, where there is basically an impasse between the whole local government sector, which provides the bulk of home care services, and the State and Commonwealth Governments. The impasse has been problematical and it has affected the service quality and the type of service for consumers. I think the consumers and a number of service providers here have seen the value in the service and have, in the series of four meetings that we have had, expressed concern in respect of maintaining the achievements of the program, particularly from the consumers' point of view in terms of user rights, which the program had been quite strong in promoting.

Further, there was concern in respect of involvement of consumers in areas where they have not had experience, for example, in working with service providers and how services should be provided in the sense of making them flexible and ensuring that they are better able to meet their needs rather than accepting the traditional services provided. Those consumers have expressed those concerns and they would like some reform of the complexities but, basically, they want to maintain the achievements and the supply of services to meet demands in the future.

**Mrs KOTZ:** I refer to page 55 of the Program Estimates. Under the heading 'Issues/Trends' reference is made to the increasing numbers of aged and 'old-old' people in the community as well as an increasing number of trauma-damaged young people, placing increased demands on service providers. We all recognise that South Australia has an increasing number of aged people who have to be catered for in a range of many different areas. On page 33 of the Program Estimates, the performance indicator states that the occupied bed days in Government nursing homes in 1987-88 was 212 619; for 1990-91, that figure reduced to 174 368; and the estimated occupied bed days for 1991-92 is 163 000. There is obviously a concern with respect to domiciliary care and the RDNS, which the Minister referred to a moment ago in answer to another question, that the current status of those associations appears to be that they are not coping with the present level of demand on their services. I believe that in the past year they have had to prioritise some of their needs to cater for the over-demand that has been placed on those services.

Under the 'Issues/Trends' heading (page 33) it is stated:

> There is growing urgency to provide a range of home support and community-based care options in addition to current numbers of institutional beds. This requires a comprehensive and well-coordinated network of support services.

If the bed days in Government nursing homes have been reduced to the degree that the expectation is far less again in 1991-92—and there is concern about the existing support services—can the Government give a guarantee that the statement made under 'Issues/Trends' to support the need in the community will, in fact, be achieved?

**The Hon. D.J. Hopgood:** I think we can. First, there has been a degree of deinstitutionalisation which places further pressures on services such as RDNS and domiciliary care, but that is recognised. It is part of a commitment which occurs at Commonwealth and State level and which is seen as a more humane and cost-effective way of delivering services than has occurred in the past. Looking at our own services, I am not aware that RDNS has closed any rounds recently. It had some problems over a year ago. It was given additional funds over and above the budget that had been brought down for that particular year, and it is probably managing demand in a way that it was not managing it at that time.

It is not so much a question of a reluctant Government having to wake up to itself and provide more money to these services because, as it were, people are voting with their feet or on the flat of their backs: it is rather a Government driven thing. It is the Government saying that it much prefers to support these people in these low cost and friendlier environments (because for the most part they are home based) than in the acute hospitals. We understand that we have a real requirement upon ourselves to perform in this area to ensure that what is now agreed as virtually a national agenda will be successful and do what it claims it wants to do.

**Mr OSWALD:** That concludes our questions. I thank the Minister and staff of the department for their cooperation during this afternoon's sitting.

**The Hon. D.J. Hopgood:** We will get replies to the questions that we took on notice to the Committee as soon as possible.

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Works and Services—Department of Family and Community Services, $1 742 000.

**The CHAIRMAN:** I note that the new juvenile secure detention facility at Cavan, at a cost of $11 million, is to be commenced in November 1991. The Minister will be aware that a committee of the House is considering juvenile justice matters. It would appear on the surface that the commitment of this amount for this kind of facility would to some degree pre-empt the nature of policy decisions that would be made in future. This centre is predicated on existing assumptions. To what extent is that assumption true, and to what degree does the Minister think it is desirable for the select committee to examine this project prior to a final commitment being made for its construction?

**The Hon. D.J. Hopgood:** First, I would not presume to preclude anything from the examination of the select committee. If the select committee wants to look in some detail at this, my people will cooperate in providing whatever information the committee needs for a proper examination. To put it fairly crudely, if the select committee is to be considering how many youngsters we lock up, I do not know that that necessarily impacts on this project. This project reflects an indication of the appropriate size of a detention centre. If, as a result of the select committee and changes to the law, juvenile justice and so on, we finish up locking up twice as many youngsters, I do not think it follows that we make this facility twice as big. The advice to me might be that we had better build another facility elsewhere. As Anne Howe has done a lot of work on, and thinking about, this matter, I will invite her to address that question.

**Ms Howe:** Two facilities are planned. The first which was referred to is a replacement facility in Enfield that has capacity for 36 children. The two facilities all up have a capacity for 72 children, and on average that is 30 greater than we have experienced in secure care in the last few years. Without pre-empting what the select committee might be talking about, I point out that there is capacity there and we think it is a comfortable capacity given what we know about trends in the past and potential trends for the future.

**The Hon. D.J. Hopgood:** Perhaps I might add something from personal experience. Most experience is that there is very little demand for custodial sentences for girls, and this is reflected in our present practices. On my most recent visit to our detention centre for girls, I noticed that there were two inmates. There was more happening there, because very young children are also involved. As has been indicated, there is considerable capacity in our plans so that, even if we finished up putting much greater stress on custodial sentences, there would be some capacity in the present or in the planned system to cope. However, one could not rule out the possibility of a further detention centre at some stage down the track.

**The CHAIRMAN:** There being no further questions, I declare the examination of the vote completed. I thank the Minister and his officers for their cooperation during the day.

## ADJOURNMENT

At 8.27 p.m. the Committee adjourned until Thursday 19 September at 11 a.m.