HOUSE OF ASSEMBLY

Wednesday 23 September 1992

ESTIMATES COMMITTEE A

Chairman:
Mr K.C. Hamilton

Members:
Dr M.H. Armitage
Mrs C.F. Hutchison
Mrs D.C. Kotz
Mr C.D.T. McKee
Mr J.K.G. Oswald
Mr J.A. Quirke

The Committee met at 11 a.m.

The CHAIRMAN: 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 must be supplied no later than Friday 9 October to the Clerk of the House of Assembly. A flexible approach will be adopted in giving the call for asking questions, based on about three questions per member from alternating sides. Members may also be allowed to ask a brief supplementary question to conclude the line of questioning before switching to the next member. Subject to the convenience of the Committee, a member who is outside the Committee and desires to ask a question will be permitted to ask that question once a line of questioning on an item has been exhausted by the Committee. Indications in advance to the Chairman are necessary.

I remind members of the suspension of Standing Orders that allows for Estimates Committees to ask for explanations on matters relating to Estimates of Receipts and the administration of any statutory authorities. Questions must be based on lines of expenditure and revenue as revealed in the Estimates of Payments and the Estimates of Receipts. Reference may be made to other documents, for example, Program Estimates, the Auditor-General's Report, and so on. Questions are to be directed to the Minister and not to the advisers, but Ministers may refer questions to advisers for a response. I understand that an agenda has been agreed.

South Australian Health Commission,
$789 100 000

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

Departmental Advisers:
Dr D. Blaikie, Chairman, South Australian Health Commission.

Dr D. Filby, Executive Director, Planning and Executive Services Division.

Mr P. Davidge, Executive Director, Finance and Information Division.

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

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

Mr C. Johnson, Executive Director, Community Services Division.

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

The CHAIRMAN: I declare the proposed payments open for examination. Before calling upon members to ask questions, does the Minister wish to make an opening statement?

The Hon. D.J. Hopgood: It has been traditional that the Minister says a few words by way of perhaps assisting the Committee in the shape and presentation of the Estimates. I draw the Committee's attention to changes in the presentation of information that have occurred since last year, and I will outline the reasons for these changes. I know that traditionally the Committee has had problems in reconciling what is in the various documents that are placed before it.

In the first instance the South Australian Health Commission, with the approval of the Treasurer, has changed the program structures for external reporting purposes. The revised structures appear in the Program Estimates and the blue book and will also be used for reporting in the commission's annual financial statements. The new programs reflect more closely the manner in which the health system is managed and should provide an improved basis for reporting to Parliament. Secondly, the commission has significantly simplified the format of the blue book, which provides supplementary information to the Committee on commission activities. The blue book is presented using the new program structures, which supersede the health services category information previously reported upon and better reflects the new net funding arrangements, particularly at the health unit level.

Returning to the Estimates, the commission's net draw from the State budget for 1992-93 will be $789.1 million, an increase of $15 million on last year. This represents a small reduction of 0.5 per cent in real terms (rather than the 1.4 per cent reduction reported earlier in the budget process), after taking into account additional funding for the increased superannuation guarantee levy. The reduction in the net draw, however, represents the combined effect of payments less revenue. Revenue is expected to increase in real terms by 3.2 per cent primarily due to increased Commonwealth funding and sales of land and buildings. Payments both recurrent and capital, will increase by $63.2 million or 2.5 per cent in real terms; a substantial increase despite the difficult budgetary situation facing the State. Total recurrent expenditure is estimated to increase by $41 million, an absolute increase of 3.2 per cent or 0.8 per cent in real terms.

Included in this estimate is funding for a number of high priority initiatives involving rehabilitation services in the western suburbs, child protection and child development services and a new inner West Community Health Service to service the local government areas of Thebarton, Hindmarsh and parts of West Torrens. The Noarlunga Hospital will also receive additional funding

for extra beds and the day surgery unit opened during 1991-92, and there is increased Commonwealth funding for booking lists and highly specialised drugs. In line with other Government agencies the health system will be expected to absorb award increases and any inflation on goods and services above the 1 per cent provided. The impact of these cost pressures in 1992-93 is expected to be less than the direct funding reductions of $20.3 million already advised to health units.

The Committee should also note that the Central Office of the commission has been set an overall savings target of $1 million, on top of the $1.5 million reduction achieved in 1991-92. While considering the budgetary pressures that health units may face during the year, it is worthwhile reflecting on achievements during 1991-92. The Health Commission balanced its budget and carried forward $12.6 million for use in 1992-93. Of this amount, $7.1 million will be available to meet savings requirements and cost pressures during the year. Individual health units were able to implement significant productivity improvements, which will continue in 1992-93. Despite the budget pressures in 1991-92 the number of hospital admissions increased and more elective surgery procedures were performed at the five major metropolitan hospitals.

Finally, I refer to the capital works program of $57.7 million, which is an increase of $22.3 million over 1991-92. The program compares favourably with expenditures during the late 1980s and early 1990s (average of $48.8 million) and includes the following major projects: $14.2 million for the Women's and Children's Hospital, which is the largest hospital project undertaken in the State since the Flinders Medical Centre; and $4 million for the new Gawler Hospital.

This project will provide the people of Gawler with a high standard and efficiently planned facility on a new site to replace the existing Hutchinson Hospital, which is outmoded and deficient in many aspects. I might add, for the benefit of the Committee, that the new hospital is now planned as an 86 bed facility (56 public, 30 private) not a 70 bed, as printed on pages 10 and 43 of Financial Information Paper No. 3, Capital Works Program 1992-93. Three other projects are: a $6.2 million for Mental Health Services; $2.9 million for redevelopment of the Port Augusta and Port Lincoln hospitals; and $10.6 million for medical equipment and computer projects.

I think that should suffice by way of general introduction, and I leave the Committee to seek more detailed information in areas of its particular interest. My procedure in the past, while taking full responsibility for policy matters, has been to allow my officers to have plenty of interaction with the Committee on matters of fact. We look forward to an informative and lively day and also to the results of the member for Adelaide's circular of 18 September.

Dr ARMITAGE: I have a number of questions, as a result of the circular of 18 September. I refer to the Program Estimates (page 31), 'Development and control of health services'. On 13 August 1992 the Chairman of the South Australian Health Commission circulated an internal Health Commission memorandum, attaching a document which he proposed to be the Health Commission's response to the green paper on area health service administration in South Australia, about which the Minister has made a media release today. The document states on page 2:

> The Health Commission acknowledges that the specific proposals outlined in the discussion paper are not supported . . . and recommends they not be pursued.

It goes on to say:

> The commission is firmly of the opinion, however, that the current system is unwieldy and that structural reform is a matter of priority.

For how long has the South Australian Health Commission been of the opinion that the system is unwieldy and that structural reform is a matter of priority (I can only assume that it is at least a year since the release of the green paper mark I); why have the Health Commission and the Minister not taken urgent action to reform the system prior to now; and what inefficiencies have been caused by this recognised unwieldiness?

The Hon. D.J. Hopgood: The South Australian Health Commission coordinates health service delivery, which is provided by about 200 bodies, all of which are separate employers. This has long been recognised. It has long been recognised that there was scope for efficiencies in reining in a system that was as decentralised as that. So, the green paper was an attempt to address that matter. In the process, what the green paper put forward, which is not supported, really implied that the boards of hospitals would be done away with, that, at Maitland or somewhere, one would no longer have a board at one's hospital. After extensive consultation, that has been seen as something that has so little support that there is little point in proceeding with it. However, what seems to be reasonably supported is a system whereby, notwithstanding that the boards of hospitals will continue and there will be valuable local input, nonetheless, the number of employers in the system can be considerably simplified and reduced, particularly to a regional health model. So, that is the work that is being done.

As for the time it has taken, change in a system as large and decentralised as this, where there are so many conflicting interests, is always difficult. It is one on which we consult because, if we do not, almost certainly the honourable member's next question and the next question of every member of this Committee and perhaps of the Parliament would be, 'Why did the Government not consult before moving in these areas?' So, what we have tried to do is to get a balance between, on the one hand, giving a lead in these matters and, at the same time, giving the very large number of people in the system and without an opportunity to have their say.

Dr ARMITAGE: What inefficiencies have been caused by the unwieldiness?

The Hon. D.J. Hopgood: It is very difficult to point to anything specific, except to say that almost certainly we could have saved some money if in fact we had taken some of the more drastic actions which are not supported around the system. Maybe there should be only one pay clerk for all the 25 000 people in the system. I am sure that would be resisted by the boards of the major teaching hospitals, and there has always got to be some trade-off between what can be reasonably supported, given that health administration, like politics, is the art of the possible and, on the other hand, what we are going to save money on. I guess some of these realities have been there for a long time, but it has been only as we have moved through the 1980s and budgets have become more

constrained that these things have been seen as a priority over some of the other things that might have been seen as a higher priority in those earlier days when cash seemed to be easier to get hold of.

Dr ARMITAGE: Given that the Minister just said that there has long been recognised scope for efficiencies in the system, why has he condoned cuts to the provision of services in the health system when these problems have been identified previously but no action has been taken? I guess the corollary of that is, will the Minister guarantee funds to the health units so that cuts to service provision will not have to occur whilst these structural reforms which his advisers have identified to him are rectified?

The Hon. D.J. Hopgood: First of all, let us remember again that the way the system is organised at present, the basic and one of the few powers that the Minister and the Chairman of the commission have available to them is the power of the purse. I have not condoned, and I have certainly not required, cuts to service provision. I think I have put before this Committee an indication that it is very difficult to establish that there were cuts to service provision in the past 12 months, given the level of activity that actually occurred in the system. What we have said to the units is, 'This is your budget; this is what you have got to live within,' and obviously the units will try, wherever possible, to go for structural and administrative reform to ensure that there are no cuts in service provision. That is their task. A different system, a regional system, might make it a little easier for all of us to ensure that that process continues, but it will always be somewhat of a dilemma.

Dr ARMITAGE: My second question is related to the Program Estimates (page 34) regarding the implementation of efficiency reviews at the Women's and Children's Hospital, ACH campus. Will the Minister confirm that discussions have taken place between the Women's and Children's Hospital, ACH campus, the unions and a contract management firm which have identified savings of between $500 000 and $600 000 in addition to those already identified by Booz Allen and Hamilton and the GARG reviews by offering for competitive tender the management of the cleaning services? Why has the Government not enthusiastically embraced this potential saving, and will the Minister guarantee that hospital budget cuts will be restored until such identified savings are made as a matter of urgency?

The Hon. D.J. Hopgood: The budget will, of course, remain in its present form, subject to the will of the Parliament. I would like Ray Blight, who is our Executive Director of Metropolitan Health Services, to comment specifically on the matter of the Women's and Children's Hospital but, before he does so, I point out to the Committee that a number of initiatives have already been taken in the area of cleaning; in particular, the major improvement has been a saving in labour costs in the year 1991-92 of about $1.7 million. The primary results to be achieved in 1992-93 are as follows: health units to reduce cleaning costs by a further $2 million, and all health units to achieve a cleaning standard of 750 square metres per full-time equivalent employee. Housekeeping staff in health units have reduced by 128 FTEs in the 12 months to 30 June 1992. I ask Ray Blight to explain what is in prospect at the Women's and Children's Hospital, but I think the Committee will realise from those figures that the commission and its units have hardly been still on this matter.

Mr Blight: Despite the very considerable gains in cleaning service improvements, senior management at the Women's and Children's Hospital is of the view that there is further potential within the Adelaide Children's Hospital campus to achieve further savings in the cleaning services. In support of that, they have invoked a practice in recent times of not filling on a permanent basis any vacancies that have arisen in the cleaning work force. In terms of achieving those savings, they have looked at the interstate experience, in particular, the use of contracting the management of cleaning services in New South Wales. From that, I understand they are of the opinion that contracting the management of this function is a sensible way to go, but there is more than one way of doing it. One way is to go completely to the private marketplace and have external managers manage a private cleaning capacity. The other way is to simply bring in the management component to manage existing employees.

I understand it is their view that the more effective of those two pathways, from interstate experience, is where internal staff have been retained and a private manager has simply been brought in. They are of the view that there are gains to be made by taking this approach, and they have discussed this approach internally and have received a proposal from the internal staff of the hospital which indicates that savings can be made. They are about to put forward a proposal to the Health Commission, and that will be given consideration in due course. At this stage, it is most likely that it will be based on internal staff resources.

Dr ARMITAGE: I would hope that 'due course' is very quick, given the savings that are identified already. I refer to page 36 of the Program Estimates, relating to Country Health Services. I have been provided with a copy of the notes of the South Australian Health Commission Country Health Services Division 16th Quarterly Liaison Meeting of Directors of Nursing held at Northgate Centre, Glenside campus, on Friday 4 September 1992. The minutes of that meeting indicate that the meeting was briefed on the budget position for the Country Health Services Division, and the minutes record the following comment:

> The upfront overall cut to the total health budget is approximately $20 million, but in real terms is closer to $30 million due to the usage of a revenue reserve held by the South Australian Health Commission which was kept for major natural disasters.

Will the Minister provide details of all revenue reserves held by the South Australian Health Commission, and will he detail all usage of those reserves by the Health Commission in framing the budget for this year?

The Hon. D.J. Hopgood: I will ask the Chairman to comment on that. My advice is that we do not have any revenue reserves.

Dr Blaikie: I do not quite understand the term 'revenue reserves'. The Health Commission, like any prudent manager, does keep some money centrally for unheralded events of some sort. I can assure the member for Adelaide that that amount of money is very little, and almost all the funds of the Health Commission have been allocated to health units or are shown in the blue book as yet to be allocated, but the Health Commission does have

a small reserve. I did not understand all the notes of those minutes. It is certainly true that budget reductions of the order of $20 million have been given to the health system, but I do not understand the rest of those minutes.

Dr ARMITAGE: I did not understand whether the Chairman does not understand the question or the minutes. The question is clear: the Country Health Services Division quarterly liaison meeting of Directors of Nursing was told that there was usage of a revenue reserve in framing the budget for this year, which made the total health budget cut approximately $30 million rather than $20 million. I want to clarify whether the Chairman does not understand the question or the minutes.

The Hon. D.J. Hopgood: I can only amplify what the Chairman has already told the Committee. He has indicated that there is a small amount of money that is held back for contingencies (using that term in the broadest sense), but it goes nowhere near the $10 million that would be necessary to reconcile the figures the honourable member is quoting. All I can say is that that meeting was given incorrect information if the minutes reflect correctly what was given to the meeting.

Dr ARMITAGE: I did ask for details of all revenue reserves to be provided.

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

Mr QUIRKE: In relation to teaching hospitals, metropolitan non-teaching hospitals and country health services, there are references to the implementation of efficiency and productivity reviews: will the Minister inform the Committee of progress towards greater efficiency in the State's hospital system?

The Hon. D.J. Hopgood: I will be reasonably brief because I could go on for some time. Perhaps what I should do is undertake to give the honourable member what fuller information we have. Briefly, we can say that hospital productivity has improved more than 8 per cent in the past five years. Same day admissions have increased by over 100 per cent over the past seven years and now make up 28 per cent of all public hospital admissions. There have been 4 000 more elective procedures in major metropolitan hospitals in the past three years. The average length of stay in our hospitals is the shortest in the country and it continues to decline.

Major efficiency reviews have been undertaken at Royal Adelaide Hospital, Queen Elizabeth Hospital, Flinders Medical Centre and, to a lesser extent, Modbury and the Women's and Children's Hospital. During 1991-92, to be a little more specific, the Health Commission took part in five reviews under the auspices of the Government Agencies Review Group. Savings of over $3 million have been found in the past year alone and include housekeeping of $1.7 million, catering $460 000, maintenance $160 000 and portering and orderlies $760 000. There is then the Booz Allen Hamilton reviews which have identified annual savings of about $12 million for a one-off cost of $4.5 million.

The objects of the review were, of course, to improve efficiency and productivity and to make organisational changes while improving the quality of care for patients. I will not go into the specific gains that have been made in the individual hospitals, but I can make that available. Finally, I will mention five very specific reviews. First, there was a review of the workshops, with potential productivity benefits of between $2.5 million and $3 million. Health unit budgets have been reduced by $500 000 in 1992-93 in this area alone and will be adjusted by a further $750 000 in 1993-94 to reflect increased productivity gains. I have already talked about cleaning services in response to a question asked by the member for Adelaide and the savings that health units were expected to make there.

There have been changes to courier services in the past financial year that will mean savings of $70 000 annually, with more to come. There has been a review of security. SACON has completed a review at four of our hospitals and we have set aside $200 000 this financial year for security initiatives; and, finally, there has been a review of vehicle use. This was finished at the end of July this calendar year and we will be considering the recommendations as soon as the working party has completed its report on the review. We have about 1 400 light passenger vehicles, which comprise 24.4 per cent of the Government fleet. The largest holders are: Domiciliary Care, 268; RDNS, 198; IDSC, 167; CAFHS, 109; and IMVS, 65. With a fleet of that size, one can see the potential for savings where modest changes in procedure can be implemented.

Mr QUIRKE: Page 34 of the Program Estimates refers to additional Commonwealth funding for booking lists. I understand that the Commonwealth proposes that these funds be targeted at people who have been on waiting lists for some time. What are the findings of the recent review of long-wait booking lists and what is the level of Commonwealth funds to be provided to South Australia?

The Hon. D.J. Hopgood: The two go together because, as I explained to the House a week or so ago during Question Time, the availability of the funds from the Commonwealth—$4.3 million for this financial year and amounting to over $7 million over the two-year period—will be contingent upon the units agreeing to operate within the recommendations of the review by Mr Ronald Hunter, an eminent Adelaide surgeon. The review found, for example, that a much better indicator of the adequacy of hospital resources was clearance time rather than the length of booking lists. However, it also went on to say that medical supervision of the review of booking lists is variable and specific medical review of patients on the list is almost totally non-existent, and it strongly recommended that those reviews should occur. The review was really saying that, while patients are generally admitted from a booking list according to medical urgency, some are forgotten and languish on the lists because there is no review of their condition, which may change in one direction or another while they are on the list.

It was also pointed out that there were considerable variations in both the numbers and waiting times for particular specialties between hospitals. For example, orthopaedics was the major problem at Royal Adelaide; ENT at Lyell McEwin and Flinders; urology at Modbury; and vascular surgery at Queen Elizabeth. Almost 40 per cent of all long-wait patients were waiting for ENT surgery, and almost a third of those were on the booking list at the Lyell McEwin Health Service. More than a third of the ENT patients at Lyell McEwin were waiting for tonsillectomies, a situation of some concern given that

Sax has previously identified tonsillectomy rates at Elizabeth, Munno Para and parts of Salisbury at 83 per cent higher than the State average.

So, Hunter recommended that non-responders, those who had deferred their surgery, those waiting for cosmetic procedures or investigations such as arthroscopy, cystoscopy and laparoscopy should be excluded from the public booking list numbers. He also recommended targeting of the booking lists where people have been waiting for more than 12 months, further expansion of day surgery, more medical review of the booking list patients and more cooperation between the various hospitals including the voluntary—and I stress that word—transfer of elected booking list patients between surgeons and hospitals, including country hospitals. So, the $4.3 million will be contingent upon hospitals being prepared to operate within those general guidelines.

Mr QUIRKE: Community Support Incorporated is referred to on page 40 of the Program Estimates. How many people are assisted by this organisation and what is the level of funding and the range of services offered?

The Hon. D.J. Hopgood: Community Support Incorporated is important beyond this specific portfolio, and there may be questions later in the area of family and community services. Approximately 3 000 people have been supported to date by Community Support Incorporated, which was a means whereby we were able to expand the $1 million applied in the budget a year or so ago by more than matching it with Commonwealth money. I will ask the Director, Colleen Johnson, to report briefly on the areas in which the funds have been spent.

Ms Johnson: The allocation for Community Support Incorporated is $3.8 million for this financial year. Those funds are available for the following services: intellectual disability, $1.7 million; autism, $64 000; brain injury, $767 000; a physical or neurological disability, $352 000; a sensory disability, $48 000; a psychiatric disability, $793 000; or a behavioural disorder, $64 000. Those moneys are utilised to provide services to assist people to participate in community activities. Typical examples of services are: holiday respite, child care, personal care, cooking, home and garden clean-up or communication activities and transport.

Mrs KOTZ: I will continue the line of questioning begun by the member for Playford regarding waiting lists. Page 43 of the Program Estimates and Information refers to the specific target to review hospital booking lists for people waiting over 12 months. I wish to put on the record two anecdotal examples as the basis for the question I wish to ask. I refer, first, to a patient from Murray Bridge who, because of medical problems, was put on a waiting list for a cholecystectomy at the Queen Elizabeth Hospital rather than the local hospital. Recently, she was rung at 11 a.m. by clerical staff at the Queen Elizabeth Hospital and told that she could have her operation at 2 p.m. on that day if she could get straight down to the hospital.

She informed the caller from the hospital that she had just had some morning tea and knew that she would not have fasted for the prerequisite four hours by 2 p.m. She also rightly informed the caller that her own doctor had wanted the operation done at the Queen Elizabeth Hospital so that she could have a consultant anaesthetist and physician work-up because of her other health problems. She did not see how she could arrange to leave at 11 o'clock, as she could not locate her husband who was down the street, and get through Queen Elizabeth admissions by 2 o'clock. Therefore, she quite rightly refused admission on that basis, whereupon she was told that she was obviously not serious about having her operation and was being removed from the waiting list.

The second patient to whom I refer was told that she still had 18 months to go on the waiting list for a knee replacement. Six months later she was told she had a further 12 months to go. When she rang again having waited about three years she was told she was not on the waiting list and she never had been. The local doctor wonders whether she was rung while she was away on holidays and because she did not answer immediately was presumed to be no longer interested. Will the Minister provide details of the precise methodologies by which people are removed from waiting lists and say upon whose authority such removals occur?

The Hon. D.J. Hopgood: The first thing I want to say is that, naturally, I will be only too happy to have my officers follow up these particular matters. However, the Hunter report suggests that the overall picture is not one of people being removed willy-nilly from waiting lists but rather being left there despite the fact that a change in their physical well-being may well mean that they no longer need to be there. They are Mr Hunter's conclusions from the work that he did. I do not know whether there should be any criterion for the removal of anyone from a waiting list other than a medical one if they no longer require the treatment for which they were originally listed.

While this matter of booking lists is before us, I simply point out that, apart from the matter of the Commonwealth money, which will be specifically directed to the longer stay patients, and apart from the continuing dilemma of being able to attract specialised services to the public hospital system—and I will not again bore the Committee with the set speech I have given on a number of occasions on that—it also partly relates to the efficiency of admission and discharge procedures within hospitals. There will always be the matter of ensuring that people who are urgent and people admitted from accident and emergency will get their treatment when they need it. From time to time this may mean rescheduling a booking list procedure.

However, the greater efficiency with which the hospital is doing its core work will determine the extent to which the booking list procedure can be reasonably predictable. I guess that is what the honourable member is pleading for—that people should get their procedures when they are told they should get them. I agree entirely that that is the ideal situation. I take this opportunity to table a report that has just—

The CHAIRMAN: Before the Minister does that, I point out that there is no provision under the Standing Orders for the tabling of a document. However, if the Minister wants to circularise the document he is quite at liberty to do so.

The Hon. D.J. Hopgood: I have a report that members are at liberty to peruse. It relates to adult acute care and admission and day of stay in hospitals—what we are calling the 'utilisation review'. It was carried out by

people working in the field from the Royal Adelaide Hospital, the Queen Elizabeth Hospital, Flinders Medical Centre, Modbury Hospital and the Health Commission. It was chaired by Dr Verco. The important conclusions from this utilisation review were that 15 per cent of all admissions to the hospitals which were targeted did not need acute care and 28 per cent of day of stays did not need acute care. This does not apply to all hospitals; for example, I understand that Lyell McEwin Hospital was not part of the exercise. However, one of the things I am sure the Chairman of the commission will be wanting to do—as will my successor in the portfolio—is to say to the hospitals, 'We have to do better than this. We have to ensure that acute beds are for acute patients.' Where people are being treated for an acute condition they should remain in the hospital for as long as is seen as medically appropriate and no longer. I suggest to the honourable member that homing in on some of this will assist considerably in addressing some of the problems that she has outlined to the Committee.

Mrs KOTZ: As a supplementary question, I recognise the fact that the Hunter report has apparently identified that patients are not being removed willy-nilly. I hope that is the case. However, we continue to receive much evidence from individuals along these lines, and I am sure every member of Parliament could add to the list. The basis of my question, having outlined the two anecdotes, was to suggest to the Minister that in the area of methodology, even though Commonwealth money is available to look at reducing waiting lists for specialist needs, and if we in this State have not within the health system actually got to the point where our own methodology is at risk and is causing some of the problems to patients, how are we going to address that problem? One of the specifics to come out of these anecdotes was the fact that clerical staff were actually removing patients from the waiting lists and, as far as I am aware, without authority from a specialist or professional.

The Hon. D.J. Hopgood: On her own admission the honourable member has some anecdotal evidence. What I have is a report prepared by an eminent surgeon who has no axe to grind whatsoever in these particular matters. He was concerned only with determining what in practice is the way in which the lists are managed. Mr Hunter was able to establish that, in practice, overwhelmingly the presumption is to keep people on the booking list rather than to remove them. I think I can give the honourable member considerable assurances about the way the lists will be managed in the future because, of course, we now have two reports which go very much to the heart of this matter and to which an adherence as far as philosophy is concerned will be expected from the units.

In addition, there are budgetary disciplines, which I think will ensure that that is the case. There is the incentive of being able to get access to the Commonwealth money. Then there is simply the learning process which has involved all concerned and which has been part of the putting together of these two reports. I would be on pretty strong ground in suggesting that the management of booking lists and admission and discharge policy—whatever has been the case in the past—has received considerable attention in the past 12 months and almost certainly will receive even more attention in the future.

Mrs KOTZ: My second question relates to page 36 of the Program Estimates. One of the 1992-93 specific targets is the amalgamation of health services on Southern Yorke Peninsula. What remuneration has the Health Commission made available to doctors providing services to make up for the decreased level of services at Minlaton following the loss of two-thirds of the practice at Minlaton?

The Hon. D.J. Hopgood: There is a scheme to address this. I will ask Mr Dunn, who is our Regional Director (Southern), to address himself to this question.

Additional Departmental Adviser:

Mr I. Dunn, Regional Director, Southern Country Health Services Division.

Mr Dunn: The current arrangement has its history, of course, in the Commonwealth Government's offer to establish a nursing home in the Southern Yorke Peninsula area. As a result, the Minlaton Hospital board chose to make an application for those nursing home beds. As a result, the medical practice in Minlaton, which then consisted of three general practitioners, indicated that it would not like to continue in general practice if a nursing home was constructed on the Minlaton Hospital site, with the acute services being transferred to Yorketown.

I think it is important to remember that one of the three general practitioners has already indicated—and I think on the public record—that he was leaving anyway for family reasons. What has transpired since is that a second of the original three doctors has left Minlaton and the Health Commission, with the hospital board, has sought actively to recruit a second doctor to replace him. I think the honourable member's question related to expenditure. To date that process has involved expenses in relation to advertising and also a locum service. It has also involved support for a doctor who has now responded to that recruiting and is currently working at the hospital three days a week—Friday, Saturday and Sunday—in support of the remaining doctor. He has indicated that he will be commencing full time at Minlaton from 1 October 1992.

Mrs KOTZ: Supplementary to that, I do not believe that the answer that I require was given. I specifically asked for the amount of remuneration involved.

Mr Dunn: The remuneration arrangements are part of an attraction package that has been offered as part of the recruiting campaign. It involves two parts: first, the Health Commission supported the hospital board—at the request and with the support of the local council—in the purchase of the medical practice at Minlaton, including the building and its effects.

As a result, the incoming doctor and the existing resident doctor have both been offered the use of that building, rent free. In addition, the doctor concerned, who has been recruited, has been guaranteed a gross maximum income of $4 500 per week, which will expire six months after the opening of the nursing home. I think it should be borne in mind that the $4 500 guaranteed gross is offset by all the income that the doctor generates from seeing patients, so it is a gross income against which will be offset those patient fees. While the doctor is there

three days a week, that guarantee is $2 500 per week. Information that I have to date shows that he has been there for five periods of three days and, as we would expect, given that he is trying to generate new business, the total expense to date has been, for those payments, about $8 800 net, which equates very much to the current market rates for the cost of locum services.

Mrs KOTZ: Supplementary to that, I believe that Mr Dunn mentioned that the current doctor is on three days a week and is looking to change to full time but that at the same time the guaranteed income of three days per week has been organised for a six-month period. Will the doctor start the full-time services at Minlaton after that six-month period, or will he have to make a choice at some time?

Mr Dunn: Obviously, I need to clarify my response further; I apologise. There are two parts to the incoming doctor's arrangements. Initially, it will be three days a week in order for him satisfactorily to remove himself from patient care where he is currently practising and at the same time to build up a practice in Minlaton. During that period, which expires on 1 October, the doctor concerned is getting guaranteed gross income of $2 500 for those three days, against which the income from patient fees is offset. In addition, he is getting assistance with transport and is provided free accommodation in a hospital-owned house and free access to the medical practice building which, as I have indicated, has now been purchased.

From 1 October, the doctor concerned has been guaranteed the level of support that I have just outlined, with additional support for nursing and clerical staff, but that guarantee expires with regard to gross income from six months after the nursing home is opened. We are currently planning that the nursing home should be constructed and available for commissioning in about December 1993.

Mrs KOTZ: As a further supplementary question, apparently the situation at Minlaton was that three doctors actually practised in that area. We are now down to one of the original doctors, plus the new doctor whom we are talking about under the arrangements we have just discussed. I am afraid I must ask, if three doctors had practised at Minlaton, why is it necessary to consider that one doctor who now makes two requires such a remuneration, which does seem rather excessive, to build up a practice which, quite obviously, three previous doctors had already established?

Mr Dunn: I am happy to respond to that in the context that the honourable member would be aware that there was significant publicity regarding the decision of the hospital board to convert Minlaton Hospital into a nursing home. I believe that the medical community had adverse reactions to that publicity. As a result, it was particularly difficult, and it has been particularly difficult, to attract doctors to go to Minlaton. I referred earlier to the recruitment expenses through a large personnel consulting team in Adelaide, and they were able to attract only one doctor after extensive advertising in the metropolitan press in Adelaide as well as in the national press. As I have said, there is a phase-in period against that environment which, I think it would be fair to say, was hostile initially, and so in our judgment any doctor who was considering going to Minlaton required some financial security.

I indicated that from 1 October this incoming doctor would be there full time, therefore there will be two but, more interestingly, prior to the advertisement that commenced all this with the Commonwealth seeking invitations for a nursing home, my inquiries indicate that there were 20 general practitioners on Yorke Peninsula at the time and today there are 20. The difference that has occurred is that the third doctor's position, which is now vacant at Minlaton, has been taken up to some degree by the single medical practice at Ardrossan taking on another partner or associate, and that team is now going down to Port Vincent, which was part of the original practice area of the three doctors at Minlaton. So, as of today, there are still 20 general practitioners, and as of 1 October there will be two full time in Minlaton.

Mrs KOTZ: As a point of clarification, Mr Dunn mentioned the sum of $8 800; is that the net payment so far regarding the five occasions he spoke about?

Mr Dunn: That is correct.

Mrs KOTZ: My last question relates to the Program Estimates (page 28), specifically to the area of Resources Summary, Flinders Medical Centre. I note that the proposed recurrent expenditure for Flinders Medical Centre for 1992-93 is $124.045 million. However, the Flinders Medical Centre August information bulletin indicated that the Health Commission's formal allocation of funds was $117.454 million. Will the Minister confirm that the actual allocation is $124.045 million and, if this is not the Flinders Medical Centre actual allocation, why is that figure recorded, and will he explain the difference of $6.591 million?

The Hon. D.J. Hopgood: I will ask Mr Blight, the Executive Director of Metropolitan Health Services Division, to confirm what the honourable member wants confirmed.

Mr Blight: I understand that the gist of the question was that the budget information internal to the hospital indicates a figure of $117.454 million while the Program Estimates shows a figure of $124.045 million. The budget allocation letter regarding the initial allocation—to Flinders Medical Centre which goes out very early in the financial year—in fact, it is within a matter of days of the Health Commission receiving its allocation from Treasury—indicated a figure of about $117 million.

However, on top of that allocation there is a whole range of budget variations to cover things like national wage increases for the year and the superannuation guarantee levy and, in the case of Flinders Medical Centre, there were funds of something like $847 000 for hospital enhancement programs. There is a range of equipment funds and, in the case of Flinders Medical Centre, that is about $500 000. When all those adjustments are made, we move from the $117 million as per the budget letter, which was reported internally, to the figure that is shown in the blue book of about $121 million. The Committee will notice from the Program Estimates that there is a range of funds still unallocated, and to get to the figure of $124 million there are some additional funds added to the figure of about $121 million—and I am talking about payments.

Flinders Medical Centre has had a notional allocation of over $1 million of the hospital access moneys to

which the Minister referred earlier—the $4.3 million. That has been added notionally to the Flinders Medical Centre budget, and there is a range of other centrally funded items. The division itself has provided some additional funding to Flinders Medical Centre for things such as improved child assessment services. So, when we add in those additional costs, the sum rises to $124 million.

Mrs KOTZ: On a point of clarification regarding the difference between the two figures, do the figures quoted to me make up the difference totally?

Mr Blight: No, I have not cited all the individual elements; there are probably some 25 or 30 individual elements.

Mrs KOTZ: Will you provide the Committee with the figures that make up the difference—$6.591 million?

Mr Blight: Yes, indeed.

Mr McKEE: Following on from the second question asked by the member for Newland, I really hope we do not have a case of the members of the medical profession holding to ransom the country folk of South Australia. The blue book, statement 5 (page 10), refers to the Alfreda Rehabilitation Service. I am also aware of a similar service operating out of the Lyell McEwin Health Service. Can the Minister advise the Committee developments in these two services?

The Hon. D.J. Hopgood: The Alfreda Rehabilitation Service, formerly known as the Western Region Rehabilitation Services, is an annex of The Queen Elizabeth Hospital and has provided occupational rehabilitation for over 10 years. It is a contracted provider with WorkCover and has been since the introduction of the Workers Rehabilitation and Compensation Act 1986. The services provided by Alfreda Rehabilitation for non-compensable patients continue to be at no charge. It gained a contract with COMCARE in 1988-89 to provide rehabilitation services to Commonwealth Government employees and, of course, since the commercialisation of Alfreda there has been increased revenue to enable us to appoint additional rehabilitation counsellors and allied health, staff and to purchase additional equipment.

To get to the nub of the honourable member's question, a major $4.1 million redevelopment is under way at Alfreda which will provide a number of things: the addition of a therapy and gymnasium complex to the existing hydrotherapy and exercise pool building; minor internal renovations to the existing workshop, internal/external renovations to the Alfreda building to form client/staff education facilities; and a new client services and administration building. This is being financed through a commercial loan from SAFA, $3.4 million, and $700 000 which is the accumulated surplus—that is, it is from the accumulated surplus of Alfreda. The loan will be repaid from the annual operating surpluses generated through the commercialisation. So, I think that looks pretty good.

As far as Lyell McEwin is concerned, its rehabilitation services is known as McWork and it was approved for establishment in July 1989; as with Alfreda, non-compensable patients continue to be treated at no charge. Profits of $148 000 in 1991-92—which is up from $116 000 in the previous financial year—are retained by the service to be used at the discretion of the board of directors for purchase of equipment or the expansion of services in high priority areas. It had 448 new referrals in 1991-92 and 10 407 revisits, and there were 13 253 occasions of service. It seems to me that both services are rattling along rather nicely, given the unfortunate necessity of our having to have such services.

Mr McKEE: As a supplementary question, will the Minister supply the Committee with WorkCover statistics regarding the Alfreda Rehabilitation Service?

The Hon. D.J. Hopgood: Yes, we can get that on notice.

The CHAIRMAN: Before the member for Gilles proceeds, as the member for Albert Park, I am interested in Alfreda. A question has arisen as to why the hydrotherapy pool cannot be used after hours by members of the public. Perhaps the Minister will take that question on notice.

The Hon. D.J. Hopgood: I am always happy to supply the member for Albert Park with a response. We may be in a position to respond immediately.

Dr Blaikie: It has been a long-standing issue, as the member for Albert Park well knows. I cannot remember all the details, but some certainly relate to liability in the event of people using the pool after hours and being hurt in some way, but I think it is best if we take the question on notice.

Mr McKEE: The Program Estimates (page 38) makes a number of references to the significant changes that are occurring in mental health services in South Australia. What is the progress of the restructuring of mental health services?

The Hon. D.J. Hopgood: Our point of departure was the setting up of the South Australian Mental Health Service to provide a specific overview of mental health services in the State, something that, of course, we had before in perhaps a more diffused way simply because of the overview that the commission itself exercises in the area. One of the initial tasks of the South Australian Mental Health Service is the devolution of beds from the Hillcrest Hospital. The honourable member will probably be aware there are 100 psychogeriatric and 20 beds at James Nash House which will remain at Hillcrest, providing 120 beds in all. However, there is the intention to move, and we are already moving into transferring 40 beds from Hillcrest to Glenside and 60 beds to general hospitals, 20 each at Lyell McEwin Health Service and Noarlunga and 20 in the western suburbs, probably and preferably at The Queen Elizabeth Hospital.

This devolution will release $10 million in savings, and the majority of these funds will be released for the development of comprehensive and integrated community based mental services. That is where there has been some confusion about this program. Because we have talked about community services, people have assumed that the 120 beds have simply disappeared from the inpatient system and the money has been disbursed, or will be, to community services. That is not the case. The beds will simply be there. They will continue to be at the acute hospitals I have indicated, but the savings from the devolution will be available for the additional services which will be community based.

The first stage of the relocation took place in May of this year: 24 beds were transferred from Dibden House at Hillcrest Hospital to Greenhill Ward at Glenside; and 20 patients selected from Banfield and Dibden Houses at

Hillcrest were transferred to these relocated beds following an extensive period of preparation and orientation. Given the amount of time we have been talking about this, the Committee would agree there has been no undue haste in this matter. If you are dealing with a very delicate matter of patients with a mental illness, you ensure that their best interests are looked after. Planning is now under way to relocate a further 10 high level intensive care beds as well as the remaining extended care beds to Glenside Hospital in this financial year, so Glenside Hospital will become the tertiary mental health facility for the State. Money is earmarked in the capital works budget this year to ensure that the necessary modifications needed for the relocation, particularly to those units that have not previously admitted patients with a mental illness, can proceed in the way we would want them to proceed.

Mr McKEE: I refer to page 40 of the Program Estimates, with respect to the community based services program. There is a reference to a review of the sexual offenders treatment and assessment program (SOTAP). Will the Minister report on the impact of that program?

The Hon. D.J. Hopgood: The program review covered, among other areas, the extent to which the original objectives of the program were being fulfilled. The early indication of the review of the other Government agencies and community services of the services provided by SOTAP and its administrative accountability structure is that it has provided an effective program for treating perpetrators of child sexual abuse. However, it has not been able to do all we originally envisaged. It has not been able to accept adolescent offenders, those with disabilities or those who deny their offences. The report of the review will be finalised next month.

Since it was established in 1990, it has received 147 referrals. Of those referrals, seven clients did not attend for assessment and nine were found to be unsuitable for the program. Of the 131 found suitable for the program, none has since re-offended. One has to be a little careful how one draws conclusions from that. One would assume that those suitable for the program were those less likely to re-offend. However, I do not want to sell the program short. I am sure that that is a statistic which is very encouraging, and I guess we now have to move to considering how we might address those matters that we hoped would have been addressed originally in the program but so far have been found difficult to address.

Dr ARMITAGE: I refer to page 28 of the Program Estimates with respect to teaching hospitals. I have been told that the Women's and Children's Hospital recently decided to discontinue the supply of incontinence pads to patients at the hospital, and a memo to staff at the hospital indicated this was because of budgetary cuts. The spina bifida community has been advised to obtain incontinence pads from Adelaide Surgical Supplies at a cost of approximately $70 per carton, which is about one month's supply. That amounts to approximately $840 per year, whereas previously clients were able to obtain them from the hospital at about $15 per month.

The situation is that older clients who attend the spinal injuries unit at the Hampstead Centre are able to obtain one carton free of charge every three months if they are on a pension, and if they are not on a pension they are allocated $800 per year through the Da Costa fund to pay for the supply of these items. The patients themselves contribute about 10 per cent of the cost of the pads. The proposed continence aids assistance scheme, which was foreshadowed in the recent Federal budget, will only be applicable to disability support pensioners—in other words, those patients 16 years or over. So, it clearly means that the assistance for children aged between three and 16 years has been abandoned because of budgetary cuts. Will the Minister guarantee financial support for the parents of children who are affected by this decision of the Women's and Children's Hospital, taken for budgetary reasons? Lord knows they have enough on their plates to cope with, anyway, without this further additional burden.

The Hon. D.J. Hopgood: We will have to obtain further information for the Committee. None of my officers knows anything about this. Clearly, if this is a decision of the board, and the boards in the present system have autonomy, it is a decision that it can take. If it has been taken, certainly it has not been taken with any consultation with the Health Commission or any of its officers. I undertake to obtain the information for the Committee.

Dr ARMITAGE: I am happy to receive the information, but I know that the information I have provided is correct. I am asking the Minister if he will provide financial support to the parents. I am not asking him to go to the hospital and ask the board to change its decision. I am asking whether the Minister will make up the money that these parents are now expected to pay because of budgetary cuts from his budget recently announced.

The Hon. D.J. Hopgood: I cannot understand why the honourable member would not want me to take it up with the board of the hospital to see whether or not there could be a review of its decision. Why not? That is where the money is. There is none anywhere else. It is implicit in our getting the information that we will discuss the matter further with the hospital. Again, I make the point that it is the hospital's decision. We can politely ask whether it has its priorities right in this case, but it has to be its final decision.

Dr ARMITAGE: With respect to page 40 of the Program Estimates, one of the 1991-92 significant achievements was to have developed a hospice and palliative care policy. I have been advised that there had been one clinical nurse provided by the Royal District Nursing Society (RDNS) in each region specifically to deal with palliative care. An internal RDNS evaluation revealed that they were a particularly valuable resource, and the select committee (which the Minister chaired) recommended that these positions be retained. I am further informed that these positions have now been eliminated because of funding restrictions. Given that there is a waiting list for palliative care patients to get into Daw House, because insufficient funding is provided to open up more beds than are opened at present—which means quite specifically that people who would otherwise be admitted for palliative care die at other locations—and given that the other regions are similarly affected, with beds having been closed in the west and Philip Kennedy Hospice having had staff cuts and so on, will the Minister provide details of the hospice palliative care policy which

was developed as a significant achievement in 1991-92, and will he review the funding position which has led to the curtailment of clinical nurse positions in palliative care?

The Hon. D.J. Hopgood: All that has happened is that the palliative care services have been absorbed into the ordinary nurse rounds. The consultant positions will be retained to provide support for field staff and it is not anticipated there will be any reduction in services at all. However, as to the development of the policy, I will invite the Chairman to respond.

Dr Blaikie: The South Australian Health Commission has developed a policy, and it is a significant achievement. It is out there in the community. It was used by the Minister's select committee into death and dying and I do not see anything at all incongruous with some changes in operations at the Royal District Nursing Society and the policy of the South Australian Health Commission. Funds for palliative care services in South Australia have increased by 25 per cent in 1991 and have been maintained this year. There have been no further increases this year, but there is no doubt that palliative care has been one of the greatest achievements of the commission and the Government in the past half a dozen years.

Dr ARMITAGE: I will review the answer in *Hansard*, but I understand that these four clinical nurse positions are to be maintained—is that the substance of the answer?

The Hon. D.J. Hopgood: I will ask Colleen Johnson to further expand.

Ms Johnson: It is important to clarify that we are talking about two different lots of staff. There are nurse consultant positions in palliative care and those positions were first funded in 1990 to assist with the treatment of terminally ill patients. A further consultant position—making five—was established from Federal-State AIDS matched funding to focus on the needs of HIV positive clients. These positions were created because there has been increased demand in palliative care services over the past few years and the RDNS now receives 407 clients a month, clients requiring palliative care.

We had those five consultant positions and, in addition, RDNS used its own capital funds in the 1990-91 financial year to establish four palliative care rounds, one for each area in the metropolitan area. Those rounds were staffed by clinical nurses. The RDNS has looked at the workload of those nurses and has made a decision on the basis of efficiency that the work of the clinical nurses will be absorbed into the general rounds, so the general nurse who now covers Richmond or part of Richmond will also provide the palliative care but the consultant positions—the people who are available to give guidance to the hands-on care deliverers—will still be available. Those positions will still exist, so we will still have consultant positions in palliative care.

The hands-on nursing will be absorbed into the general rounds. Hence RDNS does not expect that there will be any reduction in services. It will still be seeing about 400 patients a month and there will still be consultant palliative care nurses to provide guidance to general nurses in delivering that service.

Dr ARMITAGE: This efficiency, so termed, which gives people a lot more work to do in a very demanding area—has that been caused by budget restrictions?

The Hon. D.J. Hopgood: There is a general perception in this Parliament and in the wider community that all State funded services should be subject to efficiency review so that we can provide the service in the most cost effective way. This is something we have got into as part of the general discipline on us, rather than as a result of a specific budget outcome. That is how I would answer the honourable member's question: it is something that he would expect of me.

Dr ARMITAGE: The specific budget outcome is the outcome from the RDNS and not the result of the budgetary restrictions. I refer to page 36 of the Program Estimates: a specific target identified in 1991-92 was 'expansion of specialist services at regional and sub-regional hospitals'. I have a copy of a memo from the Murray Bridge Hospital to the Acting Executive Director of the Country Health Services Division of the South Australian Health Commission in which the subject of budget cuts is discussed. The memo, dated 9 September, indicates that there is a shortfall of funds at Murray Bridge of $200 000 in the budget allocation for 1992-93 and, in order to accommodate this, a number of outcomes have resulted, amongst which is a closure of theatre from 24 December 1992 to 26 January 1993, which is a period of five weeks.

The anticipated outcome of this service cut is that 100 operations will be curtailed or cancelled and that waiting lists clearly will be extended by a further five weeks. A list of present waiting lists at Murray Bridge Hospital includes ophthalmology, 10 months; gynaecology, four months; urology, four months; plastics, three months; ENT, three months; orthopaedics, two months; and oral surgery has been cancelled altogether. Does the Minister seriously believe that the country health services, as the specific target indicated, has expanded specialist services at regional and sub-regional hospitals, given the information which I have just provided, which is reflected throughout many country hospitals?

The Hon. D.J. Hopgood: I will ask Mr Dunn to talk about the details associated with this matter.

Mr Dunn: I am aware of the memorandum referred to. Essentially it is correct in the information that has been tabled. It needs to be seen in a background of the fee-for-service allocation and the Country Health Services strategy for specialist services in regions. The fee-for-service pool available for medical services generally in the country in 1991-92 was about $19.6 million and in 1992-93 it will increase to about $19.8 million. The strategy that was touched on as a target last year was to see whether we could redirect funds for specialist services from very small hospitals that might have small volumes of specialist procedures under way and to aggregate those into a more efficient arrangement in regional and sub-regional hospitals, as we term them, in the country.

To some degree we have been successful, but not in all locations. The Murray Bridge Hospital has been communicating with us over a number of months about its last year's budget outcome and the pressure that would be upon it this year. We were very sympathetic to the matters raised with us and minimised the effect its

budget overrun last year has had on the allocation for this year. We have still only allocated four months of the fee-for-service pool to date directly to the hospitals, because the fee-for-service agreement has only recently been renegotiated with the AMA. We will be sympathetic to Murray Bridge's plight when we come to make that decision.

Mrs HUTCHISON: For a long time, and certainly while I was chairperson of a country hospital's board of directors, I have been concerned about the difficulty in attracting and retaining doctors and specialists in country areas. In the program involving country health services at page 36 of the Program Estimates there is a reference to a rural training practice unit. Can the Minister advise the Committee what progress has been made in training people to become general practitioners in the country and in retaining those who are already there, because this is the major problem?

The Hon. D.J. Hopgood: Briefly, a medical consultancy was appointed in November 1991 to investigate the establishment of a rural practice training unit based at Modbury Hospital. A full-time director and secretary are now in process of being appointed. Commonwealth funding from the Rural Health Support Education and Training Program over three years, that is, 1992-93 to 1994-95, totalling $410 000 has been secured to establish the unit and to initiate programs for the recruitment and retention of country general practitioners in this State. Additional funding from this program of $135 500 has been secured over three financial years to finance what is being called the Country High School and Undergraduate Program, which aims to attract country origin students to medicine and to encourage senior medicine students to enter country practice.

In 1992-93, Federal Government funding for the two projects I mentioned is expected to be about $200 000. It is planned that, by 1994, 15 additional country origin students will be attending medical courses at the universities. Currently, there is a deficit of about 20 general practitioners in country South Australia, and finance is being sought separately through the Federal rural incentive scheme to fund rural bursaries for senior medical students agreeing to enter rural practice at the end of training, with the South Australian Health Commission being liable at this point only for the cost of administration of the whole matter.

The rural practice training unit is seeking to have existing specialist training posts transferred for the use of training general practitioners for rural practice. The commission will continue to allocate funding towards rural placement of sixth year students from both universities in South Australia, and a budget of $6 800 has been allocated to that process. The commission provides a continuing medical education program of about $231 000—I will not go into the details of that—and a locum allowance is payable to solo medical practitioners for up to four weeks in any 12-month period.

Finally, in the past month I have received a report from the review of general medical practice in South Australia on country general practice, and that outlines a number of initiatives to be implemented by the commission, universities and country health services aimed at attracting and retaining country general practitioners. It is not easy. Often people leave well established country practices and come back to the city for social and family reasons, but I think the Committee can see that a good deal of work is being put into not only retaining those who are there but also attracting young graduates into country service.

Mrs HUTCHISON: As a supplementary question, the Minister mentioned rural bursaries. Can he indicate the extent of those bursaries at the moment, or is that still in the melting pot?

The Hon. D.J. Hopgood: I will obtain that information for the honourable member.

Mrs HUTCHISON: Under the specific objectives/targets on page 42 of the Program Estimates there is reference to the establishment of a cervix cancer screening program in 1992-93. Will the Minister provide details of this program, which I feel is very important for the women of South Australia?

The Hon. D.J. Hopgood: I seem to recall answering a question in the House about this matter on one occasion. There was about a 90 per cent increase of cervical cancer in women under 50 years of age during the period 1978-87, and that was a cause of considerable concern and one of the reasons for the program. Since 1987, that incidence has been reduced by about 17 per cent in that target group of women, and that almost certainly reflects, at least in part, the increased screening activity.

The 1987-90 data shows a continued downward trend in women aged 50 years and over. So, in either age cohort there is a downward trend, and that is very good. The honourable member will be interested to know that the Upper Spencer Gulf region presented its lowest number of cervical cancer incidents on record, and that is almost certainly attributable to the pilot screening project that operated in the region in the period 1988-90, given of course that early detection is very much the answer to this problem.

We have agreed to participate in a national program to improve the effectiveness and reliability of screening and targeting at-risk women, including older women, Aboriginal women, women of non-English-speaking background and women from isolated rural areas. Many younger women who are at relatively less risk of developing cancer of the cervix in contrast are being screened, we think, more frequently than is absolutely necessary. The Commonwealth is providing matched and unmatched funds. The State program will be based on existing service providers, laboratories, GPs, community health centres and so on.

In 1991-92, there will be new Commonwealth and State funds of $770 000 and a carry-over of $200 000 from 1991-92. A key element of the State program will be a central records system comprising screening information provided by pathology laboratories. A coordinator's position for all of this has been advertised though not yet filled, and a program advisory committee is being established. The program will operate as a unit of the Public and Environmental Health Service, but will be geographically separate from it.

Mrs HUTCHISON: On page 41 of the Program Estimates reference is made to the employment of Aboriginal graduates of the enrolled nurse training program at Whyalla, of which I am sure the Minister

would be aware. Will the Minister provide details of that training initiative?

The Hon. D.J. Hopgood: We are attempting to bring about improved Aboriginal use of hospital services, which we believe is more likely to happen if that community is more confident about services—and that is likely to happen if there are Aboriginal-enrolled nurses—and also to contribute towards the commission's target of 1 per cent overall Aboriginal employment. We are attempting to get higher hospital admission rates amongst Aborigines by employing more Aborigines in the clinical service areas of hospitals. The way in which we have tried to tackle this has been, first, to appoint Aboriginal hospital liaison officers, to improve the acceptability and therefore the effectiveness of hospital services to Aboriginal people and also to train and employ Aboriginal-enrolled nurses in those country hospitals that serve Aboriginal communities.

The North West Nurse Education Centre Incorporated started its final enrolled nurse education program in April 1992, and included seven Aboriginal people: two from Port Lincoln, three from Whyalla and two from Port Augusta. Normally, the students are employed by the Whyalla Hospital for the duration of their training, and after graduation each is responsible for finding their own employment. However, the Aboriginal students will be formally sponsored by their home town—if I can use that term—hospital during training and, on successful completion of the course, they will be actually guaranteed employment at that hospital.

A six-week orientation program conducted on a residential basis for applicants recruited from the three targeted regions was provided by the North West Nurse Education Centre in conjunction with the Whyalla Hospital and Health Services Incorporated. Clinical experience was gained in the Whyalla Hospital and the theoretical component was conducted by nurse educators employed by the centre. Of the seven trainees, one has decided that nursing is not the career for her and has withdrawn from the course. The remaining six have all shown a great deal of commitment, high standards of practical care, a great deal of self-esteem and written and oral communications skills, and they seem to be coming through the program very nicely indeed.

Mrs HUTCHISON: As a supplementary question, when is that course due to be completed and what stage has the achievement of the 1 per cent objective reached?

The Hon. D.J. Hopgood: The course is to be completed in, I think, October. We have not yet reached the 1 per cent benchmark. A report released some time ago at Tandanya indicated our commitment to this aim. The number of Aboriginal employees has increased in the past 12-month period from 98 to 117. Paul Case may want to add a little detail.

Mr Case: The Minister has given the broad framework for the program, but Aboriginal people have been employed in specific traineeships for developmental care workers, dental assistants and enrolled nurses, as has already been identified. There has been a specific apprenticeship for a dental technician and cadetships in speech therapy and medical laboratory science. In the nursing area two registered nurses have been employed and several clerical traineeships have been provided.

Mrs KOTZ: At page 36 of the Program Estimates reference is made to the country health services. I refer to a previous answer given by Mr Dunn which related to fee for service and the fact that only a four-month allocation of the budget had so far been presented. In the meeting of directors of nursing, which was alluded to in a previous question, the principal finance officer outlined the process for the allocation of fee for service within the Country Health Services Division. That briefing included the fact that the fee for service allocation to the goods and services area has attracted a 1 per cent inflation factor, but that this would not meet the overall CMB increases that had been allocated. So, all health units have been advised that they should plan for a 2 to 3 per cent reduction in activity relating to fee for service payments. Will the Minister explain which services will be cut in this 2 to 3 per cent reduction in activity?

The Hon. D.J. Hopgood: That is a little difficult to credit given the fact that in the past fee for service was treated as a salaries and wages item only. After all, these country doctors are not employees of the country health units; they provide services on a contract basis. In 1992-93 the fee for service will be classified as a goods and services expenditure item and the pool of fee for service funds will attract the inflation allowance provided by Treasury. The Committee has already been given the figures, including the increase in the fee for service that will be made available globally—a modest increase, I admit, but an increase nonetheless.

I think that the Committee has also been told why at this stage there has been only a three-month allocation. The strategy has been, wherever possible, to ensure that what in other jurisdictions might be called the 'base hospitals', but which we call the regional or sub-regional hospitals, attract the bulk of services that are funded on a fee for service basis. That sometimes takes a little bit of sorting out as the financial year goes along. In that situation one does not commit oneself fully to hospital A when six months down the track the wish is that more of those funds had gone to hospital B. That is how I would explain it. Perhaps the Chairman would wish to add to that.

Dr Blaikie: The substance of the question, of course, was which services or whatever will be cut. The commission does not accept that it has achieved all of the productivity and efficiency gains in the system. We give global allocations to hospitals and health centres. In framing the budget we expect that those hospitals and health centres will look for further efficiency gains. So, merely because there has been an inflation factor of 1 per cent in the fee for service allocation in a year during which we might expect a CPI increase of 2.4 per cent or thereabouts does not necessarily indicate to me that there will be a need to cut services. It depends upon the other efficiencies within the hospital system.

Mrs KOTZ: As a point of clarification, if in fact a 2 to 3 per cent reduction has to take place in the planning procedures in these areas and throughout the health units, is the Chairman suggesting then that the budget allocation is for three months as stated by the Minister (although I believe the information we were given mentioned four months)? In other words, do the health units have to take account of what effectively are rather large reductions

and plan accordingly for a year's budget but on a quarterly basis?

The Hon. D.J. Hopgood: I did not quite understand all of the question. Perhaps the Chairman picked it up.

Dr Blaikie: I did not quite understand it all. However, the essential reason for the four-month allocation—

Mrs KOTZ: I will explain further if you did not get the point of the question.

The CHAIRMAN: Order! Let Dr Blaikie finish the answer. The member for Newland can have another chance.

Mrs KOTZ: I hardly think he can answer when he does not understand the question.

The CHAIRMAN: Order! The member for Newland will come to order. Dr Blaikie.

Dr Blaikie: The four-month allocation of the fee for service budget line was primarily because we had not negotiated a new fee for service agreement with the Australian Medical Association at the time of the budget allocation.

Mrs KOTZ: Further to that, the point of the question is that a briefing has taken place through your department to advise health units that they must effectively reduce activity to the tune of 2 to 3 per cent. All I am asking is whether you are requiring that the planning be done on a quarterly basis, because only a four-month allocation of the budget has been made, or do you expect that this is a full range budget taking into account this 2 to 3 per cent, as opposed to the quarterly planning that would obviously have to be done?

The Hon. D.J. Hopgood: Mr Blight can address this issue.

Mr Blight: On the question of quarterly planning, that is not the intention at all. The Country Health Service Division simply held back two-thirds of the fee for service funds until the new fee for service arrangements were known. When that pool of funds is allocated to the country hospitals it will increase their budgets accordingly. That was the point of the other explanation of the shortfall at the Murray Bridge Hospital. In terms of the fee for service negotiations that have just been completed, there are two areas where there may be the potential to free up some of the funds without there being a reduction in activity. Those two opportunities—and I use the word advisedly, because they have not been worked through to completion at this stage—are, first, in the area of fee for service auditing, where we have reached agreement with the AMA and the RDA to develop and implement a fee for service auditing mechanism throughout our country hospitals. There is some expectation on the part of the Health Commission that that may provide some flexibility within available funds; that is because errors are often made in the billing procedures and if we can track those down we would expect that that would lead to some funding pool.

The other area relates to travelling allowances. In the previous agreement we provided for the payment of GPs visiting the two metropolitan fee for service hospitals—that is, the Hutchinson Hospital at Gawler and Southern Districts War Memorial Hospital at McLaren Vale. We did reach agreement with the RDA that those travelling allowances were no longer appropriate, so there will be a small saving there. But, also, as far as the travelling allowances paid to visiting specialists going to the country are concerned, in the past it has been left to the visiting specialists working with individual hospitals to decide who goes where. Often we pay visiting specialists to travel long distances to provide very infrequent services to a number of small country hospitals. That is somewhat contrary to the country health strategy of trying to develop resident specialists in country regions.

So, we have indicated this and we have agreement with the RDA in this new fee for service agreement that specialist travelling allowances may be reviewed and the allowance may cease to be paid provided we give three months notice of cancellation. I am a bit baffled by the reference to a meeting of directors of nursing to talk about CMB price rises. A medical benefits schedule increase has not been announced for 1992. We do, of course, expect that to happen in the November/December timeframe. That has been the past practice.

As with all other areas of the health budget, when any price rises occur during the course of the year, whether they be award rises in the metropolitan hospitals or goods and services rises elsewhere in the budget, health units have to absorb those costs. The same does apply for the fee for service but, by shifting it to goods and services, they are already 1 per cent better off than would have been the case if fee for service had remained under salaries and wages, where our policy has been to provide no additional funds for increases.

Mrs KOTZ: I would like to state that I am quite happy to provide a copy of the minute that was used in addressing that briefing by the finance member. If the gentleman believes that those facts are incorrect, I am quite sure he will take the appropriate steps, but the details of the question I asked are stated clearly here. My second question relates to the Program Estimates, page 34. Two of the broad objectives are, first, to provide an appropriate range of inpatient and non-patient hospital service and, secondly, to provide effective and efficient high quality specialist services. I am told that the cardiac investigation laboratory at the Women's and Children's Hospital is being forced to work with outdated and failing equipment; $1.8 million is required to allow the cardiology unit to provide what is an essential investigative service for children with congenital heart disease. What provision has the Government made to provide replacement equipment for the cardiology laboratory at the Women's and Children's Hospital?

The Hon. D.J. Hopgood: Of course, it is up to the hospital to determine its own priorities with the money that is made available to it, and the honourable member would be aware also of the changes that will occur following the considerable upgrade that is occurring at the Women's and Children's Hospital. I think that probably all I can do at this stage is to indicate the information that I have in front of me as to the money that is available in some of these areas. In fact, rather than waste the time of the Committee, I can undertake to give that information to the Committee and simply say that we will try to get more specific information from the management of the hospital as to what it has in mind in this area.

Mrs KOTZ: I appreciate that. My third question again relates to the Program Estimates, page 36, country health services. One of the 1991-92 specific targets is listed as

'expansion of specialist services at regional and sub-regional hospitals'. I have been provided with a copy of a letter written by the Chief Executive Officer of the Port Augusta Hospital to a specialist surgeon who visits the hospital. The letter details the extreme budgetary pressure in which the hospital finds itself because of 'significant reduction in funding applicable to this hospital for the 1992-93 finance year'. The letter further states:

> In the case of specialists, allocation by specialty has occurred, and the hospital will be requiring practitioners to manage their public patient activity within the budget limits . . . It is also important to highlight that it is intended that if necessary, limitations on elective public patients will occur. No limit on privately insured patients will be applicable. The hospital acknowledges that this may result in the establishment of waiting lists for public patients. However, it is our view that this situation is unavoidable.

Does the Minister believe that memoranda such as these circulating from many public hospitals constitute an expansion of specialist services at regional and sub-regional hospitals; what will he do to reverse this clear diminution of services under his direct control; and does the Minister acknowledge that this will lead to differential services between public and private hospitals?

The Hon. D.J. Hopgood: Of course, there are differences between public and private hospitals, and always have been, but my concern must be for the quality of services in the public sector. It is true that productivity savings of $250 000 are expected from the Port Augusta Hospital. How they are to be achieved is a matter for the hospital, except that of course the Government and the commission would want the hospital to explore every possible way to ensure that it is done without affecting service provision.

For example, the honourable member refers to what I assume are tentative arrangements for some sort of booking list at Port Augusta Hospital. The honourable member may or may not be aware of the fact that no booking lists are operated in country hospitals. If there is a suggestion that one might be operated at Port Augusta, that may not be such a bad thing. It has been seen in a number of reports to Government as a very efficient way of managing elective services. I am sure that, in the event of a booking list being developed for the hospital, there would be every effort to ensure that there is predictability in people getting their services and, in addition, every effort to ensure that the time involved in being on the booking list was as little as possible.

Again, I would get back to the point that it is no bad thing that the hospital is aware of the necessity to budget carefully and to provide productivity savings, and I am sure that, as has been the case in previous years, when certain people sit here in 12 months time the activity levels will be of far more interest to members than the actual dollars that were spent. On a number of occasions I have entertained the House of Assembly on the additional number of procedures that were carried out over the whole system in South Australia in the past 12 months as opposed to the amount of money that was actually provided. Last year, for example, at Port Augusta there was a 1.8 per cent increase in admissions. Well, we will see what happens this year.

Mrs KOTZ: If the Minister considers that the establishment of a waiting list at that hospital would be a good thing—and they are the Minister's words—that begs the question, which was part of my original question, whether there is not then the opportunity for a differential in services to be made between public and private patients?

The Hon. D.J. Hopgood: I would certainly hope not. That is one thing about which I am sure my commission officers would be very concerned and about which they would want to talk very carefully to the boards of any of the hospitals because, as far as I am aware, we would be in breach of the Medicare agreement if we were to make that sort of discrimination, and we would come under the adverse attention of the Deputy Prime Minister and the Commonwealth Minister of Health, and for good reason.

Mrs KOTZ: In terms of clarification, the initial evidence that I offered was based on the memorandum, and it states:

> It is also important to highlight that it is intended that if necessary, limitations on elective public patients will occur. No limit on privately insured patients will be applicable.

The Hon. D.J. Hopgood: Sure, but there might have to be some rethinking at that hospital in the light of our understanding of the Medicare agreement, to which we are passionately committed.

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

Mr QUIRKE: There have been a number of press reports in recent months on the future of the Children's Assessment Team at the Flinders Medical Centre and the Children's Development Unit at the Adelaide Children's Hospital. Has any specific allocation of new funds for these services been made to the Flinders Medical Centre and the Adelaide Medical Centre for Women and Children respectively?

The Hon. D.J. Hopgood: The additional budget allocation to the Flinders Medical Centre is $40 000, and that is to maintain the current level of commitment of various allied health professionals to the service. It is an important service; it was established way back in 1976 to provide a one stop assessment and review of children with learning, behavioural, motor and speech problems rather than referring them to various medical and allied health staff over a number of days. The management of the Flinders Medical Centre has given a commitment to maintaining the level of services provided over the past 12 months.

As to the Children's Development Unit, which is part of what we now call the Women's and Children's Hospital, it provides an assessment of management for service for children with multiple disabilities and it evolved from the Cerebral Palsy Clinic which was established in 1968. A review of the unit was undertaken in 1989, a number of recommendations were made, and the Women's and Children's Hospital has met all the requirements from within budget, except for the appointment of a coordinator, which in fact is needed to bridge the interface between the hospital and a lot of other agencies such as the Education Department, for example, and IDSC. An amount of $40 000 has been set aside for the Children's Development Unit at the Women's and Children's Hospital. These two very important services to children continue in a modestly enhanced way.

Mr QUIRKE: Under the program 'Public and Environmental Health Services', reference is made to injury prevention initiatives in relation to falls among the

elderly, safe design of consumer products and the application of information technology to workplace safety. Will the Minister advise the Committee of initiatives in these important areas?

The Hon. D.J. Hopgood: First of all, the service has designed and tested a home modification program, which I am advised can reduce falls by about 50 per cent. It is an average investment of $85. Some funding is available from Foundation SA and half the cost is paid by the householder. It involves grab rails, night lights and treatments for slippery surfaces. Regarding consumer product design, it is estimated that between one and two million injuries occur in Australia each year as a result of consumer products, and the service working for the industry commission has estimated that one in 10 episodes are attributable to poor product design. So, the Injury Surveillance and Control Unit will continue its work in identifying product hazards, assisting manufacturers with safer designs and writing proposed national standards. One of the obvious areas that is often talked about is children falling from bunk beds, but also, of course, children's folding chairs can create hazards.

Finally, regarding workplace safety and information technology, I think the traditional approach has differed somewhat from the newer public health approaches. The public health approach emphasises the effective use of data. The unit is working with WorkCover and the Occupational Health and Safety Commission to introduce and demonstrate new techniques for reducing the number of in-workplace injuries. In one trial program recently, the number of injuries reduced from an average of 40 per month to fewer than four. So, I guess we need a lot more of that sort of program to be implemented in the workplace.

Mr QUIRKE: Medical equipment is an important contributor to the quality of care provided in our hospitals. Will the Minister advise the Committee what level of funding for new and replacement equipment in the major metropolitan hospitals will be provided in 1992-93?

The Hon. D.J. Hopgood: I suppose this is something that could well be provided in greater detail to the Committee, so to save time perhaps I will just highlight some of the matters I have in front of me. For example, there is $1.6 million for a magnetic resonance imaging unit at Flinders Medical Centre; $1.1 million for replacement of the linear accelerator at the Royal Adelaide Hospital; $1 million for a CT scanner at the Women's and Children's Hospital; there is $800 000 for the X-ray room at the Modbury Hospital, and the last one I mention in any detail is the fluoroscopy suite at the Royal Adelaide Hospital, $700 000. In all, the proposed expenditure on equipment is about $19 million compared with $15.3 million that we spent last year.

Dr ARMITAGE: Page 43 of the Program Estimates indicates that one of the significant achievements in 1991-92—and we have talked about it before—was the review of hospital booking lists for people waiting over 12 months. The Minister would be aware that, because of budgetary restrictions at the Queen Elizabeth Hospital, 50 beds were closed recently on top of the 30 per cent of hospital beds that have been closed during the past two years. I have been provided with calculations done by some of the senior surgical staff of the Queen Elizabeth Hospital which indicate that, because of pressure on beds, there has been a cancellation figure of about 10 patients per working week day, that is, those being refused admission for elective surgical procedures. It is estimated that, should the current rate of admission refusal for elective surgical patients continue, in the case of orthopaedic surgery and general surgery alone there will be an increase of over 200 patients on the waiting list by early December 1992. I am informed that, literally, this morning at the Queen Elizabeth Hospital, three medical personnel, paid for by the taxpayer, were sitting around with nothing to do as an operating list had been cancelled because of lack of beds.

Will the Minister assess the figures that have been provided to me in relation to the rate of cancellations of elective surgical procedures, and does he agree that all the reviews of hospital booking lists in the world will not alleviate the situation that results from the cancellation of procedures in relation to bed closures? Will he further agree that some of the so-called savings which have been generated by these efficiency drives in fact end up costing money if surgeons are standing around with nothing to do because of bed closures?

The Hon. D.J. Hopgood: What I will agree—if I can turn the honourable member's logic around a little bit—is that all the money in the world is not going to work either unless there are some changes in procedures. I would concede that one cannot simply continue to close beds willy-nilly. The logical extension of that philosophy is that we get down to three beds in the Queen Elizabeth Hospital, and then precisely what the honourable member sets out, and then some, takes place. If I can indicate in this way, the nexus between beds available and procedures performed is a little more complex than I think the general public has been led to believe.

Let us look at the Queen Elizabeth Hospital in the past couple of years. In 1990-91, there were 24 closed beds and the daily average number of available beds was 532.1. In 1991-92, there were 29 closed beds and the daily average number of available beds was 492.4, a reduction of about 40. If we look at the actual booking list procedures performed at the Queen Elizabeth Hospital in 1990-91 and then in 1991-92, we find that in 1991, 5 838 were performed and, in 1991-92, 6 041 were performed. Thus there was an increase of 203 additional procedures, despite the fact that the daily average number of available beds reduced by 40. So, there was a reduction in the number of beds available and more procedures were done. Again, I make the point that I am not so silly as to think that one can continue to do that willy-nilly and still get that sort of result.

There is not that clear logical connection between the two, which is why we have had put before us and before the units the sorts of recommendations Mr Hunter has made. The important thing is that those procedures be implemented, and that we get hold of the Commonwealth money as quickly as possible. Of course, clearly State money is going into booking this procedure, as has always been the case. That additional $4 million-odd from the Commonwealth is a lot of money, provided it is dedicated specifically to the booking lists as it will be.

Dr ARMITAGE: With respect to teaching hospitals, it is indicated on page 34 of the Program Estimates that a specific target for 1992-93 is the implementation of

efficiency reviews at, amongst others, the Women's and Children's Hospital at the ACH campus. The Booz Allen and Hamilton review—this holy grail about which we talk so often—into the review of the operating theatre utilisation at the Adelaide Children's Hospital (as it was at that stage) suggested there be no operating sessions cut for the two biggest units, being general paediatric surgery in neurology, and orthopaedics. Because of a reduction in the budget for the Division of Surgery caused by general budgetary cuts, general paediatric surgery in neurology has had 23 per cent of its surgical sessions cut, and the orthopaedic service has had 22 per cent of its surgical sessions cut.

The Booz Allen and Hamilton review also recommended no cuts for cranio-facial surgery, for instance, and it has not been cut. Given the supposed benefits of the Booz Allen and Hamilton review, why are its recommendations being selectively ignored, or conversely, being selectively applied, and will the Minister guarantee funding to Adelaide's public hospitals so that the recommendations in those efficiency reviews will be actioned as they were intended by the consultants? In relation to the general cuts in surgical sessions at the Adelaide Children's Hospital, does the Minister share the concern of senior paediatric surgeons at the ACH campus of the Women's and Children's Hospital that, because of surgeons being forced to work outside the hospital due to budget cuts, the hospital may lose its accreditation as a paediatric training surgical centre, with a consequent reduction in the quality of its trainees?

The Hon. D.J. Hopgood: I am sure there is no problem about the last matter. I will ask Mr Blight to further expand on that. I would make the point that, in relation to the guarantee of money to the hospitals, what they are guaranteed is what is in this budget, and there is no more money anywhere else for particular services. I will ask Mr Blight to comment on what management decisions have been taken by the hospital itself.

Mr Blight: I cannot give a specific answer as to the reduction of sessions in the disciplines that have been mentioned, but I have been advised by hospital management that there has been considerable disquiet amongst the surgical staff about the Booz Allen and Hamilton recommendations and the decisions that have been made. Management believes that that disquiet has come about because there was a single surgical representative only on the task force, and although there was an obligation on that representative to pass onto the surgical staff the deliberations that occurred at management level, it appears that there were some communication problems within the surgical division in relation to that process. Senior management is attempting to redress that in a number of ways.

Having said that, it does remain the view of senior hospital management that there are significant opportunities for reallocation of workload between visitors and full-time staff. They dispute the claim that decisions have been made on incorrect data. That claim has come forward from SASMOA. Senior managers are of the view that restructuring of surgical services to increase productivity, particularly of the full-time staff, is a matter that they wish to pursue.

The Hon. D.J. Hopgood: Without wanting to prolong the answer unduly, I will ask the Chairman to comment briefly.

Dr Blaikie: In addition to Mr Blight's answer, the Booz Allen consultancy report belongs to the hospital. It is not a report that we have, so we do not know its precise details. It is a report commissioned by the hospital, but I do know that the changes that have been introduced to the surgical sessions and services at the hospital have actually now been agreed by the medical staff. This has been a long process of consultation and, whatever are the precise details of those sessions, they have now been agreed by the staff of the hospital.

Dr ARMITAGE: Can I clarify that? I believe that the Chairman of the Health Commission said that the Health Commission does not know the recommendations of the Booz Allen reviews of the hospitals.

Dr Blaikie: I do not know all the details of the Booz Allen reviews. That consultancy is one undertaken by the board of directors of the Women's and Children's Hospital. I know of the general recommendations. Mr Blight may know more than I.

Dr ARMITAGE: Am I to understand that the South Australian Health Commission does not have a copy of these reviews, which cost in the vicinity of $4 million over the whole of South Australia?

Mr Blight: A case in point would be the recent Booz Allen report of outpatients, ambulatory, paediatrics and patient information services which was completed in the past week or so. As a matter of courtesy, hospital management has provided my division with a copy of that report. Just as a matter of interest, it indicates that approximately $600 000 per annum savings are available. It is not a report that is endorsed at this stage by the board of directors. That is an internal process which may alter significantly the recommendations that are actioned by the hospital. In due course, we would expect to be advised of those in general terms, but the responsibility for deciding on those recommendations and carrying them through to implementation rests with the board of directors.

The Hon. D.J. Hopgood: There is a very important point implicit in the honourable member's question: we have to remember that management of the unit is in the hands of that unit in the South Australian system, and management reviews are the responsibility of that unit. The Booz Allen reviews were initiated by the hospital boards and paid for by them. They are, in a sense, their property, not ours.

Dr ARMITAGE: With respect, it is paid for by money provided by the Health Commission. Given that Mr Blight indicated that the Health Commission is lucky enough to have received a copy of this most recent review, out of courtesy, how many other reviews done at $4 million expense to the taxpayer does the Health Commission not have copies of?

The Hon. D.J. Hopgood: What is the position on what we have and what we do not have?

Mr Blight: I have copies of the Booz Allen reviews of the Royal Adelaide Hospital, Flinders Medical Centre and the Women's and Children's Hospital, to my direct knowledge.

Dr ARMITAGE: In answer to a previous question, the Chairman of the Health Commission indicated that the Health Commission did not have copies of those reviews.

The Hon. D.J. Hopgood: Clearly, the Chairman does not but, at this stage, Mr Blight does. Mr Blight has been recently given a copy by the hospital.

Dr ARMITAGE: Do you think that the Chairman might ask Mr Blight, as a courtesy, at some stage to give him a copy so that the Chairman of the Health Commission might know what these recommendations entail, and why has he not done so already?

Dr Blaikie: The essential point that I am making is that the South Australian Health Commission cannot—and is not in a position to—be dealing with the internal runnings of all the hospital systems in Adelaide. We are not the providers of service. That is the responsibility of hospital boards of directors. I am unlikely to have the time to read through detailed reports of consultants involving every single hospital in South Australia. Under our system these hospitals are legally incorporated bodies under the South Australian Health Commission Act. They have their own boards of directors, their own chief executive officers and executives and it is they who are responsible for the running of the hospitals. We determine budget allocations and policy directions but we do not run individual hospitals.

Dr ARMITAGE: But you do provide the money. I will not chase that any further, but I am flabbergasted. Page 41 of the Program Estimates indicates that one of the significant achievements of 1991-92 was a complete review of the Aboriginal Substance Review Program in Port Augusta. At some later stage, if not now, will the Minister give the results of that review to me and will he inform the Committee what specific steps will be taken to tackle alcohol abuse and petrol sniffing?

The Hon. D.J. Hopgood: I will ask Mr Taylor to come forward and give an update on that. Whilst he is doing that, the Chairman might comment.

Dr Blaikie: There has recently been a major review of the substance review programs in Port Augusta and as a result we are to establish a mobile assistance patrol and a sobering up centre. As Mr Taylor is now at the table, I will hand over to him.

Additional Departmental Adviser:

Mr M. Taylor, Manager, Health Programs, Country Health Services Division.

Mr Taylor: The review has been completed. Since it was finalised it has been received and now endorsed by a number of important bodies, the first being the steering committee for the review, which was constituted of both the service delivery agencies and the Aboriginal organisations in Port Augusta. Also, it has been endorsed by the Aboriginal Health Council, more recently by the Aboriginal and Torres Strait Islander Commission Regional Council for the Port Augusta region and by the City of Port Augusta's Dry Areas Advisory Committee.

The consultants proposed that the program be restructured and comprise five significant parts. The first is the mobile assistance patrol, which would have two major functions. One would be early intervention and counselling and the other would be the diversion of people who are at risk of coming into contact with the criminal justice system. The second component, and one that is already fully operational, is the sobering up centre in the grounds of Port Augusta Hospital. The third is a small hostel for those unfortunate members of the community who are long-standing alcoholics who are unlikely to be able to change their lifestyles but who require some safe care.

The fourth component is a residential rehabilitation program, and the fifth component is a community or half-way house for those people who are on their way back to their communities. Last week there was a meeting in Port Augusta at which it was determined that an implementation working party would be formed and that working party is now established. It comprises members of the Aboriginal and Torres Strait Islander Commission Regional Council and a member of the WOMA society (the Aboriginal organisation most intimately involved in the substance abuse programs), the Port Augusta Hospital, having the responsibility for the sobering up centre, the City of Port Augusta and the Aboriginal Community Affairs Panel, which is an umbrella body in Port Augusta of Aboriginal organisations.

The implementation committee will be meeting soon and will be resourced by the ATSIC regional office. I cannot say much more at present. Discussions are going on with the Port Augusta City Council about its involvement, but perhaps it is a little early to report on that. I hope there will be good news on that as well in the near future. From that point the question broadened to deal with substance abuse generally and with petrol sniffing. As to substance abuse in general terms, already a number of programs are aimed specifically at Aboriginal substance abuse issues.

Programs are running in Adelaide, Murray Bridge and Ceduna. There is also the program that we are trying to reinstate on a sounder footing in Port Augusta and there are other efforts in other country places. The attempt is to both consolidate those programs and establish some additional ones. Proposals are being put together for possible funding to become available as a result of the royal commission's recommendations. They will largely be Commonwealth funded and the Aboriginal Health Council in South Australia, which has a role in both advocacy and policy development and advice, has formed a substance abuse subcommittee that will be making its way through those proposals and working in with the Commonwealth hopefully to get some further programs established.

On the question of petrol sniffing, I am aware of programs that have been operating in the far north-west of South Australia and also at Yalata and Maralinga. As to funding, in the case of Yalata they are funded by the Drug and Alcohol Services Council (DASC) direct but, in the case of the north-west, it is the Department of Family and Community Services that has been operating the program in that region. While petrol sniffing fluctuates a little, because it depends on the individuals in the community at the time, it is still a matter of concern within some communities and I am sure it is a matter that the substance abuse subcommittee of the Aboriginal Health Council will want to come to terms with in the coming months.

Dr ARMITAGE: I look forward to those results from that substance abuse subcommittee because, as I have just been up there, I know that it is a fact of life that what we have done so far in respect of petrol sniffing has not worked.

Mr McKEE: In the resource variation section on page 34 of the Program Estimates relating to teaching hospitals there is a reference to Commonwealth funding for highly specified drugs. Can the Minister inform the Committee of the levels of funds provided and the benefit of this program to those South Australians who require such drugs?

The Hon. D.J. Hopgood: From January 1991 to June 1992 the Commonwealth provided South Australia with $2.75 million to assist in meeting the cost of two high-cost but essential drugs Cyclosporin, for organ tissue transplant recipients, and Erythropoietin, for the treatment of patients with severe anaemia due to renal failure. In 1992-93 the Commonwealth provided the addition of AZT, which is for the treatment of AIDS and HIV individuals with a T cell count of less than 500, I am advised.

There are a number of other drugs being considered as meeting the criteria for funding under the highly specialised drugs program, and that information can be made available to members. The one that is best known is Interferon Alpha 2a, which is an anti-viral agent used in treating patients, particularly in relation to hepatitis B. In 1992-93 Commonwealth funding of $6.5 million has been provided. In the case particularly of Cyclosporin, once a person is on it, they are on it for the rest of their lives because they have their organ transplant, and I understand that the State pays for the first six months of treatment and the Commonwealth pays thereafter for as long as the individual requires that treatment. It is a reasonably good arrangement from the State's point of view.

Mr McKEE: Page 43 of the Program Estimates refers to health planning and the Social Health Atlas of Australia. Will the Minister describe its use in health planning processes?

The Hon. D.J. Hopgood: The Australian Social Health Atlas followed on from the Social Health Atlas of South Australia. It was a major project of the national better health program which provided the funding for it. It is obviously a major information source for those involved in the planning, management and delivery of health and welfare services. My problem is where to put the damn thing given its size—it does not fit particularly well on an average library shelf.

It is in two volumes, the first of which includes data maps mainly by local government area for the capital cities and major urban centres, towns and rural areas. Volume two shows data from the two major Australian Bureau of Statistics population sample surveys.Data from the 1989-90 national health survey and the 1988 survey of disabled and aged persons are mapped for statistical reasons. I suppose it is one of the matters that has assisted us in looking at regional resource allocation, because it enables us to look at variations in health status and health service use by region and the extent to which that is affected by such things as socio-economic indicators for those particular regions. In any event, the Commonwealth is taking it very seriously, and will be encouraging the States to establish regional goals and targets. These atlases also give the public information that enables them to run their own audit on the response of health systems around Australia to their needs as they perceive them.

Mr McKEE: Page 34 of the Program Estimates refers to a joint venture between a number of teaching hospitals and Calvary Hospital, which as members would know is a private hospital, to provide a lithotripsy service. Will the Minister advise the Committee about this proposal and the cost effectiveness of this new treatment?

The Hon. D.J. Hopgood: It is cost effective because of the arrangement we have been able to enter into with Calvary Hospital. Otherwise, we may have finished up with two units—a private unit and a public unit—which unfortunately so often happens in some service delivery areas. I believe the complete name is extra-corporeal shock wave lithotripsy, and it enables one to fragment renal stones by using shock waves. The fragments then pass out of the body, usually within four weeks of treatment, avoiding invasive surgery. About two or three years ago, the Health Commission was approached by a urologist to acquire this treatment for South Australia. I will ask Dr Jelly to briefly recount what has occurred.

Additional Departmental Adviser:
Dr M. Jelly, Chief Medical Officer.

Dr Jelly: For some time, we considered how best to introduce this technology into South Australia. Clearly, on the numbers that we had before us it seemed unwise to consider having lithotripsy in both the public and private systems. Therefore, we asked private hospitals to tender for providing the service. Those tenders were received and assessed, and one was selected for further negotiation with respect to price and how the service would be provided. Eventually, Calvary Hospital was selected, and an agreement has been signed with that hospital for the introduction of that technology. Another private hospital also sought to introduce the technology, even though it was unsuccessful in its tendering process, and it has indicated that it will proceed with introducing the technology. That is not something that we welcome because we do not think the numbers justify two services in South Australia.

The CHAIRMAN: When will stage one of the redevelopment of the Queen Elizabeth Hospital be completed?

The Hon. D.J. Hopgood: I will ask Trevor Tomlinson to address himself to this question.

Additional Departmental Adviser:
Mr T. Tomlinson, Manager, Health Facilities Branch.

Mr Tomlinson: It is being completed at this very moment. A final check of the fire systems that were installed under the project is the final task, and occupation will commence over the next few weeks.

The CHAIRMAN: Is that the full redevelopment of the QEH?

Mr Tomlinson: We are just completing stage one, and we will then return to the building upgrade.

The CHAIRMAN: What has taken place in relation to dental technicians? The Minister would be aware of

correspondence from me as the member for Albert Park about amendments to the relevant Bill requested, as I understand it, by dental technicians. I understand this matter dates back to before 1979. When will that matter be resolved?

The Hon. D.J. Hopgood: A member of my staff will be available shortly to answer that question.

The CHAIRMAN: I have received correspondence from a company wanting to know whether it is the intention of the Health Commission to review the provision of catering services to all major hospitals in South Australia.

The Hon. D.J. Hopgood: There has already been a considerable major upgrade at Queen Elizabeth and Royal Adelaide. I will ask Ray Blight, the Executive Director of Metropolitan Health Services, to provide further details.

Mr Blight: There is no system to review catering services, but there is an exciting project under way between the Modbury and Lyell McEwin Health Services to look at a new food delivery system based on the cook/chill technology as opposed to the cook fresh or frozen food delivery systems that are in place in the metropolitan hospitals system. The cook/chill method appears to have a number of advantages. First, production can be centralised and done in a batch processing arrangement rather than having to cook for each meal that is served during the course of the day. That gives very significant production economies.

At the two aforementioned hospitals, they have proceeded to trial this technology on a very limited basis. So far, the results are very encouraging in terms of food quality. The system is based on rethermalisation of the food at ward level, and it can be kept hot for up to three quarters of an hour. So, any delays that might occur at ward level in the delivery of food do not lead to any deterioration in food quality. If this system can be implemented, it could lead to budget savings of about $830 000 per annum. Those savings would be primarily in the food production area and will be centralised in the Modbury Hospital. It is feasible to transport the food product from the major preparation area at Modbury Hospital to Lyell McEwin, which means that at the Lyell McEwin site we can forestall a major upgrade of the Lyell McEwin kitchen.

All that will be required at the Lyell McEwin is essentially cold storage for the product coming in from Modbury. So, there will be no need to update all of the preparation and cooking facilities at the Lyell McEwin, which should forestall a capital outlay of something like $1.75 million. The management at Modbury Hospital is very aware of some of the previous issues related to introducing new food technology and will certainly ensure that all staff are properly trained in this method before it is introduced and that the National Health and Medical Research Council standards on food preparation are adhered to in any new project.

The Hon. D.J. Hopgood: Before we leave this issue, I know the member for Stuart and, for that matter, the member for Flinders would not want us to forget the country. Whyalla Hospital has had a new kitchen.

The CHAIRMAN: Finally, should this prove to be successful, I understand that outside catering firms—large national firms—are very interested in being involved. Representations made to me indicate that they are very interested in catering for public hospitals here in South Australia.

Dr Armitage interjecting:

The CHAIRMAN: I heard the interjection from the member for Adelaide, which was that it is their policy. A submission has been made to me on this issue. Has the Minister considered the proposal?

The Hon. D.J. Hopgood: Mr Blight will address himself to this issue.

Mr Blight: We are aware of representations for the supply of frozen food product from interstate sources. In fact, some of that product is currently coming into South Australian hospitals; for example, the Royal Adelaide Hospital, where it is being reconstituted and then used in its conventional plating system. Some of it is also going to Flinders Medical Centre, which operates a complete frozen food system. So, we are aware of those opportunities. In fact, I have put those representatives in touch with Modbury Hospital to see whether they can contribute to the Modbury product line.

The Meals on Wheels organisation is also a potential user of this type of food. We have encouraged Modbury management to make contact with the Executive Director of Meals on Wheels to investigate whether there is any margin for collaboration on the Meals on Wheels side of the equation.

Mrs KOTZ: My question relates to page 43 of the Program Estimates and the line 'development and control of health services'. One of the broad objectives is to develop and implement policies and plans for the provision of a system of comprehensive, coordinated and readily accessible health services. A very fine objective. I would draw to the attention of the Minister the case of another patient in Murray Bridge Hospital at present who is awaiting joint replacement, and for whom the wait on the urgent list in the Royal Adelaide Hospital has been so long that, despite all domiciliary care and outreach service support, that person is no longer able to manage on their joints at all, and is now waiting in an acute care bed in Murray Bridge Hospital until a bed is available for this urgent operation in the Royal Adelaide Hospital.

At one stage, this patient went to a pre-admission clinic in Adelaide by ambulance and, when her x-rays were found to be lost in the system, she was returned to Murray Bridge, by ambulance, with an appointment some four weeks later to have the x-rays repeated. Her local doctor, obviously taking on her concerns, jumped up and down and arranged for x-rays to be performed within six hours of her return to Murray Bridge and, with some persuasive help from an orthopaedic surgeon, the pre-admission clinic was brought forward some three weeks. Upon going again by ambulance from Murray Bridge to the Royal Adelaide, she was sent for further x-rays, blood tests and an ECG, all of which could have been arranged at Murray Bridge with a minimum of communication. By the time she had sat in all these departments at the Royal Adelaide for these tests, and was returned to the pre-admission clinic, it was closed and she was returned, again by ambulance to Murray Bridge. Once these tests had been done, she was yet again transferred by ambulance from Murray Bridge to Adelaide for the pre-admission clinic and anaesthetic assessment.

Her local doctor points out three ambulance trips and the added five week wait for this urgent

procedure—which has been labelled by the Royal Adelaide Hospital as an urgent procedure for some seven months—has resulted in a waste of $1 800 in ambulance trips and over $8 000 in the cost of an occupied acute bed at Murray Bridge Hospital before she even gets to the operation that she requires most urgently. Given the facts that I have just related, does the Minister believe he is in fact presiding over a system of comprehensive, coordinated and readily accessible health services, which I am afraid to say—but believe most honestly—are commonplace in South Australia? Will the Minister confirm that many of these ostensible savings initiatives are in fact costing the community dearly, both in terms of money and prolonged suffering?

The Hon. D.J. Hopgood: Of course, they are not typical at all and the honourable member well knows it. It is almost impossible to comment on the specifics of a case such as the honourable member has put before this Committee. We do not have the CEO of the Murray Bridge Hospital here to respond, nor do we have the people from the Royal Adelaide Hospital. In fact, this is not the sort of thing for which the Estimates Committees were set up. We know that the typical experience of people within our system is quite different from that. All I can say at this point is that I will undertake to get a report for members on this particular case.

Mrs KOTZ: I am quite certain that the person concerned will be happy to hear the Minister's reply. My second question refers to the Capital Works Program 1992-93 (page 45) and the South Australian Mental Health Service area project. Among other capital works there is listed accommodation for approximately 200 additional staff in community locations throughout the State, but predominantly in the metropolitan area. Will the Minister explain in relation to the 200 additional staff what will be the salary and wages bill and oncosts of those people and what implication will this wages bill have for the provision of services under the Mental Health Act? What sort of accommodation are we talking about?

The Hon. D.J. Hopgood: Of course, I indicated in response to an earlier question that the devolution of services from Hillcrest would release a considerable amount of funds for client services and that obviously it is required that people deliver those services. I should perhaps ask the Executive Director of Community Services, Ms Colleen Johnson, to fill in the specifics of the matter.

Ms Johnson: As the Minister said, on an annual basis some $7 million will be available from the relocation of the Hillcrest beds for community services. This will equate to some 200 staff members. As I recall, some 50 or so of those staff will be going into the country areas and the remainder into the metropolitan areas. Detailed planning is taking place within the South Australian Mental Health Service at the moment for the creation of those area teams. I am not aware of the composition of the teams and I suspect that the planning has not gone that far. The teams are expected to be multi-disciplinary and will have medical officers and nurses as well as other members of the allied health professions—social workers, psychologists and so on.

When the Hillcrest proposal was being developed some 18 months ago, planning and costings were done at that stage, and I recall that the annual salary for the community members was worked out at about $37 000, but eventual salaries will depend on the composition of the teams, the seniority of the staff and so on. I have a feeling the honourable member asked another question.

Mrs KOTZ: Yes, the accommodation.

Ms Johnson: The area teams will have community accommodation. As far as I am aware, planning is not advanced in that area either, but it is expected that there will be at least four area officers. The South Australian Mental Health Service is certainly looking for opportunities to collocate with other services around the metropolitan area to reduce the accommodation costs, but we would expect some 40 or so staff to be based in each of the four metropolitan areas.

Mrs KOTZ: As a supplementary question, is it expected that the program that involves the 200 additional staff will be part of this year's budget and planning and, if so, what is the budget allocation for that area at this stage?

Ms Johnson: The total capital program for the South Australian Mental Health Service arising from the devolution of Hillcrest Hospital is $17 million. Part of that $17 million expenditure will be accommodation costs for these community staff. I cannot recall whether that expenditure will actually be incurred this financial year or next; the devolution of Hillcrest Hospital is over a couple of financial years, and the capital works will be progressive throughout that period.

The Hon. D.J. Hopgood: I will ask Dr Blaikie to provide further information.

Dr Blaikie: No community accommodation will be built in this current financial year. The initial allocation for capital works for the South Australian Mental Health Service will be for the establishment of the acute psychiatric wards in three general teaching hospitals to which the Minister referred in answer to an earlier question. The funds to staff the community accommodation will come as the patients are devolved from the Hillcrest Hospital, thereby freeing up staff to be transferred either to community situations or to Glenside Hospital.

Mrs KOTZ: Is it possible to have a break-down of the allocated $6.16 million for this year's capital expenditure?

The Hon. D.J. Hopgood: I will ask Mr Tomlinson to provide that information.

Mr Tomlinson: A detailed feasibility study has just been completed on the SAMHS areas project; that includes a detailed allocation, both capital and recurrent, for each component of the devolution program of $17 million. We certainly will be able to make available a cash flow for each element of the program for this financial year.

Mrs KOTZ: Regarding the capital works program, page 42, I note in the minutes of the Adelaide City Council meeting of 14 September 1992 a proposal to construct two additional floors at the Women's and Children's Hospital for use as clinical offices and plantroom facilities in the Gilbert Building. What is the cost of this additional construction, and will this or any other work on the Women's and Children's Hospital lead to a budget overrun for that project?

The Hon. D.J. Hopgood: I understand that that project was considered but will not be proceeded with so, of course, cost does not arise.

Mrs HUTCHISON: My first question relates to page 43 of the Program Estimates, the 1992-93 targets and objectives, and I note the intention to commence implementation of a nursing automated system. First, what is the nursing automated system, what will be its value in the overall provision of health services and what are the costings for the provision of this service?

The Hon. D.J. Hopgood: This is the opportunity to give Margaret Silver, who is the Director of our nursing unit, a chance to give some details to the Committee.

Additional Departmental Adviser:
Mrs M. Silver, Director, Nursing, Nursing Branch.

Mrs Silver: The project for the automated systems in nursing is a component of several modules, which will provide information systems to nursing divisions. The modules within the system are an automated nurse rostering system and a clinical information system, which includes care planning, patient dependency, quality assurance and a facility to cost nursing care. The implementation of those modules provides, first, the ability to create cost efficiencies through the rostering module by enabling staff to roster to demand, versus supply. The traditional way of rostering was to allocate a number of nurses, whether or not all those nurses were required for one shift. This will enable them to use a patient dependency system, that is, how sick the patient is, and to roster with numbers and the staff skill mix to meet the needs of those clients on one shift.

It will also have the ability for clinical staff to write standards of care, against which the outcomes of care can be measured. So, this system provides not only quantitative measures that enable efficiencies but also qualitative data that enable nurses to look at the sorts of care they give and the most effective means of giving it. I would suspect that for the first time in the history of nursing we will have enough data available to plan, to change care practices and to look at best care practices, so it is a very exciting innovation.

The second part of the question was about the cost. There has been a press release today, I understand. I think I had better give information about the way the costing has been done in both ways. We talked about $7.8 million, which was a capital and recurrent net present value cost. The estimated capital cost over three years is $5.27 million and thereafter benefits will accrue, which are estimated at this time at $4.77 million per annum.

Mrs HUTCHISON: Further to that, where is it being implemented? Is that across the whole system, or will it be in one area first?

Mrs Silver: It will be implemented in 15 hospitals across the metropolitan and country areas. Not every health unit in the State will be implemented, because a cost benefit analysis was done on every health unit and, for example, in terms of rostering, it is not feasible financially to implement the system where there are fewer than 100 nurses. The cost of the hardware and software outweighs the benefits to be gained with only that number. The larger country hospitals will be involved in that implementation.

Mrs HUTCHISON: My second question relates to country women's health services. On page 36 of the Program Estimates reference is made to the expansion of health services for women in country areas of South Australia, and I am sure the Minister is aware of my long interest in this area. Will the Minister provide details on the new services?

The Hon. D.J. Hopgood: I can. The national women's health policy was established in 1989 and the Commonwealth/State response to that policy was the national women's health program. The program includes women's health services and women's health projects for Aboriginal women. Eleven new women's health services have been established in rural South Australia through this program, and expenditure in this financial year will be a little over $1 million. The aims of the services are to do such things as to raise awareness of women's health in the community; to improve women's access to appropriate and affordable health services; to increase coordination and cooperation between the services; also, I guess, to involve women more in the planning and delivery of those health services.

Some campaigns have been to do with osteoporosis, safe sex, menopause, community development for rural isolated women in particular, the training of health workers in the health needs of women and educational programs for women. Under women's health projects for Aboriginal women, special projects have been established in the Riverland and the Murray-Mallee, particularly in relation to reproductive health services for women, and I believe the expenditure on those programs in this financial year is about $40 000.

Mrs HUTCHISON: At page 42 of the Program Estimates regarding the public and environmental health services program, reference is made to the breast cancer screening services. What progress has occurred in the establishment of this important service for women?

The Hon. D.J. Hopgood: I believe that by June this year we were carrying out about 820 screens a week, and there is capacity for something like 45 000 screens annually. The actual throughput for the service in 1991-92 was 22 799 but, of course, it did not run for the whole of that financial year. Indeed, probably from 1995 the service expects to be screening around 65 000 women each year. The mobile unit, of course, was delivered and tested at Glenside Hospital, had trials at Clare and then spent nine weeks in Port Lincoln. Of the 1 443 women screened, 50, or 3.5 per cent, required further assessment and 15 were seen in Adelaide for more detailed special assessment. All screening and assessment services funded through the national program will be done through properly accredited centres, and all existing services must apply for accreditation before the end of this calendar year. So, it is off and running in a very vigorous way and, because of the mobile nature of it, of course, it has the capacity to service most of our country areas.

Mrs HUTCHISON: What is the next step for the mobile unit?

Dr Blaikie: The next location?

Mrs HUTCHISON: Yes.

The Hon. D.J. Hopgood: We will simply provide the program.

Dr Blaikie: We are also getting a second unit under our capital works program, so we will have two mobile units.

Mrs HUTCHISON: Will that second unit go to a different area?

Dr Blaikie: That is correct.

Mrs HUTCHISON: Will the Minister give the House details of what is currently happening under the lead decontamination program in Port Pirie?

The Hon. D.J. Hopgood: I suppose one of the more interesting things we might be facing in the lead program at Port Pirie in future years will be the possibility that what are regarded as the maximal permissible lead doses, or lead levels, might be reduced, and obviously we would have to look very carefully at what the response of the program might be should that happen. It has not happened yet: we will look at it very closely. However, I can advise that, since the program began, 15 021 homes and 83 vacant blocks of land have been decontaminated, and over the next two years an estimated additional 500 to 600 homes .will undergo treatment.

There has been a good deal of work done on the planting of plants of salt tolerant species. There is a stock of something like 8 500 plants at the centre's plant nursery, and they will be planted out over the next few months. Depending, of course, on the level of resources to be put into the early care and nurture of these, and particularly to ensure that there is no loss of the watering apparatus, we get some quite varied results as far as success is concerned. There have been some areas of very high levels of success in planting and there have been some other areas of quite low levels of success. Footpath sealing is subsidised by the program and that has been continued by the city council in areas where homes have been decontaminated and, of course, the centre has worked closely with other local agencies to ensure that young children and their care providers receive the total care package covering health issues, such as diet and immunisation.

The overall results indicated that the reduction in the number of children with blood lead levels above 25 micrograms per decilitre—which is the National Health Medical Research Council level of concern—recorded in previous years was being maintained. This is on a six-monthly blood testing cycle and overall there has quite clearly been a substantial reduction in the blood lead levels of the children.

Mrs HUTCHISON: As a supplementary question, there was some suggestion that the lead level reading would go down to 20 micrograms per decilitre. Has anything come through on that?

The Hon. D.J. Hopgood: I do not think there is any finality in that matter as yet, though we are aware that it is something that could well happen and might lead to a modification of the program in the future. I know our people are planning for what the appropriate response should be should that happen. Obviously, we will want to adhere to the levels which are determined.

Mrs HUTCHISON: I am aware that the lady in charge, Miss Cathy Phipps, whom the Minister would know, has been monitoring that fairly carefully, and I have not had a chance to talk to her.

Dr ARMITAGE: At page 13 of the blue book, I note that the line relating to support services for the Minister and the Minister's office was $46 000 over the budget allocation of $671 000—a 6.9 per cent overrun. I note also the estimate for 1992-93 is $680 000, which is clearly an elevation of the budget. Does the same criterion apply with regard to over-expenditure in the lines supporting the Minister and the Minister's office as applies in teaching hospitals, namely, that any budget overrun attracts a 100 per cent penalty in the following budget year?

The Hon. D.J. Hopgood: First of all, I think the honourable member, with respect, has misread the figures. The figures I have in front of me indicate that there was a budgeted figure of $717 000 and there was a net of $671 000. In fact, we were $46 000 underspent. I would be surprised if that was not the case, because I dropped one ministerial officer, although I have never been quite sure who pays for what as between the Health Commission and FACS in these areas.

Dr ARMITAGE: The blue book (page 29), regarding the South Australian Health Commission workforce statistics, indicates that the average number of full-time equivalents is 36.92, excluding overtime and non-employees. Will the Minister define what are non-employees? What is the cost of non-employees to the commission? How many non-employees does the Health Commission employ? How are they selected and what tasks do these non-employees perform?

The Hon. D.J. Hopgood: We will ask Mr Peter Davidge, who is the Executive Director, Finance and Information Division, to explain the non-tasks that these non-employees do not happen to perform.

Mr Davidge: I do not think I can provide an answer on the spot to all those questions, but with respect to the category of non-employee a large component of that relates to casual nursing staff employed by the hospitals from time to time to supplement their work force and in situations of peak demand for nursing staff. That is the major category. I would be pleased to provide the additional information for the honourable member.

Dr ARMITAGE: At page 29, the blue book indicates a total figure for the Health Commission average full-time equivalents classified as workers compensation being 348.4. I am unclear as to what that means. Does it indicate the number of South Australian Health Commission employees being paid workers compensation? If so, can the number be clarified, including details such as the length of time off work, the diagnoses and other relevant details? If it does not represent the employees being paid workers compensation, what does it represent? If it does represent Health Commission employees on compensation, how many are there?

The Hon. D.J. Hopgood: Again I will ask Mr Davidge to respond. Some of that information may have to be provided later.

Mr Davidge: The 348.4 is the number of staff categorised as being on workers compensation during the year. That is an average figure, as are all those FTE figures shown on the chart to which the honourable member refers. The blue book for last year indicated that that figure was 406.76, so there has been a reduction in that category of the work force during the year. It reflects a number of efforts made by the Health Commission

during the year in terms of reducing the number of people on workers compensation.

The Hon. D.J. Hopgood: I should say that, in the way in which we are trying to be precise in the use of words, clearly the yellow book provides the total for that which is funded by the Health Commission—in other words, all the health units. We are not talking specifically about the central office, whose total work force is only about that figure anyway.

Mr QUIRKE: Last year I asked a few questions about the South Australian breast X-ray screening program, and I want to find out where we are 12 months later. What are the current sources of funding for the South Australian breast X-ray screening program?

The Hon. D.J. Hopgood: It is a joint Commonwealth-State funded program arising out of the strategy which was formed in 1989. I will ask Dr Kirke to provide more information as to the shares of that funding.

Dr Kirke: As the Minister has stated, most of the money for the South Australian breast X-ray service comes from the Commonwealth shared program. In 1991-92 the actual receipts were $1.464 million, and the 1992-93 budget figure is $2.113 million from the Commonwealth. Actual payments in 1991-92 were $1.984 million and it is proposed this year that the total expenditure will be $4.452 million, so it is about 50-50.

Mr QUIRKE: What has been the total cost of the program to date?

The Hon. D.J. Hopgood: We will take that on notice. We may even have the answer back before the Committee rises.

Mr QUIRKE: Still in relation to the screening program, what amount has been spent on buildings and renovations, equipment for radiology and clerical services, and external consultancy fees?

The Hon. D.J. Hopgood: Again, we will have to take that on notice.

Mr QUIRKE: What percentage of the total funding has been applied to the actual screening component—that is, the actual mammography service—as opposed to administration and capital costs, etc.?

The Hon. D.J. Hopgood: That would also require some dissection which we will do fairly quickly.

Mr QUIRKE: What was the cost of the present mobile screening unit, and who was responsible for its design?

The Hon. D.J. Hopgood: I will ask Dr Kirke to provide that information.

Dr Kirke: The cost of the current mobile unit was $400 000 plus a little extra that was donated by Lions and Weight Watchers in South Australia. The design was a composite affair. A committee of experts was set up locally to oversee the production. It was built by Recreational Vehicles of Australia in New South Wales. We had a series of basic designs from which to choose. There was much debate as to whether it should be a bus or a caravan. Eventually it was decided that a semi-trailer was the way to go: it could be taken to a place, and the prime mover could go off about its business and leave the trailer established and set up.

Mr QUIRKE: It has been suggested to me that this first unit that has been put together is too large for any prime mover within the public sector; therefore, one has to be hired from outside to make the mobile unit mobile and to shift it from place to place. Is that correct? If so, what additional costs does that incur?

The Hon. D.J. Hopgood: We would have to provide that information. I just wonder where in the public sector we would have a prime mover—perhaps in Housing and Construction. In any event, we would have to have some sort of contract arrangement with them, and we are happy with our present arrangement, as I understand it.

Mrs KOTZ: As we are discussing the mammography screenings and the caravan, I am quite sure that the Minister realises my interest in this area. I would compliment the Minister and the department on putting together the caravan that had been promised. I know that the results and the expectations from such screenings have been appreciated by women in rural areas. However, one concern was related to me just recently, in respect of the fact that there does not appear to be wheelchair access to the caravan. Upon hearing that we are about to have a second caravan introduced, has this concern been relayed to those who have anything to do with the design and construction, and will that concern be taken into consideration and the problem rectified in the new design?

The Hon. D.J. Hopgood: I understand Dr Kirke can answer that question.

Dr Kirke: It has come to our attention that the 1.5 metre lift from the ground to the door of the caravan is more than most lifting devices will manage. Initially we believed that the lifting devices on the back of small buses and so on would be the right height, but unfortunately they will only go up to the floor height of the back of the bus and that is not enough. We are now looking at various options with lifting devices and so on. This is a real problem that we had not anticipated.

Mrs KOTZ: I am also led to believe that even if you were to get access from the outside to the inside of the caravan the actual corridor within the caravan would not be able to take a wheelchair.

Dr Kirke: That is true. On the one hand we are accused of having the van too big and on the other hand we are accused of having it too small. We have tried to make the most effective compromise and for 99.9 per cent of women it is working just fine.

Mrs KOTZ: In the Program Estimates at page 42, one of the 1991-92 specific achievements was reported as 'assist in development of guidelines relating to HIV and hepatitis B for health workers'. Will the Minister release all of those guidelines, in particular, those pertaining to notification of patients treated by HIV and hepatitis B-positive health workers?

The Hon. D.J. Hopgood: Yes. The honourable member does not require a further response at this stage. She has asked for that to happen. It will happen and we will see that she gets a copy.

Mrs KOTZ: The Program Estimates on pages 28 to 32 in the column headed 'Employment, average of full-time equivalents' has no numbers at all for the 1992-93 year despite all other portfolio areas supplying these numbers. Why are the numbers classified as not being available and how can any forward budgeting for 1992-93 occur in the absence of such figures?

The Hon. D.J. Hopgood: I will ask Mr Davidge to speak to that.

Mr Davidge: That information has never been provided to this Estimates Committee. The reason is that the time frame we have to prepare this information for the Committee does not allow us to contact, check and get that information back from the health units. It is important to bear in mind with the preparation of this type of information that, to get something that is reasonably accurate for the purpose of such a document, health units are still in the process of examining what impact the budget allocations will have on them and on their staffing. For us to put that information together requires us to seek it from nearly 200 health units in the system.

Mrs KOTZ: As to Program Estimates, page 38, Mental Health Services, under the specific targets for 1992-93 it states 'establish two additional acute care wards in general hospitals'. Given the push by Mental Health Services to house acute mentally ill patients in general hospital wards, a process known as mainstreaming of beds, will the Minister explain South Australian Mental Health Services' plans to set up a stand alone acute care service at Queen Elizabeth Hospital? What is the budget for that program? Will acute care wards in general hospitals be run under the control of the general hospital or as a separate entity and under different control?

The Hon. D.J. Hopgood: I did partly answer this earlier in the day in indicating which acute hospitals would be involved, but perhaps it would be appropriate to ask our Executive Director, Community Services, to come to the table and explain how it would be sorted out as between the management of the acute hospitals and the South Australian Mental Health Services.

Ms Johnson: The matter of the management of the beds which are to be relocated to the general hospitals is being discussed between the South Australian Mental Health Service management and the management of local hospitals. The South Australian Mental Health Service would certainly want a clear contract arrangement between it and the general hospital. Discussion is going on as to the employment arrangements of the staff and so far as I am aware that matter is not resolved.

The Hon. D.J. Hopgood: There was a further component of the question about the capital budget.

Ms Johnson: As to the beds which are to be located in the western suburbs, it is not clear at this time where those beds will go. Clearly, there are some difficulties in finding a suitable location. The Queen Elizabeth Hospital does not have ground floor accommodation readily available, and obviously that is preferable when one is talking about a psychiatric ward. Accommodation is potentially available at Tenterden House, to which the honourable member has referred.

That accommodation clearly has difficulties in that it is separated from the rest of the hospital by Woodville Road. The honourable member probably noticed earlier today when we talked about where the beds were going that there was a question mark about the western suburbs for these reasons. The location of beds at Lyell McEwin and Noarlunga has been relatively straightforward but it is not so straightforward in the western suburbs, and the South Australian Mental Health Service is still considering what can be done in that area. It has not been able to find a good solution quickly. The honourable member asked about the budget: at this time $1 million is set aside for the refurbishment of a ward area in the western suburbs and that money will be expended when we have located a ward that is suitable.

Mr McKEE: At page 34 of the Program Estimates there is reference to the construction of the Queen Victoria wing of the Women's and Children's Hospital: can the Minister provide a progress report on this project?

The Hon. D.J. Hopgood: The honourable member referred specifically to the Queen Victoria wing and I will ask Mr Tomlinson to interpret.

Mr Tomlinson: The Queen Victoria wing is being constructed on the corner of Brougham Place and another street whose name I cannot recall. The Queen Victoria wing will house the prime functions that are coming across from the Queen Victoria Hospital. The demolition of the existing building on that site is almost complete and construction will commence and take 2½ years to complete.

Mrs HUTCHISON: Page 41 of the Program Estimates refers to the efficient delivery of health services to Aboriginal people by community controlled Aboriginal health services. In my travels around the Pitjantjatjara and Maralinga Tjarutja lands I have found that there seems to be a specific problem with the hearing of Aboriginal children. What sorts of things are in place to overcome this problem, which seems to me to be fairly significant in terms of the loss of hearing of Aboriginal children?

The Hon. D.J. Hopgood: I will ask Mr Taylor to provide a specific report on that. It certainly is a problem.

Mr Taylor: I am able to provide some general information, but if that is not sufficient I will be happy to prepare some more. The information I have relates particularly to what is going on in the Pitjantjatjara lands where for some time now a cooperative project has been conducted between the Nganampa Health Council itself, the Education Department and health services from the southern part of the Northern Territory. They have been assessing two methods of assisting hearing defective children. The first method is the use of FM radios whereby the individuals who have already been detected as having a hearing problem have the teacher's voice amplified for them. There are some problems with this method because, by its very nature, hearing loss can fluctuate in some of these children. So, one day you might identify a child as having reasonable hearing but the following week that might not be the case and the child might be missed out.

Another method which is being assessed concurrently and which looks like being even better involves a system from the United States where the teacher's voice is amplified for all members of the class but in such a way that it does not become intrusive for those who have adequate hearing. It has been shown that there are benefits not only for those children who are hearing deficient but also for other members of the class: it tends to keep up their level of concentration. The only problem with this method is that in those situations where a couple of classes share a common area the teacher's voice is amplified for all members. So, it has that sort of restriction, but overall the second form of amplification appears to be the most useful.

The Commonwealth agency of the National Acoustic Laboratory is also involved in this assessment and is providing FM hearing equipment for those children currently using that system. Further effort is being put into the treatment and identification of hearing problems, in particular, the condition known as 'glue ear' or discharge from the inner ear. Some very innovative things are going on in this area. Health staff are constantly on the alert and perform toilets on the kids' ears and there is an education process for the families. In some instances, the kids have elected junior health workers who each morning check out their fellow classmates and see who has a problem. So, a lot of things are being done to identify this problem. Regrettably, it has become virtually commonplace in some areas, and in many families the fact that a kid has a discharging ear has not been a priority, but the Education Department is explaining to these families and getting them to accept that it is a problem, that kids do not have to put up with the pain and discharge and that ultimately if it is not corrected it can affect their learning, their language and their opportunities in later life.

So, quite a bit is going on, but there is still a long way to go. Unfortunately, the environmental conditions in which many of these people have to live are contributing factors, and they are also being addressed in the general upgrade of environmental conditions. However, things such as overcrowding and lack of adequate bathing facilities and dust are contributing factors, but I am pleased to say that, although an awful lot of work is still to be done, it is certainly being addressed at present.

Mrs HUTCHISON: What is being done to try to prevent these hearing problems in the first instance? It has been suggested to me that if these children swim in swimming pools there seems to be an improvement in their hearing because of the cleansing mechanism of the swimming pool and because they have to shower before entering the pool. I think this happened in Western Australia, and one of the communities I visited in the Aboriginal lands said that there had been some fairly good results from having a community swimming pool, because it encouraged children to keep their noses and ears clean. Has any investigation been done in regard to this and could the matter be pursued?

Mr Taylor: I understand that Dr Kirke may be able to provide some of the medical information on this matter, but I can comment briefly on the benefits of bathing. This has been taken on by a number of communities which have instituted a pre-school bathing session in those areas where bathing facilities in the home are considered to be inadequate. The kids come in each morning, have their shower and then go into the classroom. Dr Kirke will provide the medical side of the answer.

Dr Kirke: My experience goes back to the Northern Territory over about 30 years of dealing with children with chronic suppurating ears and consequent fluctuating deafness. My experience was that, although popular wisdom had it that letting these kids swim would be bad for them and everyone else, in fact the kids who chose to swim, whether or not they were allowed to, and who at the time had chronic suppurating ears, got better. I think it was the result, as the honourable member has said, of the physical effect of washing out the ears with water laced with chlorine of some sort or another.

The original cause of the chronic ear disease is not well known. It is sometimes thought to be due to chlamydia, the same organism that causes pelvic inflammatory disease and one or two other unpleasant things. The Menzies School of Health Research in Darwin is spending a lot of time and winning research moneys to actually look at this to try to decide whether it is such a common cause that perhaps a vaccine ought to be developed or something of that nature. So, a lot of work is going on in this area right now.

Mrs HUTCHISON: Mention was made of some work that is going on with educational programs for families in the community. Could we be supplied with a copy of those programs?

The Hon. D.J. Hopgood: Yes.

Dr ARMITAGE: Page 38 of the Program Estimates refers to a specific objective to research adolescent vulnerability with particular reference to prevention of teenage suicides. What specific results have come from this research and what action will the Government take on the findings?

The Hon. D.J. Hopgood: I will take that question on notice and provide a copy to the honourable member.

Dr ARMITAGE: I refer to support services on page 21 of the blue book. Under the heading 'Other Expenses' it is shown that $1.481 million was spent. That is 70 per cent of the total salaries and wages bill of $2.126 million for the central office. What were the other expenses?

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

Dr ARMITAGE: Page 22 of the blue book refers to non-compensable patient accounts. It states that a total of $12.643 million is outstanding, of which $3.879 million of non-compensable patients' accounts have been outstanding for greater than 60 days. Given the effect on hospitals of budget cuts, what specific steps does the Health Commission take to ensure these outstanding accounts are recouped and, in particular, what steps are taken for non-compensable accounts of greater than 30 days as would happen in the private sector?

The Hon. D.J. Hopgood: Again I will ask Mr Davidge to respond.

Mr Davidge: The figure of 3.879 greater than 60 days relates to accounts that obviously are much more difficult to collect than those less than 60 days. The hospitals look at these accounts quite assiduously. Under the net funding arrangements that we now have it is to the benefit of hospitals and health units to ensure that their collection practices are as efficient as they can possibly be. However, some accounts—particularly non-Medicare type accounts—are often extremely difficult to collect. They might relate to foreign patients or people from overseas who are being treated in hospitals here. There are some difficulties intrinsic in that type of account.

Dr ARMITAGE: I understood that from the fact that they are greater than 60 days. My question was: what specific steps are taken to recoup these outstanding accounts, because the best part of $4 million would be very gratefully received by a number of the hospitals that have suffered quite major reductions in budgetary outlays.

Mr Davidge: The basic responsibility lies with the individual hospitals. Obviously, at a central level we

monitor their performance. As a matter of course and on a regular basis we remind the hospitals of this information and how they are trending in regard to their collections. However, it is basically the responsibility of the hospitals and the health units. As I said, the incentive is there for them, because under our new net funding arrangements whatever revenues they collect provide a benefit to their budget.

Dr ARMITAGE: As a further supplementary question, given that some of the accounts are from overseas patients and various other instances such as that, can I have a breakdown, within some broad categories, of those patients who have outstanding accounts?

The Hon. D.J. Hopgood: We will endeavour to get that information.

The CHAIRMAN: It has been put to me as the member for Albert Park that in some hospitals it is not unusual to receive two or three accounts. Is there a uniformity in major public hospitals in South Australia in terms of accounting procedures? It has been suggested that when patients leave some private hospitals they receive only one account rather than the three or four that are issued by some public hospitals.

The Hon. D.J. Hopgood: Before I answer that question, I have information on questions asked previously. Regarding cardiac angiogram equipment at the Women's and Children's Hospital, my officers estimate that about $2 million is required, but at this stage we have not responded, because no specific proposal has been put to the commission by the hospital. As and when a proposal is put to us, we will respond and work it into the program.

The second response is in relation to the registration of dental technicians and clinical dental technicians. I think that you, Mr Chairman, and the Committee know the history of this matter, so I will not relate it again. At the Health Ministers Conference in April this year, there was a motion to review the need for registration of partly regulated health occupations, and that includes those not registered in all or most of the States. The dental technicians come into that category. A preliminary assessment paper has been released for comment, and the advisory council for the Health Ministers will consider the results at its meeting, which I think is next month. That would then go to the Health Ministers Conference to be held next March or April.

The effect of what happened at the Premiers Conference and subsequently at the Health Ministers Conference is that there is some expectation that Ministers will not break ranks: if we are to move in this area, we will all move together, so it will depend very much on that review, which will be reported to the advisory committee to the Health Ministers in October this year. I understand why dental technicians are anxious for some resolution, and my best advice would be to stay tuned. The third matter is hospital accounts, and Dr Jelly is in a position to give us a response on that.

Dr Jelly: The accounts in the public hospitals for full-time staff will reflect, first, an accommodation charge by the hospital, and the hospital will then bill on behalf of those private doctors involved in the care of that patient, so the hospital will send out a number of accounts. In the private system, of course, the hospital bills only for the accommodation, operating theatre charges and some ancillary charges. All the other accounts are sent to the patient by the private doctors. It has been my misfortune recently to have surgery; I have had four separate accounts other than the hospital charge in the private system.

The Hon. D.J. Hopgood: Finally, there was the matter of the Mental Health Service capital works, and Mr Davidge is in a position to give us a response on that.

Mr Davidge: The sum total of the Mental Health Service's project costs over the next three years is estimated to be $17 million, and in 1992-93, as already mentioned, $6.2 million will be spent; in the following year, $8.1 million; and in 1994-95, $2.7 million. The estimated project cost of $17 million is made up as follows: $2.6 million for accommodation for mentally ill patients in metropolitan hospitals; $3.7 million for building works and refurbishment of facilities at the Glenside Hospital to accommodate additional beds; $2.1 million for community based facilities, and that includes area offices and accommodation for staff as well as other facilities for client use; $2.1 million for demolition, site rehabilitation and relocation of services at Hillcrest and Glenside—that money needs to be spent so that land can be made available for sale, as $16 million of the project cost is being financed by land sales at Hillcrest and Glenside; $3.4 million for furniture, equipment and vehicles associated with staff, accommodation of staff and other facilities associated with the project; and the balance is made up of professional fees and normal contingency amounts for a project of this nature.

Mr QUIRKE: I want to follow up my questions about the mobile unit for the screening program. What is the estimated cost of the proposed second unit; what is the status of that proposal at this stage; how does it vary from the first mobile unit; and was it put together by the same people?

The Hon. D.J. Hopgood: The status is very firm, but I will ask Dr Kirke to give the specific details of the costs and so on.

Dr Kirke: The second mobile mammography unit for screening purposes is thought to cost about $280 000, although that is not firm yet; it is still in the early design stages. There is some debate as to whether it ought to be a caravan or a small bus. Its proposed use would be somewhat different from that of the first mobile unit that we discussed earlier. This next one will be used in the outer metropolitan area to save those people who live in those areas having to travel into the city to visit one of the screening units, leaving the bigger unit free to cover the country in remote areas. So, we are making haste a bit slowly with the design in this case in the hope that we learn some salient things from the good bits and the bad bits of the first one.

Mr QUIRKE: Unless I am wrong—and I am no expert in this area—it seems to me that mass mammography screening, as is the case in this program, even with the highest of possible standards, involves the possibility that the cancer in some women will not be detected. As I understand it, this has happened interstate and it is more advanced, so to speak, and cases are before the courts which have come about because at the screening stage the cancers were not detected. Have there been court cases interstate which have resulted in payments being made to individuals because of a failure

to detect at the point of screening? Secondly, are any cases of a similar nature pending in South Australia? Thirdly, given that this is a possibility, what contingency plans does the Health Commission have for such litigation?

The Hon. D.J. Hopgood: The debate to date, interestingly enough, has more been over the opposite situation where people are referred for further diagnosis which subsequently proves there is no real problem, and there was a bit of a national debate about over-servicing which had to be got through before the funds were approved. I think we are through that one. We are not aware (and I have just checked with my officer) of any litigation which is proceeding interstate, but we will have that matter checked out. I am not aware of any contingency plans, in the sense of any fund being set up, or anything like that, in relation to the possibility of litigation.

I suppose the possibility of litigation arises, in a sense, over any procedure which is carried out in any unit which is under the general aegis of the Health Commission Act, and that is something we well know and have lived with for some time. I am not sure that this introduces any special element into that whole area. We can talk about the actual policy on that if the Committee is interested—that is, the more general one—but I do not know that there is anything specific in relation to mammography. We will get whatever information is available in relation to anything like this that might have happened around the country.

Mr QUIRKE: In medical circles there is some suggestion that patients are being referred to the Flinders Medical Centre from, say, the northern suburbs. Some of my constituents have said that they would prefer to go to the Modbury Hospital or, at the very least, the Royal Adelaide Hospital. Are screening services carried out at all major Government hospitals? Is there some sort of waiting list in some of the hospitals and not at the Flinders Medical Centre? Why has that situation come about?

The Hon. D.J. Hopgood: Again, I will ask Dr Kirke to respond to that.

Dr Kirke: As most people are aware, this screening program is growing; it has been going for only two years. Clinics are being developed. There is one in the central business district about to open its doors. Initially, during the pilot phase, three major hospitals—the Flinders Medical Centre, the Royal Adelaide Hospital and the Queen Elizabeth Hospital—had screening units. They are gradually being replaced by more accessible community based clinics, and it is our intention that people will not have to go any distance at all to get screening. As I was saying earlier, the purpose of our second mobile is to make the service accessible to people who would normally find transport a problem.

Dr ARMITAGE: I note from page 35 of the Program Estimates that one of the significant achievements for 1991-92 was the opening of additional beds and day surgery facilities at Noarlunga Hospital. How many beds does Noarlunga Hospital still have to be opened, and what has been the total capital cost of equipping the unutilised facilities such as these unopened additional beds at Noarlunga Hospital, the purchase of private bed licences, and so on, for Noarlunga Hospital?

The Hon. D.J. Hopgood: There are 60 beds open at present and, in terms of the information that was available when the hospital started, one would anticipate 60 beds to go. I do not know to what extent the planning of my officers might have been complicated by the decision to have psychiatric beds at the hospital. That is something that is probably due for some rethinking on the matter. We will get that information, and we will also obtain the financial information that the honourable member is seeking.

Dr ARMITAGE: From page 40 of the Program Estimates, I note that attendances at the Drug and Alcohol Services Council are increasing at the rate of roughly 10 per cent or more per year. How many people with heroin addiction attend the service? How many are attending for the methadone program; what is the cost of the methadone program; and is there a waiting list for assessment for heroin addicted people?

The Hon. D.J. Hopgood: I will ask Colleen Johnson to respond to that.

Ms Johnson: As at 2 August this year, there were 817 people on the methadone program; 331 of those clients are receiving their daily dose of methadone from the Warinilla Clinic and the remainder are receiving their methadone from community pharmacies. A further 44 clients are receiving counselling only, and that makes a total of 861 clients. There has been, in the last 14 months, a 39 per cent increase in client numbers, and the reason for this is unclear at this time. I am unable to give the cost of the methadone program now; I would need to obtain that. Regarding the number of people who are waiting for assessment, as at 19 September there were 34.

Mrs KOTZ: I note page 40 of the Program Estimates, that another of the significant initiatives for 1991-92 was the establishment of a pregnancy advisory service. What was the total cost and, as it provides a service which had previously been available at the Queen Victoria Maternity Hospital, does the Minister agree this cost ought to be added to the total cost for the amalgamation of the Queen Victoria and the Children's Hospital?

Dr Blaikie: The total capital cost of the pregnancy advisory centre was $2.113 million. The centre does provide some of the services previously provided at the Queen Victoria Hospital, as well as services previously, and still being, provided at Queen Elizabeth Hospital. In addition, it provides a total service to people who require pregnancy advice. Some initiative funds in the order of $400 000 last year were provided for the pregnancy advisory service to commence. Additional funds for the operation of the service will come from Queen Victoria and Queen Elizabeth Hospitals as we shift services from those hospitals to the centre.

The Hon. D.J. Hopgood: In relation to the last part of the honourable member's question, building on the factual information provided by the Chairman, I do not mind whether it is added to the cost or not. I do not know what that does in terms of the argument one puts forward. In light of the information we have just heard, I suggest that not all the services which are and will be provided by the pregnancy advisory centre are necessarily services that automatically have come from Queen Victoria Hospital. Some of them simply relate to improvements in services, and some relate to services traditionally provided at Queen Elizabeth Hospital.

Mrs KOTZ: With respect to page 34 of the Program Estimates, one of the 1992-93 specific targets is, 'Commence the joint venture between Calvary Hospital, FMC, RAH and the QEH to provide lithotripsy services'. How will public patients from each hospital be allocated to the lithotripsy services? By that, I mean will each public hospital have a certain budget for lithotripsy services or will each hospital have a certain number of services that it can provide? What happens when either the budget or the number is exceeded?

The Hon. D.J. Hopgood: The historic charge for treating patients in the past, where they have been referred interstate, is $1 500 per patient. Additional costs associated with accommodation and transport were met from the PATS scheme. This question in a different form was asked earlier today. Calvary Hospital expects that a lithotriptor will be available in mid-October 1992 with instruction from a person with experience overseas who will instruct our urologists on the use of the machine. The Australian Institute of Health has suggested a saving of $1 100 per patient treated by lithotripsy compared with the other more invasive therapy. Dr Jelly may have some further information in relation to the rest of the question.

Dr Jelly: The negotiated price for providing the service at Calvary Hospital is $1 500, a price that is common in Queensland and Victoria for the use of that sort of machinery. Medical services associated with the treatment will be provided by the public hospitals, and the public hospitals will be responsible to refer public patients to the lithotriptor. Any additional patients over the 150 that we have identified that our Health Commission will fund in the first instance will have to be paid for by the hospitals.

Mrs KOTZ: There is no separate budget being allocated to counter this. Is it within the hospital budget system now?

The Hon. D.J. Hopgood: No.

Mrs KOTZ: With respect to page 43 of the Program Estimates, one of the 1991-92 specific achievements was to have established a gynaecological clinical program group. Will the Minister provide all the details as to the function, membership and budget for this group?

The Hon. D.J. Hopgood: Perhaps Dr Jelly is best placed to give some of those details.

Dr Jelly: At this stage we have developed a clinical program which we have been working at for some time to try to get a cooperative arrangement between those gynaecological services provided by the Women's and Children's Hospital, currently at the Queen Victoria site and subsequently at the ACH site, and the Royal Adelaide Hospital. We have provided some money to enable a director of a conjoint service to be appointed. In respect of the clinical program and its membership, I do not have a total list, but it is representative broadly of the hospitals, the Women's Health Forum and a number of other people. Future budgets have not been provided for at this stage.

Mr McKEE: Last year Dr Kirke provided an answer to a question I asked about a proposed research project into the quality of take-away food. Considering the size of the take-away food industry, has that project been completed and, if so, what were its findings?

The Hon. D.J. Hopgood: I will ask Dr Kirke to continue the saga of the take-away food.

Dr Kirke: I think last year I referred to the Australian Market Basket Survey which is something we are very much part of. All capital cities in the country are actively involved in it. The 1992 survey certainly looked closely at take-away food, pizzas in particular, if I remember rightly. So far the results have not shown anything untoward in this State. We will have to wait until next year to get the total report because the survey is done on a seasonal basis. There are four collections of food representing the four different seasons, and the report is not completed until the year after the survey. However, if there are untoward findings during the year, there is a fast track. The Australian Government Analytical Laboratories provide the State health authorities with information as to higher than expected levels of the various chemicals, pesticide residues and so on that are looked for. There have been two collections so far in this State, and neither has produced anything about which anyone needs to be concerned.

Dr ARMITAGE: With reference to page 11 of the blue book, it is indicated under 'Community Health Services' that the actual payment for the Family Planning Association in 1991-92 of $595 000 is estimated to reduce to $537 000 in 1992-93. Given the excellent work of the Family Planning Association—it is probably just as good since I have left it, I am not sure—and the clear advantage of preventative medicine in this field, will the Minister explain why there is a 10 per cent decrease in funding for the association, particularly given the expenditure on the pregnancy advisory centre, and say what services will be cut owing to the 10 per cent reduction in funding?

The Hon. D.J. Hopgood: I will ask Ms Johnson to respond.

Ms Johnson: Despite the appearance, the Family Planning Association has received no cut this financial year. It received its budget of last year plus a 1 per cent inflation factor. The perception of a cut can be explained by three items. There was an allocation last year of $60 000 for AIDS funding, and AIDS funding for this year is yet to be allocated. There is a reduction in the premium for general insurance and a reduction for the workers compensation 'burning cost' scheme.

Mrs KOTZ: At page 20 in the blue book under the heading 'Development and control of health services, health service policy development planning, central office', 'other expenditure' totals $672 000, which is 41 per cent of the total salaries and wages. Will the Minister provide the exact details of this other expenditure?

Dr Blaikie: We can tell the honourable member what is in it, but we have not got the specific details for each item.

Mrs KOTZ: As you do not have the full list, I would prefer you to take it on notice and provide full details. Turning to page 35 of the Program Estimates, as a commentary in the area of major resource variations between the years 1991-92 and 1992-93, one of the components of the increase is stated as additional funding provided for prison medical services. Will the Minister provide the following details in relation to prison medical services? Again, there is a component of five different questions and I would be happy for the Minister to take them on notice. What was the total funding last financial year? What is the total funding for this financial year?

How is funding allocated? How many services were provided and how many prisoners were treated by prison medical services?

The Hon. D.J. Hopgood: We will get that information.

Mrs KOTZ: At page 36 of the Program Estimates, in the area of specific targets for 1992-93 there is the target to complete the feasibility study for the new Mount Gambier Hospital. What does the Minister intend to do about the option of having Mount Gambier Hospital built by the private sector several years earlier than is possible under the public health budget and at no public expense, given the motion passed by the Labor Party to prevent the Minister further exploring this option?

The Hon. D.J. Hopgood: The motion which passed through the ALP convention did not prevent the study, which is being undertaken, continuing. It seems to me that depending entirely on the results of that survey, on the one hand, the Labor Party itself might want to reconsider its position and, on the other hand, those who have been pushing for what might be called a private sector solution might also want to reconsider their position. My attitude is simply to wait on the final result of the study which may well indicate that there is little to be gained by proceeding down some sort of quasi private sector track. We shall see. If there is clear evidence that there are some fiscal advantages in moving along those lines, I would want to further consult with my parliamentary and other colleagues.

Mrs KOTZ: Is the Minister happy to concede that there is still an option in that area of private funds being used?

The Hon. D.J. Hopgood: There is always a possibility because motions can always be superseded by other motions. Without wanting to unduly prolong things, I point out that, although there would appear to be some advantage in the attraction of private capital in terms of staging the project, it is not some years and I believe we could get into it 12 or 18 months earlier than would otherwise be the case. In the normal staging of capital budgets we would want to move into this in any event, if it were to be fully Government funded, by the middle of this decade.

Mrs HUTCHISON: I refer to page 36 of the Program Estimates and the country health services program: 'reviewed pharmaceutical costs in country hospitals', under 1991-92 objectives. Can the Minister give the results of that review and indicate the recommendations? Has anything been implemented?

The Hon. D.J. Hopgood: Mr Dunn has information on that.

Mr Dunn: We have the results of that survey and we can provide that to the honourable member outside of the Committee. We were trying to assess with hospital participation in the $5 million that is expended annually on country hospital drugs where there are opportunities to reduce costs or to buy in a more competitive way. The structure of that review was to separate the hospitals in the country into four distinct groups with similar client loads. Within that we felt that there were opportunities of 5 to 10 per cent where there could be more competitive purchasing. We have produced that report and are making it available to hospitals so that they can contrast their expenditure against similar cohorts and make their own judgments about whether they are satisfied with their pharmaceutical purchasing rights.

Mrs HUTCHISON: In other words, it is the bulk buying by one regional hospital for the hospitals within the area?

Mr Dunn: It has that but it also has the other complication when many hospital boards have indicated that the hospital is a significant purchaser of pharmaceuticals from a local town pharmacy, and that is a consideration we support as well. There needs to be a trade-off between cost and the maintenance of services locally.

Mrs HUTCHISON: On page 37 of the Program Estimates, there is reference to complete 24-hour automated haematology and chemistry laboratory at the IMVS. Can the Minister report on the progress of that? What is actually involved?

The Hon. D.J. Hopgood: The honourable member would probably be aware that pathology laboratories are moving towards a core laboratory concept whereby common tests performed by automation are being centralised for all disciplines. The IMVS currently has a core laboratory undertaking common tests. New automated equipment is gradually being installed. At the end of 1992, a 24-hour core laboratory undertaking all common tests, which will be largely automated, will be fully operational. In recent years, a number of major items have been purchased for the core laboratory using hospital medical equipment funds.

In the past, the Auditor-General has been critical of the on-call arrangements at IMVS laboratories, particularly at Lyell McEwin and Modbury. Centralising core laboratory services and providing a 24-hour service means that the requirement for on-call staffing at multiple sites is reduced substantially. This should somewhat mollify the Auditor-General. In addition, the 24-hour laboratory will be staffed by a 'generalist' who will be capable of performing commonly requested tests covering a wide range of disciplines. In the past, each discipline, of course, would have required the call back of its own specialist. We have further information but at this stage the Committee may be satisfied with that answer.

Mrs HUTCHISON: With regard to country IMVS services, I assume that that would be of particular value?

The Hon. D.J. Hopgood: Dr Jelly will briefly respond.

Dr Jelly: Country services tend to be core labs where they do the common tests locally and refer the less common tests to be done centrally. In the main, those laboratories are core laboratories staffed by generalists to do the broad spectrum of common tests.

Mrs HUTCHISON: On page 39 of the Program Estimates (I am not sure whether this question has been asked, but I am sure the Minister will advise me if it has), I refer to the review of services in country areas for people with a disability. Has that review been completed or is it only in the early stages?

The Hon. D.J. Hopgood: That question has not been asked today and I ask Ms Johnson to respond.

Ms Johnson: There is no formal review of services in country areas for people with disability. However, with all developments and with each project there is consideration of that matter. We are aware that service delivery in country areas is certainly not as good as it is in the metropolitan area. When new funds are made

available for such things as the community support scheme we try to ensure that a fair proportion of that money goes to country areas. So, the review of this matter is ongoing and not a one-off project.

Mrs HUTCHISON: Have any particular decisions been reached with regard to the upgrade of services in country areas?

Ms Johnson: In reference to the community support scheme, we indicated to the designated specialist agencies that provided the case management for that money that a certain percentage of it needed to be spent in country areas. I know that Julia Farr, in particular, did a tour of country areas to try to seek out people with a brain injury to ensure they could access that money. So, slowly and surely there has been an improvement. Indeed, IDSC now has four offices in country areas. It is certainly on everyone's mind; it is a matter of trying to get continuous improvement with each development and project as we go along.

The CHAIRMAN: The Minister may recall that earlier this year, as the member for Albert Park, I wrote to him about youth homelessness. Subsequently, a series of articles appeared in the *Messenger* press relating to the lack of facilities for homeless youth in the western suburbs. I again wrote to the Minister requesting information as to what would be forthcoming for homeless youth and accommodation services that are required particularly in the outer western suburbs of Adelaide. The response was that this matter would be subject to review. What is the purpose of that review, what progress has been achieved to date and what services will be provided, particularly in the outer western suburbs of Adelaide?

The Hon. D.J. Hopgood: I will probably be able to provide more information later when the estimates in relation to the Department for Family and Community Services are before the Committee because, as you would be aware, Mr Chairman, this service is provided jointly by these two areas, but FACS has perhaps a stronger policy input into the whole thing. You would almost certainly be aware, Sir, of the Mobile Health Advocacy Service now known as Streetlink, which is managed through the Adelaide Central Mission.

The Youth Sobering Service (known as the Hindmarsh Centre) is managed by the Adelaide City Mission and provides a seven hour/seven day a week service to young people. The health of young women's project seeks to provide services to homeless women in Salisbury, Elizabeth and Munno Para, and there is a peer health service for homeless youth in Whyalla. In relation to the specific area that was referred to, I am sure I will have more information once the Family and Community Services lines come up for examination.

Mrs KOTZ: Page 38 of the Program Estimates refers to the complete disposal of surplus land at Hillcrest and Glenside campuses. Will the Minister provide a schedule of all surplus land that was planned for disposal in 1991-92 on Hillcrest and Glenside campuses and a list of the areas of land that were sold and of all land that is deemed surplus and for sale at Hillcrest and Glenside?

The Hon. D.J. Hopgood: We can provide that.

Mrs KOTZ: What guarantee can the Minister provide that this land will be sold and, if it is not, what are the budgetary implications for service provision?

The Hon. D.J. Hopgood: I am sure we would be in trouble with the Auditor-General if we could not get what is regarded as a reasonable price for the sale of what, after all, is a public asset, and we would certainly want to look at where that would leave us in relation to the overall budget. However, as I understand it, with respect to the way in which the money has been scheduled to flow, the savings from devolution at Hillcrest along with the specific capital moneys that have been earmarked will almost certainly enable us to do what we want to do in this financial year even if not one additional square metre of land is sold. So, I do not think there are any problems in terms of this financial year. On the other hand, if there were no sales towards the end of this financial year we may have to look to other sources of funds for the following financial year.

Mrs KOTZ: I refer to page 37 of the Program Estimates. In the area of major resource variations between 1991-92 and 1992-93 appears the restructuring of the St John Ambulance in country areas. What restructuring has been budgeted for this major resource variation?

The Hon. D.J. Hopgood: I will ask Colleen Johnson to respond.

Ms Johnson: There has been no specific allocation from the Health Commission to St John for the restructuring of country services. In 1991-92, a review of country centres recommended that 17 extra positions be created. However, 10 of those positions have been able to be created through the conversion of overtime to full-time positions, and St John is currently looking at the remaining positions to determine whether they are necessary and ways in which they may be able to fund them.

Mrs KOTZ: The main components of this variation are listed on page 37 of the Program Estimates and it states specifically, 'St John's Ambulance—restructuring in country areas'.

The Hon. D.J. Hopgood: I think there might be a misprint in the report.

Mrs KOTZ: If there is a misprint, we are talking about a variation of over $2 million, which represents a 3.1 per cent increase. If that information is incorrect, will the Minister provide a breakdown of the allocation of this $2 million?

The Hon. D.J. Hopgood: I will provide that for the honourable member.

Dr ARMITAGE: Having heard that there is a potential misprint, the Minister will remember that last year at least two mistakes were identified in the budget papers. As the Minister may recall, I expressed dismay at this occurrence given that this is the opportunity to quiz the Government on behalf of the public. What processes are undertaken to prevent erroneous information from being presented to Parliament in the budget papers?

The Hon. D.J. Hopgood: All divisions are expected to go through the documents with a fine tooth comb to ensure that everything is set out clearly and correctly. I suppose that occasionally errors occur. I am not saying that that is the explanation in this particular case, but it seems that what appears there does not square with my officers' understanding of this matter, so we have undertaken to put the correct position before Parliament as soon as possible.

Mr McKEE: What support does the Health Commission offer to sufferers of Alzheimer's disease in South Australia?

The Hon. D.J. Hopgood: I will ask Ms Colleen Johnson to answer the question.

Ms Johnson: The only specific funding that the Health Commission has made available to this area has been to the Alzheimer's Disease and Related Disorders Society of South Australia. In the past financial year—1991-92—there was a payment $16 800. The funding for this financial year is now provided by the HACC unit and not through the Health Commission. Of course, there is provision in many of the general services for people with Alzheimer's disease, in particular, the Royal District Nursing Society. Close examination of its statistics would indicate that a significant number of its clients suffer from this disease, as do quite a few clients within the South Australian Mental Health Service. However, we have no specific program; we fund no service that provides only for people who suffer from this disease.

The CHAIRMAN: What provision is made for respite care for those who look after Alzheimer sufferers?

Ms Johnson: That question is best directed to the Department for Family and Community Services, because funding for these programs is through the Home and Community Care program.

The Hon. D.J. Hopgood: I understand that specific information on that issue will be available later this afternoon.

Mrs HUTCHISON: My first question relates to page 37 of the Program Estimates—the review of the South Australian Health Commission patient transport policy. What is the current position with regard to the patient transport policy? I am aware that a number of issues are involved.

The Hon. D.J. Hopgood: I will ask Ms Johnson to answer that question.

Ms Johnson: The patient transport policy is currently under consideration, but nothing has been resolved as yet. However, the provisions that apply in the country area are different to those in the metropolitan area. These different provisions are with regard to the payment of St John Ambulance fees by pensioners and other card holders. This matter, as I said, is under consideration; we are looking at ways in which there can be a more uniform arrangement, but the matter is still to be resolved.

Mrs HUTCHISON: I again refer to the 1992-93 objectives. One objective was to establish standards for ambulance services and the process for assessing ambulance service licence applications. Can the Minister comment on that line and give some more details?

The Hon. D.J. Hopgood: Dr Filby has some information on this.

Dr Filby: Members will be aware that there is some legislation in the House at the moment in relation to ambulance services. The new legislation alters the arrangements for the licensing of ambulance services. To assist the commission in that process we have established a licensing committee. That committee is currently considering what sort of standards it wants to impose when it advises the commission in relation to the issuing of licences for ambulance services. That will come into effect once the new legislation is proclaimed.

Mrs HUTCHISON: I refer to page 41 of the Program Estimates and the further increase in the number of permanent Aboriginal employees in the public health system. Can the Minister advise the Committee what is the number of Aboriginal employees in the public health system? Could he also advise whether there has been an increase in that number over the past 12 months?

The Hon. D.J. Hopgood: We touched on this matter this morning. The information I have before me is that in the past 12 months the level has increased from 98 to 117, which still leaves us short of our 1 per cent aim, but we are working vigorously on it.

Dr ARMITAGE: I refer to page 44 of the Program Estimates. Under the services provided mention is made of something called the 'Public Information Unit'. What are the details in relation to this unit; in particular, the number of employees, its budget, function and so on?

The Hon. D.J. Hopgood: It has four employees at present. Perhaps the Chairman of the Health Commission can give some further information about its function.

Dr Blaikie: Its major function is preparation of the annual report and other publicity material relating to advice to the system on health services in general. For instance, it was involved in the recent health facts publication that the honourable member may have seen. Whilst the information came from various areas, it was put together by the Public Information Unit. It has three staff, all of whom were previously journalists at some stage of their career, and a secretary.

Dr ARMITAGE: Page 39 of the Program Estimates indicates that one of the 1992-93 specific targets is to develop support arrangements for the integration of medically fragile children into schools. Will the Minister indicate what specific arrangements are being made and, in particular, how the teachers will be involved, or whether, indeed, they will be involved in this integration? If they are to be involved, how willing are they and what training will they be given?

The Hon. D.J. Hopgood: A small working group comprising senior staff from the Education Department, Crown Law, the commission and the non-government sector is developing a series of protocols for the management of these students. This will guide their care at school so that it will be legally appropriate, safe for students and staff and responsive to current health care practices. Those protocols are yet to be finalised, so I can not say exactly how teacher training will be involved. However, the honourable member will have noticed that there are representatives from the Education Department on the working group, and I am sure they will be able to take care of that side of it. Of course, as soon as the protocols are available they can be widely disseminated.

Dr ARMITAGE: Page 31 of the Program Estimates indicates that in 1991-92 the actual recurrent receipts for the development and control of health services line were $1 069 000, and in 1992-93 the proposed receipts are $234 000. Where do the receipts come from and what is the difference between the actual figure in 1991-92 and that proposed in 1992-93?

The Hon. D.J. Hopgood: The difference seems to be mainly in Commonwealth programs. Perhaps Mr Davidge could spell it out.

Mr Davidge: That is correct. The national Better Health Program, for example, in 1991-92 had a figure of $299 000. That is not expected to be received in relation to that particular project or program of development control of health services in 1992-93. With respect to marginal variations, in 1991-92 $42 000 was received from the Commonwealth for work associated with the Daw Park Repatriation Hospital transfer, but nothing was received in 1992-93. A new initiative involving $330 000 is not expected again in 1992-93. It is mainly in the Commonwealth programs area.

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

Family and Community Services, $165 734 000

Chairman:
Mr K.C. Hamilton

Members:
Mr S.G. Evans
Mrs C.F. Hutchison
Mrs D.C. Kotz
Mr C.D.T. McKee
Mr J.A. Quirke
The Hon. D.C. Wotton

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

Departmental Advisers:
Ms S. Vardon, Chief Executive Officer, Department for Family and Community Services.
Ms A. Howe, Executive Director.
Mr R. Bos, Manager, Financial and Physical Resources.
Mr A. Hall, Director, Family and Community Development.
Mr J. Barrett, Director, Administration and Finance.
Mr K. Teo, Manager, Juvenile Justice Unit.
Mr M. Szwarcbord, Manager, Placement and Support Services.

The CHAIRMAN: I declare the proposed payments open for examination. Does the shadow Minister wish to make an opening statement?

The Hon. D.C. WOTTON: No, Mr Chairman.

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

The Hon. D.J. Hopgood: I have one in front of me but, in view of the time, I propose merely to report from it on the changes to the budget, because I think that may specifically help members in their questioning. That is just three paragraphs. Members might have noticed some significant changes in the department's budget this financial year and the reasons are as follows. First, during 1991-92 the department agreed to convert its accounts to a special deposit account in line with proposals for all Government agencies. As a result, $10.5 million of expenditure, previously paid out of separate trust and deposit accounts, is now shown on the Estimates.

Similarly, receipts of $10.7 million appear that were not previously recorded. Secondly, further refinement of the department's program structure has been made this year, resulting in some variation between the two financial years. Thirdly, the department apportions its field services costs between programs on the basis of data gathered in a survey conducted periodically. A survey was conducted in 1991-92, resulting in a change to some of the apportionment percentages. This will explain some of the differences between costs recorded in 1991-92 and the budgets provided in 1992-93. Perhaps I can take up other matters as pertinent questions are asked.

The Hon. D.C. WOTTON: I refer to Economic Conditions and the Budget (page 42). The family and community development program funds large numbers of non-government organisations. The program has received no increases except for minor indexation adjustments for the past four or five years. We would all be aware that in its budget submission SACOSS asked that this be given priority for funding increases because of the increases in demand for services and the introduction of awards in the services funded, and because funding increases have been neglected for so long.

Why has the Government continued to ignore this extremely important area, and what percentage of the department's funding this year will go to non-government agencies? I should also point out that, for example, only recently I have been informed by Anglican Community Services that two of its programs—the family support program and the home intervention program—now have waiting lists for the first time and that in some areas people have to wait for up to six months before any help can be given. Further, the Port Adelaide Central Mission is in a situation where last Friday, for example, it was unable to see, and had to turn away, 23 people from its agency. The demand is obviously there, hence my question?

The Hon. D.J. Hopgood: It is true that the specific amounts to those agencies which are accounted for in this way have not been increased over that period, except for some minor CPI-related adjustments. However, there have been considerable increases in the SAAP and HACC areas which obviously cannot be ignored if one is looking at these sorts of problems. In addition, I would focus particularly on what the honourable member had to say about the effect of award increases. Quite obviously, the effect of award increases at a time of a static budget is to reduce the services available unless one can do it in a different sort of way. Of course, the honourable member would be aware the Government and the non-government sector have been involved in a joint operation for a couple of years in determining how, between us, we can better deliver those services.

An extensive report on the matter was jointly released by the SACOSS organisation and by me only a short time ago, and that report, amongst other things, suggests five pilot projects which we should immediately move into with a view to seeing how qualitatively different methods of service delivery can be entered into across the Government, non-government sort of divide. We believe that our moving into these areas is one way of ensuring that we can continue to provide the services but, because

they will be provided on a more cost-effective sort of basis, in fact, we will still be able to provide what is required in a time of limited budgets.

As to the percentage, the grants represent 34 per cent of the total budget. At this stage I am not able to indicate whether that represents a small increase or decrease on last year; we could have that checked out fairly quickly. I would point out, however, that that figure has to be treated with some degree of caution, because the boundary between what some might call the family and community services area and the health area is blurred, and indeed some of those funds do go to areas like RDNS and domiciliary care but, of course, considerable funds also flow to those areas from the Health Commission. That is the percentage the honourable member asked for. I will try to get some indication of whether that does represent some modest increase or decrease on last financial year, but that is the philosophy we are adopting in this area and we have had, I must say, very good support and cooperation from the non-government organisations.

The Hon. D.C. WOTTON: What provision is made in the Estimates specifically for the extension of the budget of non-government agencies to allow for increased superannuation contributions?

The Hon. D.J. Hopgood: There is $1.5 million for the awards.

The Hon. D.C. WOTTON: It has been reported to me by a number of non-government agencies and organisations that they have seen a huge increase in demand for emergency financial assistance, far beyond the demand they can meet. How has FACS provided for this need in the budget, and what other anti-poverty initiatives are being planned to address the needs of the disadvantaged, particularly as a result of the current recession?

The Hon. D.J. Hopgood: We have a good deal of information; I am sure that the honourable member would not want us to take up all the time on this answer, so it might be better if some of it was provided later. There is an Anti-poverty Advisory Committee being established to cover aspects of the department's involvement in financial support in anti-poverty activities. It will have representation from all levels of Government, as well as from the non-government sector, and it will provide advice to both sectors about management on any aspect of anti-poverty policy, strategies and service. Demands for emergency financial assistance, concessions and financial counselling are very high indeed. Of course, we have endeavoured to respond to that.

The number of pensioners eligible for a pensioner health benefit card rose from 196 000 in June 1991 to 200 000 in March 1992. That group is eligible for the full range of State Government concessions. The EFA budget was 26 per cent over expended in 1991-92, and more than 37 000 people were assisted during that year. New guidelines for the program are being developed. The initial draft has been circulated to the field for comment, and we would expect that almost certainly there will be responses to that in the short term.

There have been additional funds to Lutheran Family Care for financial counselling, and Welfare Rights has also had an additional funding. There are Commonwealth funds to non-government agencies for emergency financial assistance, which of course cannot be ignored in looking at the total scene. It is not easy at present, but I think the Committee can see that a good deal of activity is carrying on. Perhaps I should also mention financial counselling. New cases accepted in 1991 were 4 329, and in 1991-92, 4 474.

The Hon. D.C. WOTTON: Will the Minister outline the current state of the negotiations between the Commonwealth and the State regarding concessions? He has just referred to that and other areas of financial assistance. Further, will the Minister outline what plans the Government has, if any, to reduce the eligibility for concessions?

The Hon. D.J. Hopgood: As the honourable member would know, in the past eligibility has exclusively been determined by the Commonwealth criteria, for the very sensible reason that there is no point in the States getting into the business of establishing separate criteria because, heaven preserve us, that could lead to the formation of a State card, or something like that, quite separate from the Commonwealth. The reason for the honourable member's question is almost certainly that under the Commonwealth budget the Commonwealth increased or extended the benefits available to certain people in such a way that, if the present rules continue to apply, a number of categories of people will automatically be available to the State concession who have not been available in the past.

This has attracted the attention—the honourable member will not be surprised to learn—of States other than South Australia which have gone back to the Commonwealth and said, 'Well, this seems to be a humane and compassionate initiative but one where we would want some recompense from the Commonwealth to meet the costs of what, after all, has been a Commonwealth initiative.' That has been referred to the Commonwealth Grants Commission, which determines the payments, and we are awaiting a further report from the commission.

The Hon. D.C. WOTTON: What liability does the Government accept for any recompense of legal, medical and financial costs incurred by families or individuals who, in the defence of their innocence, incur significant expenditure and trauma, particularly in such cases where the department's allegations are not upheld by the courts? I am referring particularly to page 54 of the Program Estimates. What independent assistance and support is provided by the Government to these families and individuals. As an example, I refer to the Bean case; Mr Bean of Murray Bridge was charged under the Children's Court and later exonerated as a result of an appeal in the Supreme Court. Extreme trauma has been experienced by Mr and Mrs Bean and their children as a result of this case, which took some 18 months to be resolved through the justice system.

The Hon. D.J. Hopgood: I will ask the Chief Executive Officer to refer to the details but, with the Committee's permission, it is probably worthwhile my dwelling for a little while on this, because I guess this is one of the most difficult problems that our people in the field face, or are likely to face: they are damned if they do and damned if they do not. An allegation is made, if it is not investigated or not investigated properly in the eyes of some people, and if subsequently it is found that it

was a legitimate case of abuse, of course we are in trouble.

On the other hand, where there is some investigation, there is bound to be some degree of embarrassment to the individuals concerned, and should it be demonstrated later that there was not a case of abuse, again we are in some degree of trouble. As for recompense, I would not have thought this was any different from any other situation where the Crown brings proceedings in a set of circumstances and the individual is found to be not guilty. That happens in the courts quite frequently. There are circumstances in which a mechanism perhaps can be put into place for some degree of recompense, and the classic example of that would be the Chamberlain case, but it is not the normal procedure where a person is brought before the courts for whatever reason, or there is some other procedure like that—some *quasi* judicial process—and, notwithstanding the allegations, they are not proven to be guilty. Perhaps we could now home in on the specifics of the matter, and I will ask Sue Vardon to talk about the specific case mentioned by the honourable member, I guess, as a 'for instance'.

Ms Vardon: It was an interesting case because of some technicalities involved in it. The department was able to have established by Judge Crowe in the Children's Court that a case existed, and that the child was in fact a child in need of care. So far as the department was concerned, we were able to establish that after some months of examination; it was an extraordinary case. Normally, cases take a short period of time, but it was challenged. The costs were well subsidised by the Legal Services Commission for the party mentioned. We often pay psychological counselling bills and other bills for people who are taken to court by us. However, a member of the family took the matter to a higher court and Mr Justice Olsson found on a technicality against the decision of Judge Crowe. Under those circumstances, the Attorney-General's Department will pick up the legal costs associated with the case.

There is a problem, and it is a problem we see over and over again, that only about 1 per cent of all cases of child sexual abuse that are brought to the attention of the authorities actually go anywhere near a court and a case against the offender is established. It has the lowest clear-up rate of any crime in Australia. It is sometimes very difficult to sustain a criminal charge, but judges in the Children's Court accept certain statements to be true, and this was some sort of case along those lines where there was controversy.

The Hon. D.C. WOTTON: Will the Minister comment on two areas of concern that have been expressed to me about this case? First, how can the department involve itself in extensive litigation without proof of sexual abuse; and, secondly, why in the first instance does the department not seek immediate and urgent talks within a family network to attempt resolution and/or treatment?

The Hon. D.J. Hopgood: I will ask the Chief Executive Officer to respond.

Ms Vardon: I have tried to answer the question. The matter was that the children were in need of care. The issue of sexual abuse or not was not actually our primary issue. The mother of the children had agreed to the children being in need of care. It became a very controversial case because it was defended. We have about five or six cases each month that go to court. We have many hundreds of families where children are brought to our attention, and we try very hard to get a family resolution or family solution. I do not feel I can talk about the facts of this case in this situation. I am very happy to talk to the honourable member about them, but they were most extreme.

The Hon. D.C. WOTTON: Why are there no basic guidelines at either State or national level in evaluating allegations of child sexual abuse? I understand that that is the case. Would the Minister support representation which I intend making to both the Australian Medical Association (AMA) and the Royal College of Psychiatrists urging them to consider the formulation of such guidelines and, if not, why not?

The Hon. D.J. Hopgood: I think we should get more information for the honourable member on that. We understand that there is a medical protocol that has been established. It may not cover all the matters of concern to the honourable member—nor perhaps to me—but we understand a protocol is in existence and is used.

The Hon. D.C. WOTTON: I realise it is not appropriate to continue this discussion, but discussions I have had with the AMA in the past week would suggest that that is not the case. They certainly do not recognise that protocol.

The Hon. D.J. Hopgood: We will get that sorted out.

Mrs HUTCHISON: With respect to the broad objectives on page 52 of the Program Estimates, given the recent floods that the State has experienced, what has been the department's involvement in relief work following those floods?

The Hon. D.J. Hopgood: Quite considerable. As at Monday 31 August 1992 a total of 33 emergency payments were made to Adelaide Hills/Cudlee Creek residents, with three temporary living grants, totalling approximately $15 000. It was further expected there would be applications for re-establishment grants. On 16 September 1992 the Two Wells floods occurred, and an office was established in the Two Wells Institute. Staff from Gawler and Elizabeth worked in shifts, Friday to Monday. Other agencies, such as the local council, Red Cross and a pastoral ministry service, were involved, as well as representatives from Multicultural and Ethnic Affairs and the Department of Agriculture.

By Sunday 20 September, 21 emergency claims had been paid totalling approximately $8 000. It was suspected at that stage that far more than those numbers had been affected but had not actually come forward to claim payments. A four wheel drive vehicle was obtained to commence home visits, because many people were unable to leave their homes due to being inundated. It was proposed that all home visits would be undertaken by a combined group of Department of Agriculture officers, ministers of religion, Family and Community Services officers and council workers to locate and record these isolated families. Also, there were local meetings with the Vietnamese Market Gardeners Association. We have also worked with neighbours who in some cases have been in dispute over the management of flood waters and pumping. We suspect that, because of the lack of insurance and since it is a flood plain after all, there may be more claims for re-establishment grants in the

Virginia-Two Wells area than there were from the Adelaide Hills.

In conclusion, there was a meeting on 16 September with the *Advertiser*, the Department of Agriculture, Treasury and staff of my own department to determine the criteria for the distribution of the $14 000 from the *Advertiser* Flood Appeal, received on 18 September 1992, to be disbursed according to rankings suggested by the manager at Modbury in consultation with the manager of the Murraylands region.

Mrs HUTCHISON: Will there be ongoing monitoring of the situation?

The Hon. D.J. Hopgood: There certainly will be.

Mrs HUTCHISON: I refer to page 58 of the Program Estimates with respect to Aboriginal employment (and I asked the Minister in the previous Estimates Committee today a similar question): does the Department of Family and Community Services have a strategy for the employment of Aboriginal people? If so, can the Minister advise the Committee what has happened in the past year in that area?

The Hon. D.J. Hopgood: In February of this calendar year the department ran a country block recruitment program for social workers which was targeted at employing Aboriginal people. From the 31 recruits, 21 were Aborigines and they were placed in district centres in proportion to the Aboriginal population in the district which the centre serviced. As the honourable member will guess, they were areas like Ceduna, Coober Pedy, Port Lincoln, Port Augusta and so on.

A number of extensive training sessions, conferences and workshops covering a wide range of topics have been run for the new recruits. These include training in child protection, domestic violence and child sexual abuse. The orientation was provided by the department over a five-week period. I have a good deal of further information with which I will not detain the Committee, but I indicate that 5 per cent of our staff are Aboriginal and Torres Strait Islanders, well in advance of the figure I was able to report to the Committee from the Health Commission and, in the north of the State, it is about 25 per cent.

Mrs HUTCHISON: My question relates to page 58 of the Program Estimates. The reform of the Home and Community Care service was touched on in the last Committee. Last year the Minister responsible for the HACC program advised that the future of the program was being considered at a national level and some mention was made of that in the previous Estimates Committee. What is the current situation?

The Hon. D.J. Hopgood: There has been no resolution at this stage, and we do not altogether see that as a bad thing. South Australia has had a fairly happy experience of the HACC program and the pressures on the Commonwealth to do things like trisecting the HACC program into its constituent parts—aged care, disability, post-acute—have really come from the eastern States, some of which have been in effect saying (but not in as many words), 'Just give us the money and the financial assistance grants and forget about the problem.'

The Commonwealth is not going to do that. We would certainly set our face against that. We had a series of consultations last year and I think I did report to the Committee then that the net result of those consultations was that customers, as they largely were—the consumers of the services—said, 'Leave it alone. We think it is a good program.' As ever, as consumers always will say, 'Let's have some more money for it', but the general philosophy, strategy and the efficient way in which it has been managed in this State drew a good deal of favourable comment from those people.

At a March 1992 meeting a strategy was put before Ministers to pursue trisection as one of the options but, although there is general agreement that ideally there ought to be a single level of Government responsible for aged care—and that obviously would have impact on the HACC program—in practice there has been no agreement between the Commonwealth and the States as to how that should operate. I will not further detain the Committee on that now unless members ask me questions about it. There has been no resolution of that issue. As I said, in a sense we do not see that being all that bad a thing because we have never shared the perception that the eastern States have shared as to the nature and impact of the program.

Mrs HUTCHISON: There is much concern in the community because, as the Minister rightly said, it is perceived as being a good program and one that should continue, and there has been concern that funding for it may disappear. I presume that that is not on the agenda?

The Hon. D.J. Hopgood: At the political level I have no knowledge of that. I am sure that that is the last thing that is in the mind of the Commonwealth Minister. Looking at it purely at officer level, since Mr Leahy has joined us at the table, I will ask him to report briefly on where he perceives negotiations might be.

Additional Departmental Adviser:

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

Mr Leahy: So far as I am aware all States, the Territories and the Commonwealth are pursuing the HACC program with renewed vigour after the examination of its future. The general position amongst officers is that it is here to stay and, until such time as the future of aged care generally is resolved, the HACC program will continue with the work it has been achieving over the past seven or eight years.

The CHAIRMAN: There was a question from the Chair previously in relation to youth homelessnes which was touched on by the member for Heysen in relation to the SAAP program and the Minister responded. The Minister will recall that earlier this year I wrote to him about this matter and it was subsequently reported in the Messenger Press, including criticisms of a lack of accommodation in respect of youth homelessness in the outer western suburbs of Adelaide. I understand that that matter was to be reviewed, and hence my question as to the provisioning made in the budget for accommodation in outer western suburbs of Adelaide.

The Hon. D.J. Hopgood: I will ask Mr Hall to respond specifically. A good deal of this relates to the way in which we have been able to match SAAP funding. As your question was specific to the western suburbs, Mr Chairman, I will ask Mr Hall to respond.

Mr Hall: We have undertaken a restructuring of youth housing services over the past eight months. This has been a joint exercise with the peak non-government

agency, the youth housing network and the SAAP unit of the department. We have developed a new system for SAAP services or services for homeless young people. It includes major changes in directions for that program which must be submitted both to the Minister of Family and Community Services and to the Commonwealth Minister for Aged and Health Services for approval.

It would be premature to go into the exact details, but one of the premises or fundamentals of the program is to establish in each region a continuum of services ranging from intensively supported units through to medium and minimally supported units. There are plans in the western suburbs for an intensively supported shelter to accommodate young men and young women, as well as medium and minimally supported units. The range of services provided in the western suburbs will increase if this plan is approved.

The CHAIRMAN: Does that specifically address the question of the outer western suburbs *vis-a-vis* the correspondence I received previously indicating the inner western suburbs of Adelaide? The criticism has been directed in respect of the outer western suburbs of Adelaide. What consultation has taken place between the department and other agencies in relation to addressing this problem?

Mr Hall: Answering the last question first, the whole exercise has been a joint one with non-government agencies. There have been a series of seminars held involving staff of those agencies. The youth housing network did a survey of young people to identify their needs. There has been a large number of meetings. Only last week one meeting involving a representative of each of the funded programs was held to reach agreement on the basic system to be submitted to the Ministers.

Returning to the first question, we have not identified specific sites in the development of these new regional services, but we would envisage that the intensive unit would be in the outer part of the western region and not in the older inner part.

The CHAIRMAN: Is there a timetable?

Mr Hall: The recommendations will be submitted to Ministers in the next week. Implementation of the restructuring will commence slowly, we expect from 1 January, and hopefully be in place fully by 1 July next year.

The Hon. D.C. WOTTON: I wish to ask a similar but broader question about homelessness. Can the Minister be more specific in indicating increased demands not just for youth but for women and families experiencing homelessness? While I realise that Mr Hall has referred to some of these, I want to know whether any more details are available in regard to changes that are currently being negotiated with the relevant agencies in the community services sector to meet needs and provide efficient and effective services. Are any statistics available on homeless youth, women and families in South Australia?

The Hon. D.J. Hopgood: I am sure that we will make available to the Committee any statistics in the normal way, but I will ask Mr Hall to comment on strategic aspects.

Mr Hall: The recession that South Australia and the country is currently experiencing has tended to increase the demand on services for homeless people, such as women escaping from domestic violence, single adults, families and young people. There is some conjecture about the absolute numbers, but we will be happy to provide any information we have on the number of homeless people seeking these services. I think the more important thing is how we actually respond to the issue of homelessness rather than merely providing beds. We know that in the youth area a number of people become homeless and, for want of intervention with their families, become long-term homeless because the relationship between them and their parents has been broken.

The restructuring to which I referred earlier will increase resources in this area by providing a specific first-timers shelter to separate the relatively naive—if one can call them that—homeless young people from those who are more sophisticated and streetwise, so there will not be the contamination and the rapid learning of unfortunate behaviour. That service will be complemented by an extensive counselling service to intervene with families and early homeless young people. In the area of single adults, we have funded a number of housing support workers through agencies such as the Adelaide Day Centre and the Hutt Street centre to get many of the homeless men who frequent Adelaide or who move in and around the inner city into independent accommodation, so that we provide some long-term solutions to the issue of homelessness and not merely emergency beds as that really misses the causes and the major points of homelessness.

The Hon. D.C. WOTTON: We are all aware of the debate surrounding juvenile crime and the supposed link between the crime rate and unemployment. Why then does the budget contain so few initiatives to attempt to alleviate some of these problems? What initiatives are being taken by the State Government to access Commonwealth funding for education and training to address the needs of young offenders? I ask that question because I am told that there is an abundance of Commonwealth funding for this purpose. Is the Minister able to provide the latest statistics regarding youth crime?

The Hon. D.J. Hopgood: I would be very surprised if there had not been a good deal of close questioning of the Minister of Youth Affairs about this matter, because the Minister and I journeyed to Canberra for what became known as the Prime Minister's Youth Employment Summit. A number of training and other initiatives were announced at that time, and my understanding is that a good deal of the State initiative for that was referred to Mr Rann, the relevant Minister. So, I imagine this matter has had a fair airing. As far as the Department for Family and Community Services is concerned, the Executive Director, Operations, Anne Howe, is in a position to report to the Committee.

Ms Howe: The issues of unemployment, education and training for young offenders are critical with respect to their rehabilitation and long-term support. This department funded the Youth Affairs Bureau to employ a project officer to develop a long-term strategy for our department. TAFE, the Education Department, youth access centres and our own services have developed specific programs for these children including early intervention and catch-up work with tutoring as well as training programs.

That report has been finalised, and the same people who worked on that report, which will go to the two Chief Executive Officers of this department and TAFE, are also looking at funding that is available through the Commonwealth. We will meet with the Commonwealth to ask for funding specifically for some pilot programs. As part of the restructuring of our residential care area, we have looked at our vocational training programs, and we are working with TAFE to increase our capacity to have more meaningful programs within those centres that can also articulate into external programs in TAFE when they leave the centres. We also recently received money from the Department of Employment, Education and Training to employ 12 young Aboriginal people over two years as trainee youth workers. So, our department is looking at preventative sorts of programs for disadvantaged youth.

The Hon. D.J. Hopgood: Some papers were delivered at the recent conference, which of course has received considerable publicity. The statistics were analysed in those papers, and we will make them available. In relation to the way in which the honourable member began his question, for the most part, persistent juvenile recidivists are not direct sufferers of unemployment because they should not be in the work force—they should be in school, because they are typically aged 13, 14 and 15 years. They may be suffering as a result of their parents' unemployment; however, my understanding is that the more typical factor that affects their persistent recidivism is often child abuse more so than unemployment. However, I will ask Mr Teo to report on the figures.

Mr Teo: Without going into a lot of the detail contained in the paper, there is certainly a slight rise in the trend. I cannot provide the proportions, etc., but over a 10-year period the paper outlines a plateau in terms of crime with a slight rise in 1990-91 basically in crimes of illegal use and some property offences such as break and enter. However, the rise is still only to the level of 1985-86. I cannot provide the actual figures, but crime that occurred in 1991-92 is still at the level of 1985-86 in terms of total numbers. The paper provides two cohort studies of two populations of young offenders over an 18-year period.

The Hon. D.J. Hopgood: The paper was prepared by Frank Morgan, and if it is made available to members of the Committee I am sure they will find it very interesting reading.

The CHAIRMAN: Copies will be made available to the Committee.

The Hon. D.C. WOTTON: I hope the statistics I have referred to are provided in that document. I am concerned at what I am hearing about the number of foster families that are involved between the time at which a child or children are removed from their parents to the time that the Minister ceases to be responsible when the child reaches the age of 16 years. I am told that such children are placed with an average of six different families. I do not know whether or not that is right but, if it is right, I find it very concerning. Can the Minister comment on that statistic? I would like to know what is actively being done to reduce the number of multiple placements of children, particularly during the formative years.

The Hon. D.J. Hopgood: I think I should perhaps ask Mr Szwarcbord from the department to give the Committee a brief report on that.

Mr Szwarcbord: A lot of research has been done in the past few years which has identified this issue of multiple placement of children in foster care. It has perhaps been the prime focus of our foster care program in the past few years to try to redress this very concerning matter for young children. We have introduced a permanency planning policy, which has been operating for some years and which aims to establish children very quickly into permanent placements and to secure permanent guardianship.

An amendment to the legislation also pushed this concept a little bit further. It looked at the idea of being able to transfer guardianship to the actual care giver. This is all aimed at trying to give permanence. The other major change is in our support of foster parents. We have restructured the FACS district offices and there are now specific child and family teams that support the children living with foster families. In the metropolitan regions there are regional placement teams, which look at enhanced support of foster families and improved training. So, a range of initiatives has been taken to try to reduce the number of placements of children in foster care.

The Hon. D.C. WOTTON: Supplementary to that, I take it then that the department is not in a position to know whether these new methods are working. It is obviously still of concern to the department.

Mr Szwarcbord: It is always a concern and something we have to ensure against. I cannot provide the number of placements that are involved at the moment.

The Hon. D.C. WOTTON: With the information that has been made available through those reports can the department determine to what extent children are traumatised as a result of moving to different families, particularly in their early years? Has very much work been done on that specific area?

Mr Szwarcbord: I think that there is a lot of evidence, certainly about educational delay, high levels of unemployment ultimately and many more emotional difficulties for young people. So, it is all part of our concern about ensuring permanence, and fairly quickly.

Ms Vardon: A study was done in respect of the condition, so to speak, of children who came into foster care some years ago, and it was found that the children were behind other children in the normal curve on many factors—and that was before they came into care. The department takes a couple of hundred children into care in a year—some for a short time and some for a long time. However, those children come into our care because they are extremely disadvantaged at the point of our contact with them. Usually they have been grossly abused or extremely neglected, or what have you. Much of the work we have to do is to try to bring up those children.

One of things that is perhaps worth restating is that those children who come into our care—particularly those who have been sexually abused—are very hard to foster, because they are provocative, in a sense, and they have been damaged. They are very hard to look after and are very stressful on families. They test a family more than children that we know generally. In a sense that aggravates the breakdown of some placements. In a few

minutes we would like to give the Committee an analysis of what we believe to be a much better placement system—where we believe that children are not having such a high placement turnover. However, as was stated, we cannot provide the facts now. We believe the new system is working, and it will be evaluated to ensure that it is.

The Hon. D.C. WOTTON: One of the frustrating things about this Committee system is that one feels that one could discuss a particular subject for a long time, but we are not able to do that under these circumstances. I would like to come back to that issue later. I have been made aware of the extreme difficulty being experienced because of the impossibility of agencies committing funds to approved programs for a period of three years in lieu of the current one year arrangement in most cases. Has the Government any plans to recognise this problem, particularly when in so many cases so much time is needed to get specific programs up and running? Certainly, in discussions that I have had with a number of agencies and organisations this very real concern has been expressed. I would hope the Government would be addressing it.

The Hon. D.J. Hopgood: Some programs are funded for three years—a surprising number given the fact that State Government budgets run from year to year. Perhaps Mr Hall can provide more detail.

Mr Hall: The SAAP program is a State and Commonwealth funded program and it is based on a five-year agreement. Negotiations on that program will commence in 1994. So, agencies funded under that program, unless there are significant changes, are virtually assured of funding for a five-year period. In the Family and Community Development Fund we have over the past few years introduced triennial funding. I cannot give an exact number or proportion of the agencies that are funded on a triennial basis, but we plan to expand this so that approximately 80 per cent of all funds are committed on a triennial basis.

Mr QUIRKE: How is the home for some of my younger constituents going at Cavan? What provision has been made to ensure they stay safely tucked in at night?

The Hon. D.J. Hopgood: We would have been disappointed if the honourable member had not asked that question. The completion date is set for September 1993. Work commenced in March of this year. It has progressed rapidly and is now ahead of schedule and within budget. As of 30 July the following building developments have occurred:

- site services, for example, stormwater, sewerage, gas, water and electricity have been installed within the ground and below floor slabs;
- all floor slabs have been poured including the swimming pool;
- brickwork is almost completed on the administration admissions block;
- brickwork 70 per cent completed on the gymnasium;
- steelwork erected on all blocks except one living unit;
- roofing commenced on the administration admissions unit; and
- airconditioning installed in the administration admissions block and plant rooms of living units.

It will provide accommodation for up to 36 young people on remand or detention orders from the Children's Court. One can see from the facilities that every effort is made to keep them as busy as possible and occupied within the unit. Mr Teo will indicate the security arrangements that will apply.

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

Membership:

Mr Oswald substituted for Mr S.G. Evans.

The Hon. D.J. Hopgood: I think Mr Teo was about to embark upon the last part of the answer in relation to security arrangements at the new secure care centre.

Mr Teo: The security in any secure care building, and certainly in the new building, depends very much on supervision and the physical security measures. In relation to supervision, the new buildings are certainly an improvement on the existing buildings. It is purpose built and it is certainly more compact, as in the existing buildings there are nooks and crannies which are more difficult to supervise. Therefore, I believe that the levels of supervision of residents in the new building will be much better.

There will be a vast improvement in the physical security measures. The measures that have been put into the new building will involve modern but unobtrusive technology. For example, there is plenty of fresh air and light in the new buildings and there is double glazing, which forms the perimeter of the wall. The double glazing has been put into the existing buildings to test it for the past 2½ years, and it has not been found wanting. On top of that, there have been recent tests through SACON and the unit; for example, two grown men have used sledge hammers on it and could not penetrate it after an hour and a half, and to us that seems to be reasonable security. Apart from that, there are also tamper-proof movement devices within the building which would trigger alarms in the evening when perhaps there would be intruders, etc. Around the building there is also an infra-red scan to notify people if there are intruders breaching security. I believe that, with all those measures, the new building will have security that is much improved on what we currently have.

The Hon. D.C. WOTTON: I believe that some orientation and training programs have been conducted during 1991 at the Ramada Grand Hotel. What was the cost of those programs to the Department for Family and Community Services?

The Hon. D.J. Hopgood: We will get that information for the Committee.

The Hon. D.C. WOTTON: For some time negotiations have been going on with the non-government sector as far as accommodation is concerned. When will the non-government agencies be able to move into accommodation being provided by the Government? I understand that the Torrens building has been considered. Can the Minister explain the reason for the delay so far in making this accommodation available, and what arrangements are to be put in place regarding the funding of this accommodation by non-government agencies?

The Hon. D.J. Hopgood: This comes under the Premier's Department, but I will ask Mr Hall to tell the Committee what we know about it.

Mr Hall: The department is represented on the accommodation task force, which was set up by the Premier under the chairmanship of Gerrard Menses, of the Anglican Community Services Agency, to investigate a number of properties and to develop a multi-agency facility, as has been described. I am somewhat new to this committee, but I gather it surveyed a number of buildings in the inner city and adjoining areas for this facility. The Torrens building has been identified as the property.

At the moment it still accommodates some State Taxation offices and some Lands Department records. In particular, there is a large storage of Lands Department records there which need to be located elsewhere. The architects have been engaged and have drawn up a plan for the use of the building, and Cabinet has approved in principle the refurbishment and fitting out of the building to accommodate these groups. At this stage, I am not aware of an exact time line, but I believe it would be in excess of nine to 12 months.

The Hon. D.C. WOTTON: As I understand it, children's protection panels were set up some years ago to monitor the regional services in relation to child abuse. I also understand that the original objectives of these panels have been changed and that, with the increase in services, they are having difficulty coping. Are the original objectives of the panel different from the present objectives and, if so, what are the differences; will the panels be continued; and what is the total funding for the panels?

The Hon. D.J. Hopgood: I will ask Ms Vardon to respond to that. We might have to get some additional information on funding but, certainly, Ms Vardon can explain the purpose, philosophy and so on.

Ms Vardon: The original legislation gives the panel about eight or nine functions. One of the functions under the legislation is to receive notifications, but there are many other functions, such as to inform the community, to develop services and so on. The panels started off receiving child abuse notifications, and in time those numbers have increased. The panels were a very good solution for the 1970s but, as the numbers of child protection cases went up, filling those panels with hundreds of case notes, the notification of details became cumbersome and the panels were not able to carry out the other functions specified under paragraphs *(b)* to *(h)* in the relevant section of the Act, that is, the more developmental functions.

In an attempt to streamline what the panels are doing, in particular the notification system—because panel members have been complaining to us about the huge amount of personal time it took to look at notifications and comment on the department's work—most panels now receive just lists of notifications, and serious cases are drawn to their attention in greater detail. We still believe that panels have the other function to educate the community and so on, and we have tried to get the panels to undertake those functions.

In recognition of the overloading of the panels, we have recommended (and it has been indicated in this House) that an amendment to the legislation may be considered and that the panels may disappear in their present state. At the moment we are trying to do the best we can with an old-fashioned method of service delivery. I cannot give the actual cost of the panels, but we can certainly table that information. The cost would involve the secretarial time taken to give information to the panels and the individual contribution by the hospitals and others who send panel members to the meetings. The costs would also involve all the reports that our staff have to write to feed the panels information. We can add up all those figures and provide the costs.

The Hon. D.C. WOTTON: The community services sector review is to be applauded. Nevertheless, it is of concern—and it is a concern that has been brought to my attention from a number of different areas—that local government is seen as the pivotal agency for the development and coordination of community services. The concerns are that they are so numerous as to make it a most inefficient and costly exercise and, with few exceptions, local governments have a limited understanding of community welfare-type services. They are the two concerns that are brought to my attention in particular. Will the Minister comment in regard to those concerns?

The Hon. D.J. Hopgood: I think it would certainly be true to say that there is a large variation between those local government areas or authorities which deliver community welfare-type services well and some others. Since all this is very much a learning experience for all those involved, including government and the non-government organisations, we have included local government representatives on the implementation task force. It seems to me that local government's role in this is very much on trial. Local government wants to be involved—that has been made quite clear. I think I would be under considerable criticism if it had been excluded at this stage, but the ball is very much at its feet, and local government will have to demonstrate the capacity to be part of this.

We must remember that what we are looking at is a total package of service delivery which really does not pay very much respect to the traditional boundaries between State Government and local government and between the non-government organisations. If, in fact, it is eventually shown that local government is unable to respond to this sort of challenge, that is unfortunate, but the basic parameters of the project can proceed. I do not think that will be the outcome, because in so many other areas one need only question the Minister of Local Government Relations on one of these committees on this matter. Of course, local government is looking to expand the ambit of its activities.

The Hon. D.C. WOTTON: Supplementary to that, while we are talking about the review can the Minister indicate what specific initiatives have been taken since the launch of 'Solo to Symphony' to ensure its implementation?

The Hon. D.J. Hopgood: The initiatives have been to establish the six projects, as I recall, that were identified as being appropriate as pilots for the overall philosophy. Mr Hall might be able to indicate where some of those pilots have got to?

Mr Hall: The implementation task force was appointed. It has been able to meet on a couple of

occasions. There have been delays in getting advice from the Commonwealth Government as to its representation on the committee, and the Local Government Association has only recently finalised its representatives on the implementation task force. Staff have been recruited and detailed work has started on each of the projects. We are essentially prioritising those so that they will proceed in an orderly fashion because some of them are contingent upon each other.

As a member of the second stage committee that developed the proposals that recommended local government's involvement, we thought it particularly important that local government be involved, given its role in physical planning at a local level. There are a lot of activities and services provided in the community services area that have a high dependence on or a high relationship with the physical planning activities of local government. The Committee may be aware of the opposition that occurs in some communities when facilities for disadvantaged people, be they disabled, Aboriginal, poor people, etc., are located in their neighbourhood. It is often very difficult to get planning approval to locate those facilities. The Committee which advised the Government on this matter was very concerned that, in all this, local government had a learning role and, if it understood and was involved in this process, it might be more generous in planning decisions than has been the case to date.

Mr McKEE: What position is the department taking in regard to Alzheimer's disease?

The Hon. D.J. Hopgood: Mr Leahy, Manager of the HACC unit, is in a position to report on this.

Mr Leahy: In terms of the issue of dementia, the HACC program provides a particular focus, because it is fundamentally seen as one of the growing epidemics for ageing. Dementia is, of course, associated with increasing age. As we all know, the improvements to mortality have meant that the number of older people is increasing because people are surviving longer. Unfortunately, that often means the incidence of dementia will increase. As a result, in the past seven years the HACC program has put a considerable effort into providing services for people with dementia and their carers. I have been pulling out some figures; we estimate that about 18 per cent of clients of the HACC program in this State suffer from dementia. In terms of the services provided to them, as Colleen Johnson from the Health Commission indicated, a number of the mainstream services, such as RDNS, already provide some assistance. I would estimate that $6 million worth of assistance through RDNS, Meals-on-Wheels and Domiciliary Care goes to people with dementia through their normal generalist services. As well as that the HACC program has funded a number of specific services. They include dementia workers in key country areas—the Southern Fleurieu, Mount Gambier, the Riverland and Murray Bridge. We have also provided additional resources to the Domiciliary Care Services in a couple of projects; $1.5 million worth of dementia services are specific for that target group. We have provided four pilot services worth $400 000, one to the Southern Domiciliary Care, one to Mount Barker Community Health Care Service and one to Aged Cottage Homes, which services the eastern region.

We have also paid attention to the needs of people from non-English speaking backgrounds. In the past two years we have developed a multicultural respite service for people with dementia; that is worth about $400 000. All in all, specific services for dementia total about $2.3 million, giving an estimate of about $8.3 million out of the current budget of $45 million. So, a significant level of resources is going in there.

Mr McKEE: Is any research being done, either at this level or at Commonwealth level, into the cause of the disease and ways of treating it as opposed to simply offering support services to people who already have it? Has any research been done into the origins of the disease?

The Hon. D.J. Hopgood: There has been a lot of work done around the world and, unfortunately, at this stage there are no definite conclusions. A good deal of epidemiological data has been investigated to see whether there is a specific environmental agent that might be involved and, as members of the Committee might well know, one of those that has been speculated about—it is no more than that—is aluminium. However, it is difficult to conclude from the epidemiological data that aluminium is a factor. It is also difficult to establish in any event what the causal connection would be between the invasion of aluminium into the body and this particular neurological response, as I think I can correctly describe it.

Secondly, there is the possibility of some sort of genetic origin, but certainly no gene has yet been isolated which could be regarded as a causal factor in the whole matter. It is clearly something which is associated with the ageing process but, on the other hand, it is only in a limited sense related to the ageing process. I will conclude my lecture with the following statistics that may be of interest to members. I am given to understand that, at the age of 60, about 2 per cent of the population is significantly affected in some way; at the age of 80, 20 per cent is affected in some way, but at the age of 90, only about 22 per cent of those surviving to that age is affected. If you can make it to 80, you are pretty well right from then on. What all that means in terms of causal factors, genetic or environmental origin, at this stage nobody knows. There are a number of clues, but nobody has been able to put it all together.

The CHAIRMAN: I am particularly interested in this area. With respect to Alzheimers disease, one of the criticisms I have received, particularly from the Acacia Court group in Hendon, about the HACC program is that it is fine to have that program where Alzheimer sufferers are cared for in the home, but one of the difficulties as I understand it is the problem of what respite care programs are offered to the carers of those people. My concern for a number of years, at Acacia Court and throughout my electorate, which has one of the highest ratios of aged people in the State, has been: what is being done to care for the carers?

The Hon. D.J. Hopgood: My brief answer—and I will get Mr Leahy to expand on it—is, 'Not enough.' A good deal more resources must go into this area. That does not mean that nothing is being done.

Mr Leahy: Generally, in terms of the incidence of dementia, the HACC program funds the Alzheimers Disease and Related Syndromes Association (ADARS)

for its family resource centre. That provides assistance to carers in respect of coming to terms with the disease of their spouse or parents, and enables them to provide that level of care and support in the community. Other care-type programs are the things like the regional carers support program that runs out of Mitcham and services four or five councils in the southern area. In addition to the particular dementia programs, we also fund a number of respite programs which are targeted at people in the caring role. An additional $4 million of HACC funds go there.

With respect to Acacia Court, we are aware of that criticism, which was raised at a recent conference. The opportunities are there for the Western Domiciliary Care Service to become more involved in terms of the funding that it receives from the programs, and it is yet to be explored, but there are opportunities whereby some of the brokerage funds totalling about $150 000 could be used to expand the current range of services that Acacia Court provides. As well, the Commonwealth Government provided $40 million nationally in the last Federal budget, to be increased yearly, which will supplement the current respite care services. I understand that the Commonwealth Government will be administering the scheme as an adjunct to the HACC program, and is looking at dementia as one of the target groups. It could well be an opportunity that agencies like Acacia Court could use to expand their current range of programs, by offering full-day respite for people with dementia and so forth.

Mrs HUTCHISON: I refer to page 53 of the Program Estimates and the child support scheme. I have had numerous inquiries and complaints in my office with regard to the time taken between collection of the money and the actual payment being made to the beneficiary. It causes great problems for those people. I notice that it was to be reviewed with the Commonwealth authorities involved in that scheme, so a general review of the whole system of payments was to be undertaken. What is happening at the moment with regard to streamlining the actual system of collection and payment to the beneficiaries?

The Hon. D.J. Hopgood: I am advised that it was reviewed by Justice Fogarty. A very large number of recommendations have been made because it is generally conceded that the scheme has been quite inefficient in the way it has been run. I believe that the Commonwealth is working through those recommendations. Perhaps we could get some more detailed information for the honourable member.

Mrs HUTCHISON: If I could have some information as to when a result will be forthcoming on that, and the recommendations that have been made?

The Hon. D.J. Hopgood: Certainly.

Mrs HUTCHISON: I refer to page 52 of the Program Estimates and the 1992-93 specific targets and objectives. With respect to the strategy to be developed in consultation with the Aboriginal Coordinating Unit to ensure that child protection services will be more responsive to the needs of Aboriginal clients, will the Minister supply more information as to how far that has been developed and what is being done in that area?

The Hon. D.J. Hopgood: I will ask Sue Vardon to respond.

Ms Vardon: We sponsored with other people a national conference earlier this year on child protection issues with Aboriginal people. Out of that came many recommendations. Aboriginal people are very keen to take up some of those recommendations at national level. In their view there is a need for national legislation to protect children. We have an Aboriginal staff member who is following up those aspects of our work that need to be improved, and we have an Aboriginal group that is doing child protection planning for us. It is very clear that the traditional ways we involve ourselves with child protection in the Anglo-Saxon sense are totally inappropriate for Aboriginal people, and we need a new set of advice about what we do. That is what we expect will come out of the group's work.

Mrs HUTCHISON: Many of the people who contact me are very definite about the fact that there needs to be much more involvement of staff workers in the system who can actually work with the people who have problems in this area. What is the department doing about ensuring that there are sufficient Aboriginal staff to cope with these sorts of issues?

Ms Vardon: A very large proportion of Aboriginal people are in the northern country region, and we have just built up our numbers of Aboriginal staff to 25 per cent in that region. However, there are many Aboriginal people in the metropolitan area and we need to have more Aboriginal employees. I am quite pleased with the progress we are making with Aboriginal recruitment. Just as important is the change of attitude of our other staff as well, to think more carefully about how they intervene with Aboriginal families. There is an interesting dilemma. We are accused of not intervening sufficiently with Aboriginal children. Much of it is a result of hesitation on behalf of the white workers, not wanting to do something that is inappropriate, so they stand back, and it is alleged that, because we do not intervene, Aboriginal children are at risk. We need to create new ways of intervening rather than leaving the Aboriginal children exposed because we are too scared to move in lest we are accused of breaking up Aboriginal families, as has occurred in the past 200 years. It is an extremely difficult situation for us.

Mrs HUTCHISON: With regard to the white staff who are having problems in that area, is the department looking at the cross-cultural awareness training courses that I am aware are being used in other areas? Are they being used?

Ms Vardon: Yes, we have just received some funds from the Commonwealth to do cross-cultural training. We have done a fair bit of it, but we will make sure that everyone in our organisation has done it.

The Hon. D.C. WOTTON: I am very keen to get involved in some real meat in legislation, and I know that the Minister is looking forward to being not so involved with that legislation. Does the Government intend to proceed with amendments to the Children's Protection and Young Offenders Act and the Community Welfare Act? Why has there been such a significant delay in proceeding with that legislation, given that many aspects of this legislation have been under discussion for some five years?

The Hon. D.J. Hopgood: I am advised that the legislation is fairly well ready to be presented to the

Minister so that it can be processed to the Parliament. The honourable member would be aware that there was an earlier version of the legislation which was actually introduced in the Parliament, but in the light of the public consultation which occurred following that tabling, some amendments were urged upon us, considered and approved, so I would hope that there would be an opportunity for there to be at least some debate, if not finality, on the legislation before the House rises for the Christmas break.

The Hon. D.C. WOTTON: A number of clients of different agencies, many involving sole parents, have indicated that their greatest need is for cheaper and more accessible child care and respite programs. Such services can make a significant impact on the prevention of subsequent behaviour or difficulties in family breakdown. Therefore, this may have an impact on the numbers of people needing help at the tertiary level from FACS, CAFHS and CAMHS, etc. In particular, it is believed that the child care operational subsidy should be reviewed so that it is distributed more equitably and effectively. Will the Minister comment?

The Hon. D.J. Hopgood: I never knock back an opportunity to comment except, as I understand it, this is more in the Children's Services Office area than in ours and the payment to which the honourable member refers is very much in Mr Crafter's lines more than in mine. It would be more appropriate if this was referred to him rather than us. We will do what we can in a general way but it is not really our area of administration.

The Hon. D.C. WOTTON: There is a lack of clarity about the role and responsibilities between some human services departments, where several departments may impinge on similar issues. It can result in responsibilities being shifted from one department to another and this means that clients are being disadvantaged and often receive no service at all. The experience of some agencies has been considerable with such situations between IDSC and other health units, between IDSC and F&CS and between other health units and F&CS. This is more in the area with which we are involved, and I would like the Minister to comment on that.

The Hon. D.J. Hopgood: It is not an easy question to answer because, as I have said a couple of times today, the division between the services that are appropriately delivered by Family and Community Services and the services delivered by the more community orientated aspects of the Health Commission is blurred and one can understand why. We have people with expertise in these areas. People are keen to provide a service and often these services are set up. All I can really say is that mechanisms are available to ensure, on the one hand, that there is not undue overlap so that there is duplication and wasteful provision of services or, on the other hand, the fact that there may be situations where people may be falling between two stools because agency A is leaving it to agency B.

One of those is the Human Services Committee of Cabinet, which I chair and which has on its membership the Minister of Education, the Minister of Further Education and Youth Affairs, the Minister for Local Government Relations and the Minister of Recreation and Sport. Secondly, CEOs in the human services area meet regularly and I could ask my own CEO to report on that. Part of the reason for all of this is to try to ensure that neither of those things occurs.

Sometimes we will get cognate services occurring in these areas but, on the other hand and as a result of that, I have had to indicate to the committee on a couple of occasions that maybe there can be answers on both of the sections of the committee. In particular, in relation to disability, the organisation which the honourable member would know as SCOSA, IDSC and FACS have all agreed to have regular meetings to sort out these disability issues so far as children are concerned; and where there are specific problems like that they obviously should be referred to the appropriate agency so that that agency can put the matter before this meeting, which may eventually involve other organisations (other than the three I have mentioned) to try to sort out an effective service provision, eventually leading to a sort of one-stop shop.

Mr McKEE: I refer to page 52 of the Program Estimates and the 1991-92 targets/objectives. What is the Government doing to address the high incidence of child abuse and neglect and the high number of children entering State care, particularly in the Elizabeth and Munno Para areas?

The Hon. D.J. Hopgood: We have the initiative known as CareLink. This is an inter-agency initiative jointly managed by the department, the Children's Services Office and Child Adolescent and Family Health Services. This partly illustrates the point that the member for Heysen made earlier, that all of these agencies have responsibilities in this sort of area, and so we have to make sure that the lines of communication are properly sorted out.

This was a social justice initiative as it was funded under the social justice area of the budget. It employs 14.2 full-time equivalent staff and it began its work on 1 October last year. It offers intensive long-term multi-discipline services to families at risk of child abuse or neglect and to families where there is danger of the child being removed as a result of any physical or emotional abuse or neglect. That child then can be subject to my care, control and fostering in some way or another. More than 50 families involving more than 100 children have received a range of services: individually listed therapeutic services, educational support, health screening and advice, speech pathology, occupational therapy and even physiotherapy through the groundwork services designed to decrease social isolation and import information on appropriate parenting skills.

There is a holiday program and child-care services are aimed at providing respite for parents and providing quality care for children. Families are also assisted with their transport needs. I guess the current model of operations is consistent with those aspects of programs in other locations which seem to be effective in evoking some positive change for needy families. The CareLink program will be normally evaluated within the next 12 months and appropriate changes made in the light of that evaluation.

Mrs HUTCHISON: I refer to page 52 of the Program Estimates. I have to plead some ignorance about the welfare assembly centre. It says that the register will be reviewed and that new schools in developing areas will be included in the register. Non-government schools and other community centres will also be included. Can the

Minister give more information about what is happening in this area?

The Hon. D.J. Hopgood: I will ask Mr Barrett to give more information.

Mr Barrett: That relates to the arrangements for counter-disaster as part of the State Disaster Plan. The department has responsibilities for relief in welfare matters and it is simply that a number of school facilities have changed in recent years and we want to ensure that facilities are still at the appropriate standard and that frequently the State Disaster Plan as it relates to welfare responses is tested at regular intervals to ensure efficient, prompt and effective responses.

So, the welfare assembly centre is just the terminology referring to a centre that is open in the event of a local or more widespread disaster where people in the area are evacuated and then cared for with primary welfare services.

Mrs HUTCHISON: Does that include country and city areas as well?

Mr Barrett: Certainly. We have a plan for welfare assembly centres that can be activated at short notice throughout South Australia. Some members will recall in the early '80s the bushfire situations in the Adelaide Hills where welfare assembly centres were opened up (for example, at Mount Barker school) and in 1983 the flooding situation at Angaston as well.

Mrs HUTCHISON: Page 53 of the Program Estimates refers to consumer credit information available to new settlers in the State. Apparently, a gap has been identified in the service provision and something has been done about that.

The Hon. D.J. Hopgood: I will ask Ms Zofia Nowak-Cremer to respond to that question.

Additional Departmental Adviser:
Ms Z. Nowak-Cremer, Manager, Anti-Poverty.

Ms Nowak-Cremer: The issue really arose from identified problems, particularly in the northern suburbs where large numbers of Indo-Chinese new arrivals have settled. It really concerned the lack of information that those people had about credit contracts, hire purchase arrangements and a whole range of other issues that were foreign to them. The problem is not exclusive to that group, but it seems to be quite a severe problem in those areas basically because the whole system is so complex and foreign to people who have never had access to credit cards or hire purchase arrangements and so on.

An attempt is being made to get in very early before people run into difficulties. There has been some discussion with the Department of Immigration, with other non-government agencies which have also identified those problems and with the Consumer Affairs Department. It is planned to have information or orientation sessions in a range of different languages to provide information and support to people to ensure that they do not run into a whole range of problems.

Mrs HUTCHISON: How did South Australia compare on a nationwide basis? Obviously, this problem has occurred in other States as well, but has it occurred to a greater or lesser degree in other States?

Ms Nowak-Cremer: I am really not sure about the extent of the problem compared with other States. I know it exists in other States, but I am not sure whether it is worse.

The Hon. D.C. WOTTON: The decision to focus family and community development funding in areas of most disadvantage is supported. Nevertheless, the shifting of services from, say, Norwood and Goodwood to, say, Elizabeth and Noarlunga is only part of the solution if pockets of poverty and disadvantage remain. The establishment of priorities for areas of greatest need within budget constraints is never easy. What endeavours are being made to assist those areas where funding will cease to access other resources and/or funding, if possible? What I am really saying is that the unemployed teenager or the single parent on a low income living in Norwood may only have marginally more access to resources than their counterparts in Elizabeth even if they are relatively fewer in number.

The Hon. D.J. Hopgood: I will ask Mr Hall to respond. I make the point that places such as Norwood and Goodwood are less affected by the tyranny of distance than, say, Noarlunga and Elizabeth.

The Hon. D.C. WOTTON: Or Mount Barker.

The Hon. D.J. Hopgood: Or Mount Barker; I concede that as well. Obviously, whatever the distribution of these sorts of resources, it will probably be easier for a person living at Norwood who does not have an outlet down the street to come to town or wherever to get that service. I will ask Mr Andrew Hall to expand on that briefly.

Mr Hall: The earlier part of the honourable member's question related to funding alternatives. We have indicated to those agencies where we envisage some reduction in their funding that we would be flexible on the exact timing if they were able to secure funding from other sources. A number of neighbourhood houses have had discussions with their local government authority and been given quite firm indications that they will be supported in the new financial year. We fund agencies on a calendar year basis, so there is a six month gap before alternative funding can take place. We have indicated to all those agencies that we would extend the funding for six months if there were a likelihood of alternatives.

The question of disadvantage is very complex. We have tried to take into account not only statistical but anecdotal information from agencies. One of the prime purposes of neighbourhood houses is a community development function to develop local support networks and community cohesion. Whilst a disadvantaged person is a disadvantaged person wherever they may reside, those communities that we have identified for some reduction in funding generally have higher levels of support networks. For example, those agencies or neighbourhood houses that may get a reduction in their funding have been able to respond with a lot of community support.

Those areas in which there are currently no neighbourhood houses or very low levels of community cohesion and informed support are not making any comments at all. I think this goes to prove a point: it is the overall or multiple disadvantage of the community that means that individual people do not get the support that they might get in relatively more advantaged areas.

The Hon. D.C. WOTTON: What is being done specifically to make increased provisions for and

encourage secondary and tertiary preventative programs in the areas of domestic violence and child abuse?

The Hon. D.J. Hopgood: I will ask Roxanne Ramsay to report to the Committee on this matter.

Additional Departmental Adviser:
Ms R. Ramsay, Director, South West Region.

Ms Ramsay: Work is occurring at a number of different levels. I am the State Government's representative on the National Child Protection Council. We are looking at a national awareness campaign that will start at a Federal level but in which all States and territories will participate. South Australia will participate in that, and the State Child Protection Council is working on looking at how the State campaign will link into the national campaign and how we can therefore make most effective use of the relatively scarce money that exists for a national campaign.

We believe it is important to look at primary prevention and community education and to take advantage of what other States are doing into this State as well as at the national level. Apex is also working closely with the national council at quite a different level but very successfully, and that campaign will be linked with the State and national campaign. It will tap into quite a different area and I think it will be very productive in terms of moving into another area of primary prevention. There is also the whole area of community education and primary prevention programs, and at different levels across the State we are looking at what we can do with those programs to make sure that at the local level and also linked into a State campaign we address those issues.

The Hon. D.C. WOTTON: Is it possible to be more positive about some of those programs that the department and the Commonwealth are looking at? I would like some examples of programs.

Ms Ramsay: The national awareness campaign has been built on the Western Australian campaign that is looking at valuing of children. The same group of people who looked at the child value campaign in Western Australia have been employed. That campaign has researched the attitudes of the general community in terms of how they see children, how they value them and how parenting is seen. Building on that and looking at those attitudes, we intend to look at the sorts of messages that need to go out to reinforce and support families at both a practical level and a changing values and attitudes level.

It also needs to be linked into the national violence strategy, because child protection is quite closely linked with domestic violence. We know that in families where domestic violence occurs there are also many child protection matters. That is also being looked at. It is a matter of looking at the programs that are happening across the nation and in this State that are successful. The national council has a research program to look at programs that are successful and what the components are to try to put that all together into what we call a national clearing house so that we do not have to reinvent the wheel but can build on other programs. If it is useful I can get more specific information about some of the programs we believe have a chance of being successful.

The Hon. D.C. WOTTON: Supplementary to that, at a later time can the Minister provide some of the latest statistics relating to child abuse and domestic violence?

The Hon. D.J. Hopgood: Yes, we will provide that information.

The Hon. D.C. WOTTON: What action is the Minister taking in the planning of services for children who are leaving departmental care? I understand from child welfare literature that this is referred to as post-guardianship services. There appear to be significant problems for young adults leaving the care of the Minister, particularly between the ages of 18 and 25 years. Is there a joint health/welfare policy regarding this issue and, if so, what is it?

The Hon. D.J. Hopgood: I will ask the Chief Executive Officer to answer that question.

Ms Vardon: The honourable member asked whether there is a health and welfare policy. There is not, but we have had a series of post-guardianship practices where staff are required to prepare children for leaving care. We have always been greatly concerned about what happens to children who turn 18 years of age and their foster families do not want them any more. Many children stay with their foster family and identify with that family and they do not need us. But there are some children, of course, who have not had satisfactory relationships. They are independent and our people work with them to develop some skills.

However, we have been concerned about the deficit. We set aside 3.8 per cent of our field budget this year to do some work in relation to post-guardianship services and preparing young people for leaving care. A person has just done two weeks work for us and he has proposed that we should have a series of speak outs with those young people so that we can hear what they have to say. Many young men say they are not prepared for cooking and living independently. We know we have to do something about addressing those skills. We have identified a gap. It is not the biggest gap we have, but it is certainly something we need to improve, and we intend to make that a focus of our work this year. We have funded some agencies to help with that and I can provide more information. I can certainly provide the terms of reference of that project this year.

Mrs HUTCHISON: On page 57 of the Program Estimates reference is made to juvenile justice. What did the evaluation of the Street Legal program come up with? I refer to the program for car thieves.

The Hon. D.J. Hopgood: Perhaps Ms Howe can respond.

Ms Howe: La Trobe University is in the middle of the evaluation of the Street Legal program and the Hindmarsh Industrial Training program, both of which had their genesis with the Department for Family and Community Services but have attracted significant funding from other places. The early indications are that it has been highly successful in terms of reducing recidivism in car stealing, in getting children back to school and in securing employment for participants in the program. The expectation is that the evaluation will be completed within the next three months. In fact, this Friday I am seeing the evaluator from La Trobe, who is gathering more information from us. However, he has

certainly said that the indications are that it is a highly successful program.

Mrs HUTCHISON: Given that it is a highly successful program, do you see the possibility of extending that into other areas?

Ms Howe: In fact, the Elizabeth office and the Salisbury office are participating in a new program along that line, called Classic Holdens. It is being conducted at a youth activity centre we have just purchased out there. That program involves taking old Holdens, doing them up, drag racing, and so on. We have found in the past that these programs are successful. They are usually successful because of the energy and commitment of some individuals and the ability to attract children and give them good skills. So, we expect to be developing more of those sorts of programs, particularly aligned to the development of skills and the securing of employment.

Mrs HUTCHISON: My next question relates to that same page. I notice that in the commentary on resource variation between the years 1991-92 and 1992-93 there is an increase, which is mainly due to recalculation of the field apportionment formula. The receipts include provision for Aboriginal country youth from the Attorney-General. Can the Minister comment further on that? I assume that the reference to Aboriginal country youth is something to do with the Country Aboriginal Youth team from Port Augusta. I must at this stage commend the Port Augusta office of the Department for Family and Community Services for what has been a very successful project and one I think other areas could profitably look at.

Ms Howe: As the honourable member pointed out, that program is funded for two years in three ways: from the salary budget of the department, the Crime Prevention Unit and social justice funding. We expect that it will secure continued funding because of its success in reducing offending by those children by some 50 per cent.

Mrs HUTCHISON: Were the 7.9 full-time equivalents all allocated to that one area?

Ms Howe: Yes, that is right. The salaries are made up of one supervisor, four young Aboriginal full-time workers and some six to 10 part-time Aboriginal youths who work on that program.

Mrs HUTCHISON: On the same subject, were there any full-time jobs acquired after that program, or have there been any ongoing full-time employment opportunities?

Ms Howe: The spin-off for that program has been that a number of the younger casual Aboriginal children who are 15 and 16 years old have gained at least part-time employment through the Education Department in tutoring primary school aged Aboriginal children. Of the older employees, two have gained full-time and permanent employment—one outside of this department and one in the department. A number of those Aboriginal young people are also undertaking further training at the tertiary level or are going back to school. It has had a significant spin-off in terms of a positive outcome for the participants. We are also setting aside places for employment specifically for young Aboriginal people within the department and have a strategy to continue using that as a feeder program.

The Hon. D.C. WOTTON: I am not quite sure whether the member on the other side referred to Street Legal. I know it is not my place to be making statements—I am supposed to be asking questions—but I point out that I had the opportunity with some of my colleagues to visit Street Legal recently. I was most impressed with what I saw. I hope that we may be able to expand that program significantly, because I think the work being done there is first-class.

Ms Howe: Street Legal looks like being franchised as a concept around Australia.

The Hon. D.C. WOTTON: As I understand it, the Port Adelaide Central Mission and the St Vincent de Paul seem to have been the main points of contact for the newly arrived migrants at Pennington. It is therefore somewhat puzzling to read on page 43 that the multicultural financial counsellor will link with government and non-government agencies to develop strategies to ensure that the needs of new arrivals are adequately met.

The Hon. D.J. Hopgood: We will ask Zofia Nowak-Cremer to respond to that.

Ms Nowak-Cremer: I agree that the first point of contact is very often Pennington Hostel and that people who come through the hostel tend to use surrounding agencies, particularly Bowden-Brompton Mission more so than the Port Adelaide Central Mission and other agencies. However, what is increasingly happening is that, as people are not arriving in large numbers (they are coming to join families), they bypass the Pennington Hostel system. Even if they go through Pennington, very often what happens is that the numbers are too small for the sort of orientation and information sessions which used to be organised by the Immigration Department based at Pennington. There may be one or two families who share a particular language and culture, but the groups are too small to provide that sort of structured information session.

Consequently, these people end up in the community very quickly and, particularly for people who either go through Pennington or join families who are already settled, very often the issue of credit and signing contracts, and a whole range of other things, is not their first priority. Their first priority is to find accommodation and so on. Even if information is provided right at the point of arrival, it often has very little relevance. Often, the problems start once they are in the community. Therefore, the need for information is really at the community level. The multicultural financial counsellor who is based at Woodville is clearly working with all those bodies and non-government agencies to jointly address the issues.

The Hon. D.C. WOTTON: I want to ask a question regarding INC parents. Since the change of policy earlier this year, have complaints been made to the department with regard to that change of policy and, if so, what concerns have been expressed; and can the Minister indicate how prospective INC parents are selected—in other words, how are they screened?

The Hon. D.J. Hopgood: Michael Szwarcbord has the information on that one.

Mr Szwarcbord: I am not aware that there have been any recent complaints by INC parents. We had a meeting some months ago with a group of INC parents from the

metropolitan area, and it related mainly to confusion about titles of programs and what might be happening in the adolescent INC area. Since then, I am not aware that we have had any expressions of concern.

One of the changes was the creation of replacement teams. In the past, an individual who supported INC parents was based in a regional office. With the creation of placement teams, groups of staff concerned themselves with a range of substitute care programs, fostering for children's special needs and INC. There were some concerns about the fact that some of the staff who had provided the support in the past were not doing that, but there are individuals within each placement team who provide specific support to INC parents.

The recruitment of INC parents remains similar, except that the placement team as a whole plays a bigger role; whereas in the past an individual INC supervisor might have done the training with a group of INC parents, now the placement team takes that responsibility, so there are a number of staff involved in ongoing recruitment and assessment. There are still training sessions involving INC parents, and they still receive individual support as they did in the past.

The Hon. D.C. WOTTON: How are they actually screened to ensure that they are the right type of person for that responsibility?

Mr Szwarcbord: The screening is really two-phased. There is an assessment process, which details the sorts of areas and risks with which we should be concerning ourselves regarding the family, so about 15 to 20 hours is spent in individual contact with the families, asking various questions, looking at family functioning and so on. In the second phase, they go through the process of training in six to eight sessions and, quite often, in that process families raise issues; for example, if there is child protection training, there is quite often some indication that there might be some further concerns that we should be exploring with the family. Quite often, families weed themselves out. By the end of that process, we are fairly clear that we have pretty well weeded out the families likely to place children at risk. The other component of that is that every family is subject to a police check; the first step is that we do a police check to see whether they have any police record.

The Hon. D.C. WOTTON: I am aware of concern regarding the absence of any commitment by the Minister or the department to the ongoing work necessary after June 1993 in the area of post-adoption services. It has been put to me that ongoing funding for the program would enable the organisation of the agency to build substantially on the valuable initial work completed by June 1993 and would reduce the pain which a significant number of people in the population are suffering.

The Hon. D.J. Hopgood: A two-year grant has been made available to the Lutherans to do this work, and I guess the fact that it is only a two year grant is the source of the honourable member's concern. All I would say to that is, quite obviously, whoever may provide the auspices for this sort of service beyond that date, there will be a service. So, we can at least give that sort of guarantee. We do not know whether this organisation at this stage (at least, I am not aware) would necessarily want to carry on the service after that period of time. Some other organisation may emerge, and the Lutherans may be only too happy to hand it over to that organisation. That is something that is part of the working through of the current program and, obviously, well before the end of the two-year period we would want to identify the appropriate way in which the service will continue. However, the fact that it is a two-year grant does not mean that the service will stop after that.

Mrs HUTCHISON: I would like to reciprocate the member for Heysen's comment a while ago with regard to INC parents. I am aware that there has been a difficulty in the past in attracting sufficient numbers of Aboriginal parents to be INC parents. Has the department had any measure of success in recent months in attracting more Aboriginal parents to become INC parents?

Additional Departmental Adviser:
Mr G. Boxhall, Director, Administration and Finance.

Mr Boxhall: The recruitment of Aboriginal INC parents is particularly for placing young offenders. There has been a small increase in the last year; during the last financial year, 41 youths were placed. We do not have up-to-date information on the number of families, but there has been an increase across most of the regions. The average length of stay is from six to eight weeks, and we are currently reviewing the arrangements to be able to more closely link our Aboriginal INC program with the placement support teams Mr Szwarcbord referred to a moment ago to develop the program further across all regions.

Mrs HUTCHISON: What has the department been doing to address the recommendations of the Royal Commission into Aboriginal Deaths in Custody?

The Hon. D.J. Hopgood: Again, I think I am going to have to precis harshly, because there has been a large number of programs. If I can just mention a few of them. There is the Mount Serle program, so-called, a program designed for Aboriginal young offenders based at the Mount Serle station, 700 kilometres north of Adelaide. Young Aboriginal offenders participate in a six-week work program jointly funded by the Department of Employment, Education and Training and supervisors from the local Aboriginal council, who own the station and supervise the work, including stock control, fencing and repairs to buildings.

With regard to Aboriginal group programs, the local district centre youth workers have co-run group programs with MAYT staff at Elizabeth and Woodville offices for Aboriginal young offenders. There is intensive personal supervision (IPS); they have assisted district centres to recruit and use Aboriginal people to work with young offenders as intensive personal supervisors on request. There has been Aboriginal intensive neighbourhood care. There has been Camp Coorong, which has been used as an alternative community work placement for Aboriginal young offenders. There has been family and individual support and, of course, there has been recruitment of Aboriginal staff. In all of this, we have endeavoured to ensure that what we have been doing has been cognate with the programs that have been run by other departments, particularly the Department of Aboriginal Affairs and the Attorney-General. We have sought to take our place in what has been a very large program with

considerable Commonwealth support as a response to the royal commission.

Mrs HUTCHISON: My next question refers to page 58 of the Program Estimates and the 1992-93 targets and objectives. An evaluation of the productivity impact of restructuring is to be undertaken; registers of departmental policy documents as required under FOI will be created and lodged in the department's library. What progress has been made with regard to that?

The Hon. D.J. Hopgood: I will ask Ms Howe to reply to this.

Ms Howe: In terms of the evaluation of the restructure, it was always intended after the initial 12 months that we would go back and make sure that we had got the structures right, the number of staff and the level of resource in any given area. It is quite an extensive evaluation. It is in three parts. We are looking for an external tertiary tender to have an objective look at the management of change in the structure. There is the work site reform aspect. We did make a promise that we would pick up 1 200 unallocated cases. We have picked up, so far, an additional 500 cases, and we are looking at work practices and the micro-changes that can go on in individual work places. The whole of the department is involved in that, and that process has in fact started. The third objective of the restructure was to improve quality outcomes for clients, and our strategic planning division is working with our staff on developing some methodologies regarding client satisfaction. It is quite a lengthy process. The work place reform aspect of the productivity review, however, we expect to finalise by the end of this year.

The Hon. D.J. Hopgood: I ask Mr Layton to respond on the freedom of information aspect.

Additional Departmental Adviser:
Mr R. Layton, Director, Executive Projects.

Mr Layton: The department, like any other Government department, is required to produce two publications relating to its documents. The question related to the policy documents. That process is well under way. Every division of the department is currently sorting out what are its policy documents, and we are in the process of developing a system for registering that. The intention is that the majority of those papers will be lodged in the departmental library in the spirit of the Act available for all members of the community.

Mrs HUTCHISON: With respect to the evaluation of productivity measures, mention has been made of a pilot evaluation, client satisfaction and the review of response to complaints. Will the Minister elaborate on that?

The Hon. D.J. Hopgood: I will ask the Chief Executive Officer to respond.

Ms Vardon: A total of six of our staff are going through a customer service management program at the moment, looking at all aspects of our contact with the public, from our correspondence through to our telephone manner, to what happens at the counter, to what happens when a social worker visits a person's home, and so on. We are conducting a series of forums with people who have experienced our service, through any of those mechanisms, and we will be using the feedback to improve the way we do those things. The project will last about six months.

Mrs HUTCHISON: Has there been any initial feedback on which you can comment?

Ms Vardon: The actual project has only just started but across our organisation, since we have taken a customer service bent and we have trained everyone at The Grand in customer service, we have had a lot more positive feedback generally throughout our organisation and many more positive letters from people than we have ever had before.

The CHAIRMAN: Does the Government perceive a difference between the presentation of some papers at the National Conference on Juvenile Justice, or the attitude of some people in relation to juvenile justice, in terms of reparation, fronting victims of crime and the like, as against what is perceived by some people in the community—and perhaps some members of the Judiciary both in Australia and New Zealand—in relation to the question of family conferences, for example? Does the Minister see any conflict between the Department of Family and Community Services and the attitude of certain members of the Judiciary? It has been my experience when talking to people interstate and at Neighbourhood Watch meetings that a conflict between these two areas of jurisdiction is perceived by some people.

The Hon. D.J. Hopgood: I have not been involved personally in the conference; therefore all I can do is draw on such conversations as I have had today, particularly over the dinner break, with my officers who have been involved in the conference. They report to me that what is coming through from the conference is very much an endorsement of the sort of position which the department put to the select committee of this Parliament, that the general model that we have advocated to the select committee is very much one which is endorsed by the main speakers at the conference. You asked specifically about family conferencing: I have not had any advice on that. Without taking up any undue time, I will ask the Chief Executive Officer to make any further comments on what has been said at the conference about that matter.

Ms Vardon: There has been much talk at the conference about the need to improve police cautions and to improve policing on the ground, and a model from Wagga promoted by the Chief Judge in the Children's Court was put on display today and was highly accepted by everyone. The notion of improving police cautions is acceptable to all. The family group conference notion from New Zealand was spoken of by both the Chief Judge in New Zealand and people evaluating the program, and the notions of restoration, restitution and accountability, but sensitivity to young people's needs as well, were clearly coming through from all speakers, including the Judiciary, people like myself and others. I believe there was much harmony in the room and I am sorry that there is a public perception of conflict, because Mike Duigan said today that everyone from South Australia took credit that their submission to the select committee was reflected in the conversations today. I think there was a harmony in the South Australian position as a result of today. There was agreement on general principles.

The Hon. D.J. Hopgood: We predict that, before too long, no family should be without a Wagga model.

The Hon. D.C. WOTTON: Why is the Government refusing to recognise its responsibility in matching HACC funding? I am particularly concerned with the implications that this has on the aged. The South Australian Government is once more not matching funds that the Commonwealth Government is providing. Even Victoria is matching more so than South Australia, even though we have in percentage terms the largest aged population. The HACC services, particularly domiciliary care, are under resourced. A review was conducted two years ago, and a review committee spent many months looking at the problems of waiting lists, etc. That committee costed the needs of this body, but once more we are the only State not matching the funds. The social justice question of user rights is also not being resourced. The Commonwealth funds the Aged Rights Advocacy Service on behalf of people in nursing homes and hostels, but the advocacy on behalf of people electing to stay in their own homes, which is a HACC responsibility, is not being resourced. This scenario exists despite the fact that demands for advocacy are being made by older people on an ongoing basis.

The Hon. D.J. Hopgood: There will be growth in HACC funds this year as a result of such matching as we have been able to manage in what has not been an easy budget. I will ask Mr Leahy to spell out exactly what that means.

Mr Leahy: In 1991-92 the South Australian HACC budget increased by approximately 18.5 per cent over the previous year. According to the only published figures I have seen so far in *Bottom Line*, a newsletter of the Australian Pensioners and Superannuants Federation, that is the highest rate in Australia. The next highest rate was Queensland, with an indexation factor of 15.59 per cent. Those figures are indicative because they are not based upon the acquitted figures at the end of the year but they are the estimates of expenditure from the Commonwealth. So, one could in fact say that, in 1991-92, South Australia did experience a significant rate of expansion. The budget for 1992-93 does provide for the capacity for growth of the order of 5.8 per cent which, as I understand it, is slightly higher than Victoria's position, which is only providing for a 4 per cent growth. Those funds represent some allowance for an indexation factor and for the full year effect of projects that started last year.

The domiciliary care review, to which the honourable member referred, had some 73 recommendations, many of which have been implemented. They include the Age Line, which was set up in 1989 as a result of the perceived need for information for older people. That was one of the recommendations. Last year the Government put in additional funds to the areas identified by the review in terms of disability through the community support scheme. That grew again by $1 million to a total of a $3.8 million budget. That was designed to respond to the needs identified in that domiciliary care review. The funds I mentioned before for multicultural respite were again an issue raised in that review. In total, we estimate that approximately $5.7 million of additional resources have been provided to implement the recommendations of the domiciliary care review. It certainly is the case that the estimates of the total costs of that report were of the order of $17 million, so the $5.7 million is in fact going some way towards it. Obviously there is a lot more to do there, but it certainly is not the case, as far as I am concerned, that the recommendations have not been responded to and that the growth has not been there.

The Hon. D.C. WOTTON: When is work scheduled to commence on the development of a policy and plan for the aged?

The Hon. D.J. Hopgood: We have a number of policies and plans for the aged. Would the honourable member be a little more specific?

The Hon. D.C. WOTTON: Discussions that I have had with a number of agencies in recent weeks have suggested that the Government is just about to embark on the development of a policy and plan for the aged; hence the question.

The Hon. D.J. Hopgood: The honourable member must be referring to some plans in the South Australian Health Commission. The Health Commission has developed a number of policy statements in relation to youth health, Aboriginal health and migrant health, and that would be that to which the honourable member is referring. There are a very large number of programs in the Health Commission in this area, and as the honourable member would know, older people—particularly some of what are called the old old—per capita are very much the largest consumers of health resources, as perhaps would be expected. Yes, there is some expectation that a number of these matters will be pooled together in a statement similar to those others that have been issued in recent years and to which I have referred. I know of no other, so I think I have probably got the honourable member fairly well right.

Mr OSWALD: This is perhaps a follow up question to that asked by the Chairman. The conference today fairly well supported the submission of the Department of Family and Community Services to the select committee. It was my understanding of an interview with a New Zealand Children's court judge on the Keith Conlon show the other morning that he was very specific in saying that he believes the equivalent of Family and Community Services in New Zealand should be divorced from organising and controlling family group conferencing. When we visited New Zealand, he implied something along the same lines during our discussions. I will not canvass that area, but he is on the public record here—and we could get a transcript—recommending that FACS should not get involved in the actual organisation or controlling of family group conferences but that officers could be present. That is at variance with the earlier statement that the conference agreed with the submission to the select committee. I seek clarification of what was actually said at the conference. Did the judge change his attitude at the conference? On the radio he was very specific as far as the role of FACS in family group conferencing is concerned as against what he said on air.

The Hon. D.J. Hopgood: Or was the judge only a component of the conference rather than the whole of it? I will ask the Chief Executive Officer to respond.

Ms Vardon: The conference had many themes, but there were three components of our submission. I am not talking about the administration of our department but

about the themes that came through the conference, and they are clear. One is that the juvenile justice system should not be purely a justice or welfare model but should move away from those notions altogether and take a new position. In fact, it was called a republican communitarian model, which separates out from all of that and looks at the notion of restoration, community accountability, accountability of the young person, the involvement of the victim and so on.

It was this republican notion that was supported in a different language by the key speakers, Braithwaite, Brown and others. The fundamental position that the department took in its opening statement was that the restorative justice model, which is very similar to that, should replace the rehabilitative and retribution model. So, we have suggested that the underpinning of the juvenile justice system should shift, and that was supported today.

The second major submission that we made was that there should be a huge increase in police cautions. This was very clearly a theme of the conference and of everyone who spoke. The third underpinning of our submission was that there should be a family group conference. That was the third pillar on which we stood in a sense. As far as administration is concerned, I do not say that the conference supported every aspect of our submission. What I am saying is that we placed ourselves in the modern thinking, for want of a better phrase, but the notion of who administers which bit of it is up to the select committee to recommend.

The judge did not actually reject the department's submission. What he said was that the professionals should not control the whole of the process; that we should take into account leaders of the community if they are Maoris and senior people who are respected, that those people should chair the conferences, that professionals are not necessary, that they should play a limited role in identifying which parties should be there, and making sure that professional help is available if needed by psychiatrists and psychologists. This republican notion requires that the community should find a solution and make a recommendation on it.

We do not have any problems with that notion. The judge in conversation is not as rejecting of the department's involvement at all, but we will not go to the wall about who organises and runs conferences. For us the more important thing is the underpinnings of the new system, and we believe the underpinnings that we talked about were reinforced today.

Mrs HUTCHISON: My question relates to the Wami Kata Old Folks Home, which is an Aboriginal old folks home. Is the Minister aware that there is a funding problem with the Wami Kata Old Folks Home which is putting at risk its continued operation? Is he aware of that problem and has he had contact with his Federal colleague about its funding? I believe it is currently funded through ATSIC. In the past it has been funded through Aboriginal Hostels or it has had partial State/Federal funding.

The Hon. D.J. Hopgood: I have had no contact with the Commonwealth Government because it has been done for me by my colleague Mike Rann, Minister of Aboriginal Affairs. I have a letter he wrote to the Hon. Robert Tickner a short while ago in which he requested that Minister's urgent intervention to resolve the funding crisis which threatens to close the Wami Kata Old Folks Hostel at Port Augusta. The funding from Aboriginal Hostels Ltd has been reduced dramatically without provision having been made for additional funding from other sources. There is a probable budget shortfall of $153 000 in the 1992-93 financial year, and without additional funds the hostel will close at the end of this month.

The Minister goes on to describe what he understands is the problem arising out of a conflict between ATSIC, Aboriginal Hostels Ltd and the Department of Health, Housing and Community Services over the responsibility for the funding of Aboriginal residential aged care services. The Minister is appalled at this apparent administrative conflict, particularly because we are dealing with many residents who are aged between 80 and 100 years and who require a high level of cultural sensitivity as well as appropriate personal nursing care. Because of those matters it will be difficult to safely secure alternative accommodation. Mr Rann asked of Robert Tickner that he get his support to resolve the impasse so that the lives of these elderly Aboriginal people will not be disrupted. I have not heard at this stage of a specific response from the Commonwealth. I do not know whether the Commissioner for the Ageing is in a position to further report.

Additional Departmental Adviser:
Mr L. Powell, Commissioner for the Ageing.

Mr Powell: I understand that this afternoon staff of the Federal Ministers for Aboriginal Affairs and Health, Housing and Community Services met in an attempt to resolve this issue. As at this evening I could not find out what had been the outcome of that meeting because it was still going on, but I would be happy to provide the Committee with the information when it becomes available tomorrow.

Mrs HUTCHISON: I would appreciate the availability of that information when it does come through. I believe that Wami Kata is the only Aboriginal old folks home in South Australia and I do not know of any other in other States, so its continued operation is vital. I believe that some Northern Territory people have used this home because of the drift of Aborigines through the lands to Port Augusta. Is the Minister prepared to add his voice to that of Minister Rann if the occasion demands it in the future?

The Hon. D.J. Hopgood: I am happy to do so.

The Hon. D.C. WOTTON: There is growing concern about the broadening gap between concessions available in respect of water rates, council rates and the cost of such services. What representations has the Minister made to his ministerial colleagues about that, particularly as it relates to the aged? I would also like to know what arrangements have been made to include State concessions in the new pensioner concession card which was created at the last Federal budget?

The Hon. D.J. Hopgood: I think I have partly answered the second part of that question. Regarding the first part, I make continual submissions on the matter as part of the budget process. Not a budget goes past without there being consideration by the Cabinet and

Treasury officers as to the appropriate way in which concessions should be made available.

As to the recent initiative of the Commonwealth, I repeat what I think I said earlier. The effect of that initiative—well supported as it no doubt will be in the community and deservedly applauded—would be that a number of concessions that are currently not available from the States would become available to certain card holders. That will require considerable additional funding by the States. The States have approached the Commonwealth for assistance in the matter, and the matter has been referred to the Commonwealth Grants Commission. We will await its report on the matter.

The Hon. D.C. WOTTON: The lack of clarity regarding Commonwealth-State aged care responsibilities appears to be severely hindering the delivery of services to older people. Can the Minister indicate when the situation will be resolved? In addition, what is the future of the Home Assist Program?

The Hon. D.J. Hopgood: I do not know whether one would want to say that it severely limits it. Of course, it produces some artificial boundaries where they need not exist; for example, where people have to move from acute care into nursing home type accommodation, they are moving from an area which is predominantly funded from State sources to an area which is Commonwealth funded. If that could all be rolled up under the one jurisdiction, I guess there may be some advantages to us in ensuring that the services flow more naturally and inevitably from the acute to that form of post acute service. However, this is not to suggest that at this stage there are glaring problems in that area. I think for the most part it is handled relatively sensitively.

However, the honourable member is quite right in identifying that this is an area which in turn was earmarked for some degree of rationalisation from the States ever since former Prime Minister Bob Hawke got the idea at his breakfast table, or wherever else it came from. It was one of the very early areas that was identified, and there has been no specific resolution of the problem.

In contradistinction of what I have just said, which might have suggested that the way to go would be for the funding of nursing homes to come into the State orbit—of course, with adequate recompense from the Commonwealth—there are those who have suggested that there would be considerable financial advantages to the States and to the health systems and, therefore, to the customers if the Commonwealth took over all responsibility for aged health care. Of course, the South Australian Health Commission has a large number of people in country hospitals who are, in effect, nursing home type patients, yet they are being cared for with a considerable bundle of State money. Of course, that would then become a Commonwealth responsibility.

These matters are continuing by way of discussion. There has been some loss of momentum with the change, particularly in terms of the personnel of the Federal Cabinet, because I do not think that this is seen on quite the same level of agenda by the new Prime Minister as it was seen by Prime Minister Hawke. The matter will almost certainly go before the next Premiers Conference. In relation to the Home Assist Program, I will ask Mr Powell to comment briefly on where that is going.

Mr Powell: The Home Assist Program was established in July 1990 and, as members would be aware, it provides a range of safety, home security, home maintenance and social support services to the frail aged, younger people with disabilities, carers and people on low incomes. The Home Assist Program was recently reviewed with a particular focus on its dual objectives. It has hitherto had both a community service objective in the areas that I have just mentioned and an employment training objective. The employment training objective led to the program in its original form being administered through the Department of Employment and Technical and Further Education. I understand that the review recommended that the pursuit of this employment objective through Home Assist should no longer occur in the next version of Home Assist. For this reason, the Government is now considering the future of the Home Assist Program and where it should lie, with a number of recommendations being submitted to Cabinet recently.

The Hon. D.J. Hopgood: As recently as Monday of this week there was an extension for three months, effectively to the end of the year.

Mr BLACKER: The Minister would be aware of numerous discussions we have had in relation to the rural care worker position on Eyre Peninsula. The Minister would also be aware of the considerable correspondence that he and other members of Parliament have received in relation to that position, and I regret to advise that the position is not resolved and that the community concern still exists. On 19 May I wrote to the Minister, drawing to his attention further concerns and allegations; Mrs Boylan (the person to whom I refer) was accused of misappropriation of funds, and that has subsequently been proved not to be the case. There were a number of other concerns, one being that a departmental officer told a constituent in Port Lincoln that Mrs Boylan would be out of the department by the time the new position—that is, the $40 000 announcement that the Minister made early in April—became available. Obviously, there are considerable personality conflicts as well.

Will the Minister consider having an independent assessment or inquiry into the position because, without doubt, the community is most uptight about what has happened. Mrs Boylan is presently working from an office in Whyalla, and many constituents on Eyre Peninsula have contacted Whyalla and have not been put through. The matter is most unsatisfactory, and I wonder whether, if the Minister would consider an independent assessment into the matter, some resolution might be found, in fairness to all parties.

The Hon. D.J. Hopgood: The honourable member has done me the courtesy of discussing this matter directly on a number of occasions, and in particular this proposition has emerged in discussion with us. The reason why I have been reluctant to commit myself publicly to this course of action to date is that my understanding was that Mrs Boylan was applying for a particular position on the peninsula and that any public announcement of an investigation of this type could well impinge in some way on her success at the job interview for the position for which she was applying. I have been given no official indication as to what has happened there. I take it that the matter is still under consideration. I do not know whether

Mrs Boylan knows at this stage whether she has gained the position.

All I can say (and I am conscious of the fact that we are in a public forum here and I cannot duck the question, and the only reason for my ducking the question would be out of concern for Mrs Boylan, or at least for her potential to get that position) is that I am prepared to give the matter proper consideration. I appreciate the honourable member's constructive attitude to this and the patience that he has displayed in the whole matter. I also want to indicate my concern for the patience displayed by my own officers in the department in relation to the matter but, until such time as the matter of the job for which Mrs Boylan has applied is resolved, I would be reluctant publicly to commit myself to that course of action. However, the matter must be resolved ultimately, and an appropriate mechanism will have to be identified. This may be it.

Mr BLACKER: I appreciate the Minister's comments at this time and in this way. However, undertakings were given by the department that Mrs Boylan would not be either assisted or hindered in pursuit of that job. Clearly, that is not the case. As I outlined in my letter of 19 May, it had already been stated, and I also understand that a departmental officer has been in the area quite recently amongst those people who will be making a determination in the selection. So, the matter is of some considerable concern to me as well as to other people in the community.

The Hon. D.J. Hopgood: I should give the Chief Executive Officer an opportunity to put to rest any suggestion that any officer of the department has been campaigning to deny Mrs Boylan her fair chance to gain the position for which she has applied. That seems to be the gravamen of the honourable member's suggestion here.

Mr BLACKER: They are contained in my letter of 19 May where I clearly set out those concerns to which I have not yet received a reply.

Ms Vardon: I would like to assure the honourable member that every officer of the department on the peninsula was told to keep their mouth shut on this matter, and as I understand it the department only wished Mrs Boylan well in applying for that job, and there is no officer of this department who did anything in any way to hinder her. In fact, in many ways it would solve all our problems if that were to be the case and we would be very happy for that to happen.

Mr McKEE: I understand in New South Wales the Government made compulsory retirement unlawful for the majority of that State's public sector employees as of 1 January 1991. Can the Minister tell the Committee whether any steps have been taken to provide similar benefits to South Australia's public sector employees and indicate what these steps are?

The Hon. D.J. Hopgood: South Australia was, of course, the first State in the nation to make amendments to legislation to make discrimination on the ground of age unlawful. In relation to employment, education, goods and service, accommodation or discrimination by clubs and associations, the Act is absolutely clear. However, as all members of the Committee would know, the section of the Act which bans compulsory retirement based on age comes into effect on 1 June 1993; that is the present position. In the meantime there is nothing to prevent employers acting immediately in the spirit of the law by ending compulsory retirement based on age in their work force.

As an employer, the public sector is also encouraged to adopt the spirit of this legislation so that older employees who wish to stay on in their department or authority beyond what is now regarded as retirement age are no longer barred from doing so on the basis of age. I imagine there are a number of other matters that have to be addressed. The question of superannuation is, of course, a quite separate sort of matter, but that is the present position. The reason for suspending that part of the Act to date was so that these matters could be resolved prior to the statutory power actually coming into effect. I am given to understand across the public sector that these matters are being satisfactorily resolved within that time frame.

The Hon. D.C. WOTTON: I understand that a major report has recently been prepared regarding housing for the elderly. I understand the report has been presented to the Commissioner for the Ageing and the Minister of Housing and Construction. What is the status of that report; why has it not been made public; and will it be made public?

The Hon. D.J. Hopgood: I will ask the Commissioner in the first instance to give us the factual information.

Mr Powell: The report the honourable member refers to is a report prepared by a working party jointly convened by my office and the housing strategy unit, which is part of the Housing Trust. The report was made available publicly about four weeks ago by both the Minister of Housing and Construction and the Minister for the Aged. I am sorry the honourable member does not have a copy but I will certainly take the opportunity to furnish him with one tomorrow.

The Hon. D.C. WOTTON: I would appreciate that. There are obviously a lot of people in the community who did not know it was public.

Mr Powell: We have made it known that the report is available for public distribution for people who want it. I was on radio at some length on the John Fleming program (which as you will know has an extensive listenership of older people) with the Chairperson of that working party, Ms Heather Southcott, and the General Manager of the Housing Trust a few weeks ago. So some publicity about the report has gone out through the media. I have not taken steps to distribute large numbers of copies simply because of the cost of distributing and printing a fairly substantial report.

The Hon. D.C. WOTTON: Is the issue of aged abuse of particular concern in South Australia, what statistics are available to identify the significance or otherwise of this issue, and what action is the Government taking to monitor and address it?

The Hon. D.J. Hopgood: Growing concern has been expressed among professionals and in the media in both South Australia and the other States. I do not know that there is any evidence that suggests that the propensity of this population for elder abuse is any greater than any other equivalent population within Australia. However, an elder protection project jointly sponsored by the Commissioner, the Guardianship Board and the four

metropolitan domiciliary care services is tackling the issue.

The objectives of the project are to secure agreement about the definition of abusive behaviour towards older people, particularly that which might warrant investigation and intervention; to define policy goals for such investigation and intervention; to secure agreement among the key agencies on the division of responsibility; to help these agencies establish procedural guidelines for handling cases of alleged abuse; and to make recommendations on any legislative initiatives if these are seen as appropriate.

A number of agencies will be involved. I have mentioned domiciliary care services, RDNS, the aged care assessment teams, the police, hospitals, mental health services, the Guardianship Board, the Public Advocate, Crisis Care and the Public Trustee. The only other point worth making at this stage, unless the honourable member can think of others, is that in some American States there is mandatory reporting of elder abuse. That is not considered appropriate at this stage although, if any criminal act is involved, naturally one would want that reported immediately to the police.

The Hon. D.C. WOTTON: The matter of transport is of considerable concern to the elderly, and older people have been more severely disadvantaged by recent changes to STA services. When will a transport strategy for older people be developed to address their needs and, in light of the cuts to the STA's services, what measures are in place to protect and extend the Access Cab scheme, which provides a much needed service for disabled older people? I realise that this is more the responsibility of the Minister's colleague the Minister of Transport, but because of the concern that is being expressed and the very real concern by elderly people in this State, I would like to know whether or not specific representations have been made by the Minister to his colleague the Minister of Transport regarding the concern being expressed by older members of the community relating to these and other transport issues.

The Hon. D.J. Hopgood: The honourable member is correct: the service delivery is in the hands of the Minister of Transport; our responsibility is in the area of advocacy. The Commissioner for the Ageing recently approached the STA about this matter and, as a result, the STA has established a consultative forum for both older and disabled public transport users. This forum will advise the authority on the needs and views of this sector of the market and will be an avenue for user representatives to be informed of the authority's changing circumstances and plans. That is a very recent initiative, and we will see what response we get from the STA as a result of that advocacy forum. We currently fund 20 Access Cabs through the HACC project. There may well be the capacity for that number to increase in light of the existing arrangements with HACC.

The Hon. D.C. WOTTON: What are the implications of the use of diagnostic related groups for older people; what measures are being taken to ensure that older people when discharged from hospital are provided with appropriate support in the community; and why is it a Health Commission practice not to designate rehabilitation beds to older people who obviously have a need for slow stream rehabilitation?

The Hon. D.J. Hopgood: Very briefly, DRGs is a classification system for acute inpatients in which patients within a group require compatible resources for their treatment, and the groups are clinically meaningful. As the name implies, diagnosis is one of the variables used in the classification process. Other variables include secondary diagnosis procedures, age and sex. The commission has been using the third version of the Health Care Financing Authority DRG group, which has 471 groups. It has been revised a number of times and the seventh revision is available. The commission is planning to move to the first version of the Australian national DRG system. One can see from this that the DRGs have the potential to provide some really meaningful way of ensuring that the health cake, for example, is sliced effectively according to the real needs and the complexity of the procedures which are being carried out in various areas, and the age would represent a component in working through all of those calculations.

What it means in practice is that the introduction in a comprehensive way of DRGs as a basis for health financing would almost certainly enable us to take more account of the needs of the elderly in this area. As to the relationship between acute care services and domiciliary care services, I have already commented on that. The reviews that have recently taken place in domiciliary care services have been with a view to marrying more closely the acute care services and the needs there with domiciliary care services so that as people are discharged into the community there are services that are appropriate to their needs. That is particularly important so far as the aged are concerned.

The Hon. D.C. WOTTON: Can the Minister say what progress has been made towards establishing an integrated adequately resourced equipment scheme which it is generally agreed is highly desirable for the aged?

The Hon. D.J. Hopgood: I will ask Mr Leahy to comment.

Mr Leahy: In fact, the equipment is part of the South Australian Health Commission's bailiwick. The HACC program provides some funds which supplement the Disabled Persons Equipment Scheme (DPES). HACC provides funds to Domiciliary Care Services for the items not available through DPES, ready made wheelchairs and off-the-shelf type equipment. Essentially what we have out there are a number of schemes which work side by side. We also have a situation where hospitals provide equipment to clients on discharge.

Work is under way at the moment and an equipment working party was set up in November 1991 to examine the current arrangements and to recommend some structural reforms to tidy up that system, which has a number of different components, sometimes not adequately working together. The commission is chairing that working party and we are hoping to get some resolution later this financial year.

The Hon. D.J. Hopgood: Briefly, because I do not want to mislead the Committee in any way, I point out that the preliminary budget allocation and information supporting the 1992 estimates stated that the 1992-93 budget for the South Australian Health Commission Equipment Scheme was $2.861 million. In fact, there was a carry over fund from the previous financial year of $292 000 and it would be more correct to say that the

new moneys amount to $2.568 million as opposed to $2.532 million in the last financial year.

The Hon. D.C. WOTTON: Can the Minister provide information about funding of a slow stream rehabilitation service at Winchester Nursing Home that is creating some interest?

The Hon. D.J. Hopgood: The Commissioner can address that.

Mr Powell: This issue has been the subject of continuing discussion between the Commonwealth and State Governments as to which level of Government should be responsible for slow stream rehabilitation. The matter needs to be seen in the context of the form of Commonwealth/State responsibilities in aged care, which was the subject of an earlier question. I spoke recently with the proprietor of the Winchester Nursing Home, which is the only private nursing home to provide slow stream rehabilitation services in this State. I am informed that the funding system that has been introduced recently by the Commonwealth as an interim measure using respite care moneys to fund rehabilitation places is working more or less effectively. There are still ongoing issues about the long-term future of the service, but certainly I did not get the impression of such a degree of instability in the funding of this service as was the case perhaps two years ago.

The Hon. D.C. WOTTON: I refer again to adoption. I am aware of correspondence that has been occurring between the Adoption Privacy Protection Group and the Minister. I note in one of the pieces of correspondence that this particular group has asked for the legislation to be repealed and if the Government is not prepared to repeal the legislation to instigate a review of the Act as soon as possible. Would the Minister like to comment on that?

The Hon. D.J. Hopgood: I think it is unlikely that the Government would want to respond publicly to that. On the one hand it is difficult to resist the idea that after an Act had been in force for some time there ought to be some review of the way in which it has been operating. On the other hand, I do not think we would want to do that in such a way as would throw up promise of considerable changes. After all, I remind the Committee that the legislation went before a select committee of the Parliament. Therefore, it passed the Parliament with some degree of bipartisan support. If members of Parliament are signalling—and I do not think they are—that it is time to considerably rethink that, well and good.

Of course, it is open to any honourable member to introduce amendments to the Parliament. While I am attracted somewhat to a limited review of the functioning of the legislation, I think at this stage it would be correctly reading the mood of Parliament to suggest that the Parliament is not looking for any large-scale changes or what one might call backsliding in relation to the basic principle of the legislation.

The Hon. D.C. WOTTON: I, and I think some of my colleagues, have received correspondence in recent times regarding the State's burial of Peter Shane Sumner. In this correspondence there are accusations of bureaucratic bungling by the department. I have some concern about this particular issue and I wonder whether the Minister or officers of his department may wish to comment on this matter?

The Hon. D.J. Hopgood: I will ask the Chief Executive Officer to comment briefly.

Ms Vardon: It is a very sad case. The facts of the matter are that a body was released to the next of kin. In this case the next of kin was determined by the Coroner to be the wife. The wife then proceeded to bury the person and approached us for help, which we gave her. We were in a sense controlled by the Coroner; it is the Coroner who makes that decision and that is the legal advice that we have. Other family members had another view about how that should be, and that is unfortunate. We have now asked the Manager of our Aboriginal and Islander Coordinating Unit to try to negotiate some resolution. However, we are not in a position to authorise an exhumation and the placement of the body in another place when the Coroner released the body to the wife. That is how things are.

The Hon. D.C. WOTTON: I refer again to adoptions. Until recently the Department for Family and Community Services was supporting the resolution of placements where it had been proved that children could not return home. That was achieved either by transferring the guardianship of the children to foster parents or by the foster parents adopting the children. Many of the foster parents who could adopt their foster children started fostering them when they were told that they would not be able to adopt. Many of them are on low incomes and depend on foster care subsidy to balance the family budget. There appears to be a moratorium on subsidised adoptions at the moment, which means that children who could legally belong to the family are being denied this right because of a lack of funds. Is this the case?

Mr Szwarcbord: We have just finished drafting a policy and standard procedure in the area of what we are calling 'in need of care adoptions', and we have circulated that for comment within the department and amongst people knowledgeable in the adoption area. It is our interest to encourage adoption where all parties support that—where foster parents have been caring for children for a long time and want to make a total commitment to the child and where the natural parents are prepared to endorse that. Within the new payments system, a basic subsidy will be availabile upon application.

Ms Vardon: There is a problem about adoption when a child has been in foster care. We have had some feedback from young people themselves that, when the foster parents have the child adopted, the child realises that they have now lost legal contact with their siblings and their family in some other place. From time to time they have sought to reverse the adoption so they can legally go back and rejoin the family of origin. Of course, there is no legal provision for such a reversal, so our preferred option in the department is to go for transfer of guardianship so that the legal relationships back to the family of origin are not changed but there is security of guardianship with the foster family. That is the preferred position that we take.

The Hon. D.C. WOTTON: This is the last question that the Minister will be asked in this forum as a Minister, so I am privileged to be able to ask it. I have been made aware recently that elderly people (and I think we all understand) are fearful that, interest rates having fallen, and so on, they may be forced to realise on their

equity. This applies particularly to superannuants and is a very real problem at the present time. It has been put to me that some form of mechanism should be adopted by Government to protect people who find themselves in financial difficulty as a result of this problem. Has any thought been given to the introduction of such a mechanism?

The Hon. D.J. Hopgood: It seems to me that almost certainly if something like that emerged it would be at the Commonwealth level, because it is the Commonwealth that is responsible for what is sometimes called the transfer payments. I think that probably in any event people would look to the Commonwealth, if only because one could have a rag tag and bobtail set of schemes between the various States, which could become quite inequitable. I look to the Commissioner to indicate what theoretical work might have been done on this matter, but I think it is probably one that needs to be looked at within the total context of social welfare provision, which is very much a Commonwealth matter.

Mr Powell: I agree that it is really a matter for the Commonwealth and also, in the area of taxation policy, groups which have suffered declining income as a result of falling interest rates, which the honourable member has mentioned, have proposed a number of tax concessions that would at least relieve them of some of the burden of this declining income. If I may refer specifically to the question of their having to realise assets such as a home, there is indeed a fear amongst a number of older people that at some stage in the future they may be required to enter into some sort of home equity conversion scheme as a means of supplementing their retirement income.

The Commonwealth has moved in the recent Federal budget to introduce a national home equity conversion scheme. We are not yet aware of what consumer protection mechanisms will be put in place in conjunction with such a scheme, but I am aware that the Standing Committee of Consumer Affairs Ministers has been looking into this question, and some work on a set of consumer protection guidelines for such schemes is being undertaken in Western Australia on behalf of those Ministers.

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

I thank the Minister, his staff and the Committee for their cooperation. In particular, as this might (and I emphasise 'might') be the last appearance before the Estimates Committees of the Minister of Family and Community Services, I must say that the Minister, in my experience in the Parliament, has always acted with a dignity that perhaps surpasses that of many others of us who sit on the back bench.

The Hon. D.C. WOTTON: I also add my thanks for the cooperation shown by the Minister and the officers of his department.

The Hon. D.J. Hopgood: Thank you, Mr Chairman, and members for your sentiments. Can I say, in relation to my role in this place for the next 12 months or so, that I would like people to think that perhaps they have not so much lost a Minister as gained a parliamentarian.

ADJOURNMENT

At 10.2 p.m. the Committee adjourned until Thursday 24 September at 11 a.m.