HOUSE OF ASSEMBLY

Friday 17 September 1993

ESTIMATES COMMITTEE A

Chairman:
The Hon. D.J. Hopgood

Members:
Dr M.H. Armitage
Mr M.J. Atkinson
The Hon. B.C. Eastick
Mr V.S. Heron
Mrs C.F. Hutchison
Mrs D.C. Kotz

The Committee met at 9.30 a.m.

South Australian Health Commission, $728 814 000

Witness:
The Hon. M.J. Evans, Minister of Health, Family and Community Services and Minister for the Aged.

Departmental Advisers:
Dr D. Filby, Executive Director, Planning and Executive Services.
Dr D. Blaikie, Chairman, South Australian Health Commission.
Mr P. Davidge, Executive Director, Finance and Information.
Mr J. Blackwell, Executive Director, Country Health Services.
Mr R. Blight, Executive Director, Metropolitan Health Services.
Dr M. Jelly, Chief Medical Officer.
Ms C. Johnson, Executive Director, Disability Services Office.
Dr K. Kirke, Executive Director, Public and Environmental Health.
Ms M. Silver, Director, Nursing.

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

The Hon. M.J. Evans: I have a brief opening statement to set the scene for today's proceedings. In 1993-94, the Health Commission's total payments budget (recurrent and capital) will increase by $78.9 million, or 2.4 per cent in real terms, to $1.429 billion. This increase is particularly pleasing, given the difficult situation and the continuing demand for health services throughout the State. The key components of the increase are worth exploring briefly so that the Committee clearly understands how the budget compares with the actual result for 1992-93. The benefits to the State in 1993-94 from the new Medicare agreement are estimated to be $22 million. The Commonwealth-State disability agreement results in extra funding of $31 million, $26.4 million of which relates to disability services transferred to the State from the Commonwealth. The balance will fund a series of important new initiatives for people with a disability.

The capital works program has been increased by $18.4 million; $34.2 million will be carried forward from the Commission's 1992-93 budget allocation. The Committee should be aware that 70 per cent of this ($24.4 million) relates to known commitments as at 30 June 1993, and the balance of $9.8 million relates to provisions set aside by health units to meet future cost pressures. The net funding agreement in place with Treasury provides for this flexibility and has encouraged improved financial management throughout the health system.

For the benefit of the Committee members, the health budget has been reduced by $25.6 million to take into account of the transfer of the SA St John Ambulance Service to Emergency Services. I should also draw attention to the commission's net draw of $728.8 million, which is significantly lower than the corresponding figure of $788.3 million for 1992-93. The main reason for this reduction is that the increase in the hospital funding grant paid directly to the commission by the Commonwealth under the Medicare agreement has been offset by a reduction of $70 million in the Commonwealth's general purpose funding to the Consolidated Account.

If an adjustment is made for the change in treatment between general and specific purpose funding by the Commonwealth, the commission's net draw from the State budget reduces in real terms by 2 per cent in 1993-94, continuing the trend of real reductions since the introduction of net funding in 1991-92. It is worth noting that, despite these real reductions, admissions to recognised hospitals have increased in 1992-93, as well as one-to-one contacts at metropolitan domiciliary care services and community health centres. The commission was able to meet this increased activity with an average work force 541 FTEs below the previous year.

Allowance has been made in the budget for a rearrangement of priorities, and I am pleased to advise the Committee that increased funding has been provided for additional child protection and domestic violence services, for an additional outreach service of the Second Storey Youth Health Centre and to CAMHS teams in the north, south and inner west. Hospital services will also benefit, with additional funding for increased activity in the northern metropolitan area, booking list initiatives and increased elective surgery procedures in country hospitals. Health units will once again be expected to absorb wage and salary increases and price inflation. Based on productivity initiatives currently occurring and the excellent results achieved by the system in the past two years, I am confident that the health system in 1993-94 will once again meet its budget challenge while still maintaining services.

Proposed expenditure on buildings and major equipment amounts to $67.7 million, which compares more than favourably with expenditures during the late 1980s and early 1990s—an average of $48.8 million. Major projects to be funded include: $15.5 million for the construction of facilities at the Women's and Children's Hospital; $11 million for the construction of the new 86 bed hospital at Gawler; $9.9 million for the purchase of major medical and computing equipment; $5.6 million for upgrading country health facilities; and $3.4 million for hospital and community services for the seriously mentally ill. This completes my introduction. I leave it to the Committee to ask more detailed questions in areas of interest.

Dr ARMITAGE: I refer to page 17 of the blue book in which the 1992-93 total South Australian Health Commission net budget is given as $1 185 603 000. On consulting the blue book from last year, which I do not expect the Minister or his advisers to have with them (nevertheless, the facts are there), the net estimate for the same line last year was $1 193 377 000. I take it that the net estimate for 1992-93 was the money that was available, specifically given that receipts have increased so dramatically during the past year, and I note that the Minister is nodding in agreement. Given that, what has happened to the $8 million difference between the net estimate for 1992-93 and the net budget figure for 1992-93 in this year's blue book? That $8 million is a significant figure. When was Parliament informed about this matter? Given the pre-election context, I am very suspicious.

The Hon. M.J. Evans: This variation is on a budget and not on actuals. If there was a variation of even $1 on actual expenditure recorded, that would clearly be a matter to be very zealously investigated, and I am certain the auditors have done so already. However, we are talking about variations to budgets. By their definition, budgets are to be varied. That is the very purpose of having a budget in the first place. In addition, there are always a number of technical changes to the way the budget and expenditure of the commission or any major authority is constructed during the year.

For example, we have had changes in the way funding to Minda is allocated. The same dollars are being allocated to the service, but the way that is recorded in the budget has changed. That affects that kind of outcome. There have been changes to the way in which we record our motor vehicle fleet and, for example, as I indicated in my opening statement, St John Ambulance has been transferred to the Emergency Services Department, and so on. Naturally, those kinds of processes will always occur during the year as individual reforms or administrative changes take place. They do not reflect the kind of variation of which the honourable member need be suspicious. It can and will be explained in detail on notice, but I draw his attention to the technical variations, which I mentioned in my opening statement and which he will find contribute to it. For example, statement 3 in the blue book outlines those increases and changes in payments during the year.

Dr ARMITAGE: I accept that there are variations and I understand that there are budget differences from year to year, but all the things mentioned by the Minister—Minda, motor cars and so on—are all accommodated within the blue book for this year. The point I am making is that $1.193 billion was available at the end of last year—that is the money that the Minister was prepared to tell Parliament was available to be spent in the health area. What has happened since then is that the receipts have increased—and I intend to explore that later—so there can be no excuse for not getting expected receipts. Thus we have an $8 million shortfall in a net budget estimate in comparison with an expenditure. As I say, in an immediate pre-election period, it makes me very suspicious that there is a hollow log.

The Hon. M.J. Evans: I assure the member for Adelaide that he need not be concerned about hollow logs, and he need not be concerned about hollow logs created in the context of accounting technicalities. These are variations to a budget which out of $1.4 billion must be expected to occur.

Technical changes will be made, budget allocations will be revised and department areas, like the ambulance and Minda, for example, change with respect to the way in which funding is allocated. Those are the kinds of changes which result in the variation that the honourable member has before him. I give him an absolute assurance that it is not based on hollow logs; it is based on technical accounting variations to a very large budget, which we will be pleased to reconcile for him, if not later today then on notice.

Dr ARMITAGE: I very much look forward to the full reconciliation by 8 October, and I would assume that that reconciliation will be valid enough to stand up throughout the ensuing year. I am not questioning the right of the Health Commission or of the Minister to alter programs and move money around within total figures, but I do question the fact that there was a total figure last year, which was $8 million more than was spent over the ensuing year.

I now refer to page 526 of financial paper No. 1, which deals with the hospital funding agreement whereby the Medicare base amount identified for 1993-94 is $422 734 000. As the Minister is well aware, the ratio of public and private bed days is a stipulation of the new Medicare agreement, which the Minister signed, I believe precipitously, 12 months ago. This ratio is causing concern, confusion and anxiety in the health system at the moment.

The problem for the hospitals is that last year, because they were net funded, they were encouraged by the Minister to increase the number of private paying patients. This increase, I have been informed, has led to a skewing of the private to public bed day ratio as expected in the Medicare agreement with potential enormous penalties for South Australia at $405 per occupied bed day during which the ratio is exceeded. One hospital administration has told me that this new Medicare agreement, which the Minister signed, means that commonsense efficiency measures, such as reducing the average length of stay, will result in substantial financial penalties being imposed on the South Australian health system.

The early discharge system, which the commission and the Minister have encouraged, is now of little or no benefit to the hospital, according to the administrator and, indeed, the letter goes on to say, 'We cannot afford it.' Will the Minister confirm the number of private occupied bed days by which South Australia was over the required ratio last financial year as a guide to what may occur this year? Can he explain how this bungle has occurred, and what will he do to correct the confusion? It is rife in the health industry at the moment given that it is now expected to change direction totally from one year to the next because of the new Medicare agreement? Does the Minister agree that this new Medicare agreement provides an incentive and indeed a financial inducement for hospitals to be less efficient?

The Hon. M.J. Evans: While it is true that the Medicare agreement is based on our retaining the same public to private ratio this year that we had in 1991, which is 52.96 per cent public, the fact that that is not varying between 1991 and this current financial year as a target means that there could hardly be wild swings in the public to private ratio. The reality is that the target for this year that the health system as a whole must meet—not hospital-by-hospital, but the health system as a whole—is the same as the ratio in 1991. As the member would know, the number of people insured for private treatment in a public hospital is declining. That is the one area which has declined substantially as distinct from those insured for private treatment in a private hospital. The number of those insured for private treatment in a public hospital is declining, and therefore to meet the same ratio that

we had two years ago I would not have thought required dramatic or wild swings in the ratio of individual hospitals.

For example, in the country private occupied bed days went down 4.1 per cent last year. The reality is that, with very little management of the situation, hospitals should not have enormous difficulty in meeting a target which was the actual percentage only two years ago, in a climate of declining private insurance in public hospitals. In order to ensure that that occurs, the budget contains provisions to allow us, if you like, to buy public-occupied bed days at specific hospitals where that will be necessary, namely, Modbury and Women's and Children's Hospitals, Flinders Medical Centre and country hospitals. We are spending in the order of $1.6 million in the country and, if you will forgive a rough calculation, about $2.5 million in the metropolitan area to buy those occupied bed days to ensure there is no penalty under pool A. This is management of the system. The member for Adelaide finds that amusing, but the reality is that it is good management. I am not surprised that he would find that aspect of our work amusing, but I find it very worthwhile.

I encourage people involved in the health system to be good managers. The reality is that the State secures massive benefits from an overall Medicare agreement, which naturally we do not support in every minute detail—I do not think there is any agreement which the State has reached with the Commonwealth where it would not have sought some variation in a clause of the agreement. The reality is that the Medicare agreement taken as a whole—and it is the whole agreement we get, not parts of it—provides substantial benefits. Individual clauses in it impose constraints which we may have preferred were otherwise. But the Commonwealth, in providing that benefit, seeks to impose its own ideas on the States as well; that is the nature of this kind of relationship. Therefore, within that agreement, we must manage it to secure the best possible outcome.

I think this is the best possible outcome. I also agree with the honourable member that it provides the wrong incentives for our hospitals in general and, as a management incentive, we should seek to base this kind of payment on admissions and, therefore, encourage reduced lengths of stay for people to take part in early discharge schemes. We are negotiating that with the Commonwealth at the moment. I do not anticipate that that aspect of the agreement will last. But the reality is that in this financial year where it is in place, our percentages are not changing from those of two years ago, and individual hospital units should not have enormous difficulty in meeting that kind of target, especially with the specific assistance that is provided to those who may have a problem.

Dr ARMITAGE: I find amusing beyond belief the fact that I am hearing the Minister say that the Health Commission and the Minister are purchasing $4.1 million worth of public-occupied bed days; is that correct?

The Hon. M.J. Evans: No; it is about $3.5 million.

Dr ARMITAGE: Well, $1.6 million plus $2.5 million is $4.1 million, but let us not quibble. The point is that the Minister is purchasing public-occupied bed days; is that correct?

The Hon. M.J. Evans: We are simply giving them extra money; I do not understand the point.

Dr ARMITAGE: That is exactly the point I am making. The Minister is committing extra money to the hospitals to purchase public-occupied bed days when I thought that is what the public hospitals were for.

The Hon. M.J. Evans: We got $22 million extra out of the Commonwealth. In order to get that, we had to spend a bit. That is not unusual; we encourage that all the time. We say to people, 'We'll give you part of the grant if you will fund the rest of it.' That is a perfectly normal arrangement in order to ensure the best possible outcome. Would the member for Adelaide have sacrificed $22 million over an expenditure of $2 million or $3 million? It seems to me a very good return on investment; I wish I could get that.

Dr ARMITAGE: The Minister failed to answer my original question, which was: how many private bed days are we over the ratio? I ask that because scuttlebutt in the industry at the moment is that we are 30 000 bed days over, and that, at a cost of 405 bed days, is another penalty of about $12 million or $13 million. So, it is extremely important that that be clarified for the whole of the system.

Dr Filby: I do not have the actual number of bed days; it is about 28 000. If we had done nothing else, those 28 000 bed days would have been required for payment of a penalty under the agreement. In our estimates to the Commonwealth in relation to the funding agreement, we indicated to it that we anticipate not having to pay a penalty because we expect to pick up those 28 000 occupied bed days, and it is the expenditure of the sums that the Minister indicated that will allow us to pick up those bed days.

Dr ARMITAGE: So, by spending that we are avoiding a potential penalty of about $12 million?

Dr Filby: Yes.

Dr ARMITAGE: A stupid agreement, as I see it. I refer to the blue book, statement 5, page 5: I wish to draw the attention of the Committee to the line relating to the metropolitan non-teaching hospitals and in particular Noarlunga hospital. I have received a copy of a letter written by the Chief Executive Officer of the Noarlunga Health Service to Dr David Close, who is an ear, nose and throat surgeon operating at Noarlunga, and the letter indicates:

> Following a detailed budget review, the executive of Noarlunga Health Services has determined that we can only sustain five ENT lists per four week cycle for 46 weeks of the year. The limit of three public patients per list will be strictly applied, as will the requirement that these patients be resident in the Noarlunga Health Service catchment area.

The letter goes on:

> Nor can we accept bookings for cases which will take afternoon lists beyond 5 p.m.

And further:

> Cancelled and unused lists are still not to be given to any other surgeon.

Dr Close informs me that this is obviously a totally inadequate service for an area which has a large number of children who are waiting excessively long for middle ear fluid to be drained and, in the meantime, whilst they are waiting, suffering all of the ill-effects of prolonged hearing loss. Dr Close in his letter to me says:

> I cannot offer patients a position on my waiting list for Medicare surgery at Noarlunga hospital as this would imply (a) that the surgery will eventually be done, and (b) that I take some responsibility for the treatment eventually being available.

Given these statements, my question, related to the Ear, Nose and Throat Department surgery there, is: why have the ENT lists at Noarlunga hospital been curtailed? Why is a limit of only three public patients per list being applied? Why can bookings for cases which would take lists beyond 5 p.m. not be accepted? Why are unused or cancelled lists unable to be

utilised by any other surgeon who is willing to do so in order to provide services to the children who need them?

The Hon. M.J. Evans: ENT is certainly one of those areas that deserves extra attention in this State, and that is across the board, not just at Noarlunga. It is a particular problem area in a speciality, and I am sure Committee members would be aware of that. That particular area certainly needs additional attention and we are providing that, in part through the hospital access program—the booking list money which was obtained earlier this year—and a substantial number of additional ENT procedures in the south will be done through the Flinders Medical Centre, including a list on Saturday mornings.

In general, the Noarlunga Health Service has certainly experienced some very rapid and significant growth in recent times both in its work demand and in the funding and beds which are allocated to it. For example, same day surgical procedures have increased by 44 per cent to 170 a month, which accounts for approximately 40 per cent of all surgery admissions. Emergency and primary care attendances increased by 900 to 26 000 last year, and total admissions (inpatient and same day) increased by 92 per cent to over 5 000 in 1992-93 compared with 1991-92. Average daily occupied beds have risen from 23 in 1991-92 to 35 in 1992-93.

So, I understand what the honourable member is saying in relation to ENT. I accept that ENT is an area which needs additional allocations. That is being provided through the hospital access funding at Noarlunga but Flinders patients are being dealt with there. The Noarlunga hospital, of course, must make its own decisions about the way in which it allocates its funding and resources. Noarlunga has a substantial budget. It has a board of management and that board must make allocations within its overall determination.

Dr ARMITAGE: The Minister indicates all those glowing figures—I accept they are good—but the Minister must recall that it is the first 12 months that the hospital has been open, which is why they look so good. The Minister talks about the potential need for increased allocation, but is he prepared to do that because, in his media release of 31 August, he talks about increased money being given to Noarlunga Hospital but that money, as I saw the Chairman indicate to the Minister, is to be spent on patients waiting at Flinders Medical Centre and has absolutely nothing to do with patients who are waiting at Noarlunga? It is merely that the operations will be done at Noarlunga. All of that will not solve the problem at all.

The Hon. M.J. Evans: But it is the same catchment area—Flinders and Noarlunga have the same catchment area. I have indicated that I accept that ENT is an area of special concern and we are considering funding a Chair in ENT to encourage leadership in that area. Certainly, it is one that needs additional leadership and additional allocations. That is part of the hospital access program, the booking list funding, which is now being spent throughout the State. Certainly ENT is a major part of that. It needs to be and it is. I cannot say much beyond that, except that the figures are from a low base at Noarlunga but the reality is that they represent real increases in patient services and, while it is certainly the case that they start from a relatively low figure and therefore the percentage increases are high, the reality is that absolutely they represent services to patients. They represent dollars of budget allocations and they represent surgical procedures on the day.

I accept that the percentages look good from that point of view; I did not paint them in any special way. We all know that Noarlunga is a relatively new hospital area. The reality is that they are real patients, they are real dollars and real surgical procedures.

Mr ATKINSON: At page 491 of the Program Estimates reference is made to booking list policy. What has the Government done to improve the management of metropolitan public hospital booking lists?

The Hon. M.J. Evans: The State Government is putting in place a policy which will lead to long term and widespread reform of the management lists of South Australia's public hospitals. I made a significant announcement about that some weeks ago. That report has been prepared over a significant period and has the support of the AMA, the Royal Australian College of Surgeons, the Royal Australasian College of General Practitioners and key public hospital staff, including CEOs and medical administrators.

These groups are represented on the South Australian Health Commission working party set up in July last year to look at developing a policy on booking list management. It followed the release of the Hunter report in July last year which recommended ways to decrease the time people wait for elective surgery. The policy is aimed at ensuring booking lists are managed so that waiting times for patients are as short as possible. The report notes that waiting times for elective surgery are necessary if the public hospital system is to achieve maximum efficiency in patient treatment.

The policy also sets out ways to improve the whole process of putting a patient on a booking list at a public hospital with the aim of making the process more efficient with less trauma for patients and shorter waiting times for everyone. The policy recommends a system of medical review for patients who wait excessive periods for treatment for their particular condition or who wait more than 12 months. The needs of the patient must be considered by the key players in the public hospital system as they carry out their day-to-day management of elective surgery patients.

The working party has come up with sensible and realistic measures to improve every step of the process that a patient will go through in order to have elective surgery. I am pleased with the cooperation the commission has received from all groups represented on the working party and with its recommendations. It is the first time key players in the public hospital system have come together to develop practical measures to improve waiting times for elective surgery patients.

The new policy has the long-term aim of improving the experience of patients by reducing cancellations and reducing average waiting times, increasing the involvement of patients to ensure they provide the appropriate information about their medical condition to their doctor and ensuring that, if surgery has been cancelled, it is rescheduled at the time of cancellation for the next available booking. The policy provides patients, hospitals, doctors and medical administration staff with measures they can put into place immediately. At every step along the process this policy will help patients and health professionals make more informed decisions about their treatment.

The Health Commission will regularly provide GPs with average waiting times for the most common procedures so that, if possible, patients can be referred to the hospital with the shortest waiting time. Patients will be encouraged to keep in contact with their GPs and specialists if their condition worsens, and hospitals will be encouraged to put in place better coordination between doctors, administrators, booking list coordinators and heads of units. The official starting date

is 1 January 1994 but some hospitals are already putting into place many of the measures which I have detailed in that policy.

Mr ATKINSON: Page 499 of the Program Estimates indicates that the mammography screening program is to be expanded. How many women are expected to be screened for breast cancer this year and how much will the Government set aside for this purpose?

The Hon. M.J. Evans: Breast cancer is the leading cause of death from cancer in women. In 1992, 743 cases of invasive cancer were reported with 207 deaths in the same year. The number of cases of breast cancer diagnosed in 50 to 59 year olds between 1989 and 1992 was 36 per cent higher than expected, and that is due to earlier detection by mammography. It is our goal to screen more than 50 000 women this financial year.

Because of earlier detection many of these cancers are fortunately treatable and a fall in mortality from breast cancer is anticipated within a few years. The SA breast X-ray service is part of the national program for the early detection of breast cancer and is cost-shared on a 50-50 basis: the Commonwealth contribution in 1993-94 is expected to be $2.4 million and consequently the contribution from the State Government will also be $2.4 million. The service targets women aged 50 to 69 years, and those aged 40 to 49 years, with a strong family history of breast cancer.

Its objectives are to provide knowledge and awareness among health professionals and women regarding the potential of screening mammography to reduce deaths from breast cancer and to encourage appropriate referral. High participation rates amongst the target age group are critical to the success of the program and considerable efforts go into recruiting. There is currently one fulltime mobile screening unit covering the outer State rural area; that is, Port Lincoln, Mount Gambier and Whyalla. A second screening unit is planned for this financial year to cover the Yorke and Fleurieu Peninsulas and the outer metropolitan area, and there are several fixed clinics including a fulltime unit in Rundle Mall, which opened in October last year. The number of screenings over the last few years would be of interest to members. They are as follows: in the year 1988-89 there were 2 135 screenings; in 1989-90 there were 7 873 screenings; in 1990-91 there were 7 973; in 1991-92 that figure jumped to 22 800; in 1992-93 the figure had again risen to 37 800; and for this year, 1993-94, our target is 50 000 screenings.

Dr Armitage interjecting:

The CHAIRMAN: Order!

Mr ATKINSON: Statement 6 in the blue book refers to expenditure on the South Australian Dental Service. How much does the Government spend on this service, in particular the Pensioner Denture Scheme, and how many pensioners receive subsidised dentures?

The Hon. M.J. Evans: The total budget for the South Australian Dental Service (SADS) this financial year is $27.6 million. The component of the Pensioner Denture Scheme is $1.6 million dollars. Every year nearly 5 000 pensioners receive dentures through the scheme. In fact, since 1981 the Government has spent more than $22 million on providing subsidised dentures through the scheme, helping more than 70 000 adults. A recent change, an increase of 1.9 per cent, to the patient contribution fee for dentures provided by dentists means pensioners will now get cheaper dentures if they are provided by a clinical dental technician.

Pensioners will now pay at least $20 less towards the cost of a full set of dentures if they are provided by a clinical dental technician. Fees paid to clinical dental technicians by the SA Dental Service are lower than those paid to dentists, so the patient contribution has been reduced accordingly.

After reviewing the fee structure for the next 12 months, it was considered that pensioners should benefit from the lower fees paid to those technicians. Each person receiving dentures through the scheme pays a contribution of up to $110 towards the cost of a full set of dentures, which can be up to $587 if provided by a dentist or $458 if they are provided by a clinical dental technician.

Mrs KOTZ: Page 17 of the blue book refers to an estimated payment figure of $1.351 billion. Are there any additional specifically funded items that have to be passed on by Treasury that will increase the payments in the budget or is that figure the absolute limit provided?

The Hon. M.J. Evans: As far as I can understand, that is the amount we expect. Additional Commonwealth grants, involving palliative care, dental grants, and so on, will be received by the commission during the year, and they have not been received yet. However, I am not quite sure what the honourable member is getting at in terms of her reference to Treasury. We expect that to be the payment figure, but there are extra amounts for special purpose Commonwealth payments.

Mrs KOTZ: I am interested in not so much the receipts as the payments and whether there have been additional specified funded payments.

The Hon. M.J. Evans: We are net funded, so if we get a receipt that becomes a payment. If we receive palliative care funding, we will pay that out. The honourable member would not want us to retain that, I am sure, given the previous discussion.

Mrs KOTZ: Of course, especially when we can find $34 million at some stage or other. Is the Minister saying that the estimated figure of $1.351 billion is the absolute limit?

The Hon. M.J. Evans: No; that is the figure we expect, but I suggest to the honourable member that there is additional Commonwealth funding—the Commonwealth/State disability agreement, the dental agreement and palliative care funding—which we expect to receive but which we have not yet received, and the exact amount of which depends on the Commonwealth. So, when we receive that during the year I would expect that to be added. Apart from that, that is our expectation; that is our budgeted figure, but I am cautioning the honourable member that we are expecting to receive additional Commonwealth funding.

Mrs KOTZ: Has the Minister covered some of the areas of expectation? Can the Minister provide details of the additional specifically funded items and the amounts of funding they are liable to attract? If that cannot be given to the Committee now, I am quite happy to have that taken on notice. Further, when are those funds likely to be allocated?

The Hon. M.J. Evans: I have covered the topics; the honourable member is quite right. Because we really do not know the exact amount we will receive from the Commonwealth, of course, we cannot incorporate that figure precisely. For example, I am advised that our current estimate for dentistry is about $1.8 million, but there are a number of other areas, and if the honourable member wishes I will supply a list of our best assumptions for those figures.

However, I would want it understood that they are assumptions at this stage, because that is a matter for the Commonwealth to determine. But, apart from those areas, the $1.3 billion is our best estimate as part of the budget.

Mrs KOTZ: Referring again to the blue book under the same page, this time under the heading of 'Support services, executive, professional and technical', there is an amount of $3 096 000 under funds to be allocated. Why is there a negative balance under the net budget figure and a positive balance under the net variance figure? Why does that figure I have just noted of $3 096 000 variance not appear at all in the budget papers for the year 1992-93?

The Hon. M.J. Evans: I understand that most of the reasons for that are technical accounting ones and do not represent a change of policy, but we will obtain an explanation of that $3 million for the honourable member.

Mrs KOTZ: Does the Minister believe that the present Medicare system needs to be changed in any way?

The Hon. M.J. Evans: I would have to say that that does not bear directly on my relationship with this Parliament in the context of this budget, because the Medicare scheme is one of the Commonwealth, but I have already indicated that of course there are areas in any given Commonwealth agreement that I am sure could be made more advantageous to the States. One can always find ways of securing a better deal for oneself out of any agreement negotiated. But agreements are negotiated by at least two parties, and usually all the parties expect to receive some understanding of their viewpoints in these agreements.

One must be prepared to negotiate about these matters. I have already touched on one aspect of that agreement, which is in relation to the public/private split, where I think that another arrangement could be struck that would be more effective and efficient, but one must take agreements as an overall understanding. The overall benefits of that scheme were way in excess of the disadvantages and, therefore, the deal is worth accepting. I doubt whether there will ever be a contract, agreement or understanding negotiated where one party receives all the benefit.

Mrs KOTZ: As a supplementary, I appreciate the Minister's taking the time to answer that question and I am pleased to see that he recognises that there are areas of change—which, of course, does not conflict with his Chairman's comments in a recent address where, apparently, the Chairman of the Health Commission also agreed that there are areas in which the Medicare system needs to be changed in some form. Could the Minister elaborate on some of the areas that he sees as necessary for change?

The Hon. M.J. Evans: I have already given one very specific and substantial example of where I would seek to secure change. However, I would again advise that, wherever one strikes agreements with the Commonwealth in whichever area it may be, it would be an unreal expectation to think that you will negotiate an agreement with anyone that is all our way; that simply does not occur. The other party to agreements is making substantial payments to the State and expects some consideration of its viewpoint in the matter. So of course, over time, we will seek to negotiate and evolve all agreements, including the Medicare agreement; it is one of many and it contains many aspects. We will always look for ways to improve that service.

I do not defend any public service, and I am sure no private service would defend itself, as being perfect. Such is not possible in this world. When you negotiate such understandings, you look for ways to improve them from your perspective, and we do that. I have given one example. When the next and ongoing rounds of negotiations of these things occur, I am sure that all the States will put forward ideas. I should like to see the agreement focus further on ensuring efficiencies and the best practice direction taken for the Medicare agreement so that all of our health units experience even more incentives to adopt best practices and the most efficient use of dollars. Whether one strikes an agreement on one basis or another, there will always be opportunities to improve it, and I would always strive to do that. I think that is the objective of management in this context.

Mrs HUTCHISON: My first question relates to capital works funding for rural areas, statement 8 in the blue book. How much money will be spent in rural South Australia this financial year on capital works, and could the Minister outline what works will be undertaken during this financial year?

The Hon. M.J. Evans: I know of the honourable member's interest in country South Australia, and in particular the hospital system and the need for additional capital works. Indeed, the honourable member has accompanied me on visits to Port Augusta and other hospitals in that area. The 1993-94 health budget includes a $5 million boost for the upgrading of country hospitals and health units. This forms part of the total budget of $67.7 million on capital works for building and major equipment all over the State. Capital works in the country include the following projects: a new Gawler hospital, in which I know the member for Light shares my interest and enthusiasm, of $11 million; replacement aircraft for the Royal Flying Doctor Service of $1.4 million; and upgrading of country hospitals generally, $5.1 million.

Some of the specific details are: Port Pirie Hospital, specialist obstetric theatre equipment, $51 000; Crystal Brook Hospital, upgrading of patients' toilets, $60 000; Millicent Hospital, purchase of medical and catering equipment, $46 800; Port Broughton Hospital, upgrading of patient bathroom and an X-ray machine, $20 000; Bordertown Hospital, replacement of a ventilator unit, $8 000; Penola Hospital, kitchen equipment upgrade, $210 000; Karoonda and District Hospital, cleaning equipment, $8 700; Cleve Hospital, completion of upgrade, $150 000; Tumby Bay Hospital, kitchen upgrade, $50 000. I was recently in some of the Eyre Peninsula hospitals and the staff and patients were very pleased with some of those purchases. Kangaroo Island Hospital, replacement of equipment, $100 000.

In addition, there are major works at Port Lincoln Hospital, which will receive $1.4 million for its continuing development. Port Augusta Hospital will receive a total of $2.276 million, which is broken down as community health centre, $796 000; fire upgrade, $480 000; and hospital redevelopment, $1 million. The Southern Yorke Peninsula Health Service will receive $829 000 for capital works at the Minlaton Hospital. The Clare Nursing Home will receive $450 000 for capital works. The Quorn Hospital will receive $23 000 for the upgrading of patient accommodation. The Woomera Hospital will receive $100 000 for the upgrading of patient accommodation and facilities. The Southern Yorke Peninsula Nursing Home at Minlaton is receiving a $632 000 contribution towards the total cost of $2.1 million, with the Commonwealth providing $1.225 million and the State providing in 1993-94 $0.632 million and in 1994-95 $0.247 million. The Lower North Nursing Home at Clare will receive a $450 000 contribution towards the total cost of $1.3 million. The Booleroo Centre Hospital will receive $200 000 towards stage 1 of the redevelopment program. The Kapunda Hospital will receive $195 000 towards the upgrading of long-stay patient accommodation. General funding for country areas includes $400 000 for the replace-

ment of 10 mobile X-ray machines and $80 000 for the purchase of 12 CO_2 monitors.

Mrs HUTCHISON: My second question relates to page 499 of the Program Estimates and the national cervix cancer screening program. When did South Australia agree to take part in the national cervix cancer screening program and, if so, what resources will be directed towards this very important initiative this year? I am aware that country health has benefited from some of that money in the past.

The Hon. M.J. Evans: In 1992 South Australia agreed to participate in a national cervix cancer screening program aimed at reducing the incidence of invasive cancer of the cervix. The program encourages women aged between 18 and 70 years to screen regularly and it will specifically target Aboriginal women, women living in rural and remote areas, women from non-English-speaking backgrounds and older women who are currently under-screened. It will involve specific recruitment strategies aimed at increasing the level of regular screening, promote reminder and recall systems, put in place mechanisms to improve the reliability of pap smears and promote guidelines on the treatment of abnormalities. The program is based on existing service providers: general practitioners, community health services and laboratories. Commonwealth and State funds of $1.7 million have been made available for this program, which is currently funded until June 1995.

An important element of the program is the establishment of a back-up record system which will consist of screening information provided by pathology laboratories. It will be used as a back-up to the individual laboratories for case management and assist with quality assurance. The system is currently being established and, when fully operational, it will also be able to be used as a back-up system to remind women to screen regularly. It will also provide data for monitoring and evaluation of the program.

A State Program Advisory Committee, with wide representation from professional groups, women's organisations and laboratories, has been established to provide expert advice for establishing and monitoring the program. A coordination unit for the program is operating as a branch of the Public and Environmental Health Service and is located in spare accommodation at the Queen Victoria Hospital. Regional country community awareness and education programs are planned for all regions of country South Australia as a way of reinforcing national education strategies with support being provided by the Country Women's Health Services. Local regional plans will be developed and implemented with central support provided by the South Australian Cervix Screening Program Coordination Unit.

Mrs HUTCHISON: I applaud the monitoring and reminder notices, because that was one of the problems of the past, but is that being done from a central point?

The Hon. M.J. Evans: Yes; from the Queen Victoria Hospital program coordination unit that I mentioned.

Mrs HUTCHISON: My final question relates to the breast cancer screening program and the mammography program, which I applaud, which is doing great work in country areas. I believe that a computer system has been developed specifically for the breast X-ray service. Can the Minister give any details of that, and what is its potential for use elsewhere?

The Hon. M.J. Evans: In fact, two computer systems, designed and developed in South Australia from within the Health Commission, are setting the standard across the country. They have been sold in a number of other States and are putting dollars back into our public sector. The systems have earned more than $415 000 in licensing fees through sales to other States and the Commonwealth. Officers from the Health Commission are now investigating potential sales of the systems to Asia. We should all be proud that computer-based systems being used all over the country were developed here by our public sector. The State Government realises that we must build a competitive edge in this State if we are to be a player in the world market, and achievements like this one show that we are leading the way in that area. The Premier's Meeting the Challenge statement in March outlined just how crucial that edge will be to the future of the State's economy.

The two systems used in the SA Breast Cancer Screening Unit and community health centres have been developed to ensure high levels of security, with operator access to client information being highly restricted. There is no access to non-staff, and staff have restricted access to information. In the breast cancer system, an in-built system keeps track of clients to ensure that any abnormality is followed up or that they return for a screening when due. Follow-ups in this type of screening are vital. This program has been sold to the Commonwealth, Victoria, Queensland, Tasmania and the ACT. The community health centres system, already used in 40 health organisations in South Australia, has been sold to Queensland, Tasmania and the ACT. It provides health care workers with automatic reminder messages about immunisation, cervical cancer or blood pressure checks, due either when a client arrives or in advance in the form of reminder letters.

The Hon. B.C. EASTICK: One of the unfortunate aspects of present-day life is the fairly massive increase in and difficulties associated with drugs and alcohol, yet I notice from the information that is available that the Drug and Alcohol Services Council is not going to provide a service for greater than the number which was provided for in 1991-92 of 22 000 and 21 000 in 1992-93.

Page 497 of the program performance shows the consolidation of DASC substance abuse services. Are the plans to move all the services of the Drug and Alcohol Service Council to the Hutt Street Hospital, when and if the hospital facilities in Hutt Street run by SGIC Hospitals move to the Queen Victoria Hospital site, at a peppercorn rental, about which the Minister has previously advised the House?

The Hon. M.J. Evans: No decision has yet been taken on relocation to Hutt Street, so that decision has not been made at this time. It is under consideration, but certainly no final decision has been made about that. I think it is important to note that DASC has at present three properties, and I recently visited all of those: Elura Clinic at North Adelaide, the Alcohol Unit at Joslin, and Warinilla at Norwood, which serve the organisations major clinical functions. The total capital value of all those properties is about $3.6 million. DASC also leases a site at Parkside, which accommodates research, valuation information, library, telephone counselling and administrative functions. Those properties are certainly quite a valuable asset for the community, and we need to ensure that we are getting the best value for money for that total asset and that they are managed in the best possible way. Certainly, if we are able to rationalise those properties, as is the ultimate intention, we will be able to obtain better utilisation of staff resources with related savings, more flexibility in covering variable client numbers, and the provision of services which are more appropriate to the particular client profile. We have had quite a good look

at a number of properties throughout the relevant central metropolitan area, and a number are being considered.

The Hon. B.C. EASTICK: As a supplementary question: is the Minister able to identify what amounts of expenditure of a capital nature have been allocated to Drug and Alcohol Service Council premises over the past five years?

The Hon. M.J. Evans: I will take that question on notice.

The Hon. B.C. EASTICK: In relation to the blue book at page 22 in regard to the expenditure at Port Lincoln Hospital that the Minister has previously mentioned, it has come to my attention that the waiting list for orthopaedic surgery at Port Lincoln hospital now extends to May or June 1994, despite the availability of at least one visiting orthopaedic surgeon to do extra operations at Port Lincoln. The medical superintendent of Port Lincoln Hospital recently indicated to visiting surgeons that there was a possibility of doing extra operating because of extra funding potentially being available—statements the Minister had made publicly. It appears however that nothing has happened with this extra funding, and the *status quo* maintains. Was an offer of extra funding made for waiting list patients at Port Lincoln Hospital in particular and in the country regions in general, and how many operations were expected to be performed with the extra funding which was publicly nominated?

The Hon. M.J. Evans: Port Lincoln was part of the hospital access program—the booking list money to which the honourable member refers—and that detail is available. I will get that for the honourable member, but they were part of that program. When I was there recently I saw under way the first part of the substantial capital program which is being undertaken for Port Lincoln Hospital, and substantial funds are being committed to that unit to ensure that it has the best possible facilities in the context of the hospital. In terms of the detailed management of the way they break up their funds and the services they provide on the ground in that hospital, that is also a matter for the hospital board, but I will seek to obtain some information in relation to the specific matters that the honourable member has raised.

The Hon. B.C. EASTICK: The Minister may be able to indicate what is the current status of the offer for extra funding which was made, not only to Port Lincoln but also across the board, and indeed whether the program is on target to obtain benefits to the waiting public.

The Hon. M.J. Evans: I understand that that hospital access program booking list money has been allocated to the country hospitals, so I will obtain details of that but, in terms of the status of the offer, I understand it has been allocated.

The Hon. B.C. EASTICK: My question is one of a very general nature and relates to page 485 under the resources summary. How much in percentage terms of the 1993-94 budget allocation has been spent at the end of July and, if it is not too early, at the end of August? In other words, are we over, under or on budget?

The Hon. M.J. Evans: I am sure the honourable member would be aware that the commission publishes the gold book at the end of every month. It is published as soon as the information is practically available and it is a very good and comprehensive record of the Health Commission's expenditure. Naturally, the more comprehensive you make the explanations and the more detail you provide to your readers, the longer it takes to put that information together. Anyone who has looked at the Health Commission's monthly accountability statement in the form of that so-called gold book would agree that it is a most comprehensive document and it would provide all the information—and far more, I would suspect—that the honourable member is seeking. However, we will seek to get the latest figures for the honourable member, which I am sure we will be able to provide in broad terms today. Generally I do not think there is any cause for concern about our being over budget; in fact, quite the reverse. One has to look at a budget over the total period of a year; it is very difficult to make judgments on the basis of month by month cash flows, which can quite properly vary enormously during the year for normal and explainable reasons over above a 12 month average.

The Hon. B.C. EASTICK: Would the Minister be happy if it was under budget rather than on budget?

The Hon. M.J. Evans: For example, if I was running a retail store I would look to see my Christmas cash flow much higher than my midwinter cash flow. Over the year the predictions would be on target, but if you took a given month, for example, December or June, you would find very substantial variations in the cash flow. One has to judge a budget on a 12 month period, not by a month by month allocation. In any given month we may be down, knowing that in other months we will be up, and that is why detailed cash flow statements are prepared. If you found, for example, that there was a percentage down or up in the July figures, it would be difficult to draw a parallel for that for the whole year. It would be a very difficult exercise indeed. Look at the cash flow for Gawler hospital, for example; look at the cash flow in local government. The honourable member is Mayor of Gawler. He would know that the receipts of the council over the next couple of months will rise quite dramatically. I would suggest to him that they are not the receipts the council expects to receive for the rest of the year.

Mr HERON: My first question refers to page 497 of the Program Estimates. What is the level of cooperation between agencies helping victims of domestic violence in the western suburbs, and what strategies are in place to address those problems?

The Hon. M.J. Evans: I am pleased to report that there is a very high degree of cooperation across a wide range of human service agencies in Government and non-government sectors concerning domestic violence. These include community health centres, Queen Elizabeth Hospital, women's shelters, migrant women's support groups, cultural associations, Police Department, Child and Adolescent Mental Health Services (CAMHS), Port Adelaide Mission, FACS, schools, churches and community groups.

Strategies to address domestic violence issues in the western area include the Western Region Domestic Violence Action Group. This group comprises representatives from a wide range of Government and non-government human service agencies and the community. The group coordinates domestic violence services in the west, and currently has two working groups looking at education in schools and in media strategies.

The Parks Community Health Service hosts a community support group, called WOWSAFE (Women of the west for safe families), which received $10 000 funding from the Attorney-General's 'Together against Crime' fund. The group has developed a training video through the SA Film Corporation and has established a 'Safe House' project and 'Buddy' system for support in court hearings. In response to the Government's extra funding to metropolitan based domestic services of $200 000 in 1993-94, the Western Region Community Health Services, CAMHS and Dale Street Women's Community Health Centre are developing a

submission for a domestic violence team program for domestic violence in the western region.

Mr HERON: I refer to page 14 of the blue book. With the major redevelopment of the Alfreda Rehabilitation Service, which was opened last week, what opportunities are there to make better use of the facilities outside normal operating hours?

The Hon. M.J. Evans: Alfreda Rehabilitation now has an excellent facility to offer people who require both occupational treatment and vocational return to work rehabilitation. I was very pleased to be part of the opening ceremony the other day, which was attended by a wide range of community figures. I think they were all very justly proud of the service. A 25 metre heated hydrotherapy pool and a new gymnasium with a wide range of exercise and testing equipment are used extensively to assist clients in their rehabilitation. Both of these facilities are not used for rehabilitation purposes outside of Alfreda's normal opening hours.

Staff of Alfreda prepared a submission to the board of QEH to commercialise these two operations either by operating the facilities themselves or asking a private operator to be involved. I understand that a swimming program is now in operation from 4.30 p.m. to 9 p.m. each night of the week and on weekends. The afterhours use of the gymnasium is in the advanced planning stages. Neither of these operations conflict with the ability of Alfreda to offer rehabilitation to its clients.

Mr HERON: With further reference to page 14, what are the funding arrangements for the Port Adelaide Community Health Centre, and what services does it provide for people in that area?

The Hon. M.J. Evans: The Port Adelaide Community Health Centre's net budget for 1993-94 is $761 000. The centre provides a wide range of services to the community in Port Adelaide and the surrounding areas, including medical staff, a community health nurse, a clinic STD nurse and a midwife clinic nurse. Several group programs are provided, including antenatal and postnatal groups. An antenatal share care program has also been established with the Queen Elizabeth Hospital. That service also provides podiatry, physiotherapy, nutrition, speech pathology, counselling services and occupational health programs. Collocated services include the SA Dental Service, the Drug and Alcohol Services Council, family planning and Family Court counselling. In addition, the centre is involved in a range of community development activities, including arthritis self-help management courses, volunteer programs and national mental health strategies. The centre also hosts the Western Domestic Violence Action Group.

Dr ARMITAGE: I refer to page 180 of the Estimates of Payments and Receipts. The estimate of the appropriation from the State Consolidated Account for 1993-94 is $728 814 000, as opposed to an actual appropriation last year of $788 267 000. This is a decrease of State appropriations of $59 453 000, which is a 7.5 per cent reduction in the State Government's contribution. I understand that the total health budget is up because of contributions from the Commonwealth Government. Did the Minister argue for this specific State Government contribution to the health services of South Australia which, as I pointed out before, is a 7.5 per cent reduction?

The Hon. M.J. Evans: That is an absurd analysis of the figures. I think that was explained in general terms in my opening statement. The honourable member must recall the variations which have occurred to the way in which Commonwealth payments are made to the State through Treasury and the way in which the financial assistance grants from the Commonwealth were dealt with by the Premiers conference and the Loan Council meetings. Those matters were covered in my opening statement. When you take the net effect of all those changes, certainly you can factor out most of the variations to which the honourable member has referred.

I accept that there is a slight real reduction in the net State draw from Treasury, but additional substantial Commonwealth funding has taken the total budget to the position which we have now, which is a 2.4 per cent increase. Given the nature of Federal-State relationships and the changing method of payments to the Health Commission, either directly or through financial assistance grants and the offsetting payments that are made to balance out those two areas, there will be significant variations, which the honourable member has correctly identified, in the accounting provisions. One must look to the total budget, and I refer to the figures I went through in my opening statement.

While you can concoct a scenario in which there is a figure such as that which the honourable member has mentioned, you need to look at the total budget to see the effect of that, and you need to offset the technical accounting variations that have brought that about, which I detailed in my opening statement. I can assure him that I argued, as did every other Minister, for the highest possible allocation. The net outcome, I understood at least, and I thought the honourable member did from earlier discussions, naturally includes some variations due to the change in Commonwealth-State accounting calculations.

Dr ARMITAGE: As a supplementary question, the Commonwealth receipts are specifically detailed on pages 180 and 181. It is not hard to sit down with a calculator and work them out. As I say, this appropriation from the Consolidated Account is down 7.5 per cent, despite the fact that if you look back through the same figures, in the year 1989-90, the appropriation from the Consolidated Account was 9.9 per cent greater than the previous year, in 1990-91 the State Government appropriation was 8.4 per cent greater than the previous year, in 1991-92 the State Government contribution was 2.2 per cent greater than the previous year, and in 1992-93 the amount was 1.8 per cent greater than the previous year. Whilst I accept that those Consolidated Account contributions are decreasing in percentage terms, they are still increases. This is the first time in five years, under this Minister's stewardship, that the State Government appropriation has gone down.

The Hon. M.J. Evans: The honourable member is not taking into account real increases as distinct from actual dollar amounts. He is organising his percentages in a way that seeks to make a particular point but which does not examine the total impact on the system. It does not matter to the hospitals or the patients whether the Commonwealth pays the money direct to the Health Commission or whether it pays a certain amount to Treasury and has it through financial assistance grants to the States, or whether it makes direct payments to the Health Commission. It does not matter whether the St John Ambulance Service budget is paid through the Health Commission or whether it is paid through emergency services. None of those factors are relevant at the end of the day in the hospital.

One has to look at the total balance of the budget, the total amount of money that has been paid. The technical accounting variations are a matter for interesting debate among bean

counters and those who make their living from such things, but they are not important to the patient in the hospital bed. The reality is that it is the total dollars being spent that is important. I draw attention to the inescapable fact that, no matter how you calculate the figures, no matter where the money comes from, there has been, since 1985-86, a 14.8 per cent budget increase in real terms, after allowing for inflation. That is the total. If you want to look at a decent statistical period, you will find a 14.8 per cent increase in real terms.

There is certainly a variation in the State's net draw and there is certainly a variation in the way the Commonwealth has paid that funding, but I think we need to look at the total figure, the actual increase. I can go through those chapter and verse, but the reality is that they are there, they are stark and they are quite real.

Dr ARMITAGE: I take some degree of exception to the Minister's indicating that I have been concocting these figures.

The Hon. M.J. Evans: No, I did not.

Dr ARMITAGE: You did, indeed.

The Hon. M.J. Evans: No, I did not.

The CHAIRMAN: Order!

Dr ARMITAGE: The Minister did say 'concocting figures' because I made a note of the words. I take exception to his assertion that I am making figures to suit myself, because the figures I quoted come direct from previous blue books issued by the Government. They are not my figures—they are Government figures. So, I take strong exception to the implication that I am concocting figures when all I am doing is reading from what I, as a member of her majesty's loyal Opposition, am given by the Government.

The Hon. M.J. Evans: I do not recall saying the word 'concocting'. I think I said, 'You can calculate the figures however you like.' However, if the honourable member felt that I said that, I was certainly not implying any personal impropriety on his part. Just as I am sure the Leader of the Opposition would not have meant it when he said that we prepared 'misleading figures' for workers compensation. I am sure that he did not mean that in any personal way, and in the same sense I certainly withdraw that if the honourable member was offended by it.

The implication that I was attempting to reach was that the figures can be presented in ways which the honourable member has presented them, but that does not convey the appropriate understanding which a patient at the end of the system would want to have. If one looks at the Health Commission's 1988-90 net draw, for example, which is one component of those figures, there was a 5.8 per cent increase; for 1991, a 1 per cent increase; in 1991-92, a .5 per cent decrease; and for 1992-93, a .3 per cent decrease.

Of course, one then has to take into account the off-setting and balancing Commonwealth funds which are provided to the State under the various agreements we have negotiated (the Medicare agreement in particular), which provide enormous funding to the State's public health system. One then needs to examine the overall increase, which is the dollars we spend on beds and medical services at the end of the day. That is a 2.4 per cent increase in real terms.

I certainly do not imply that the honourable member is in any way fraudulently preparing his figures. I understand that they are correct and that they are dollar numeric figures that he is taking from appropriate sources. However, one has to look at them in totality and match them with the funds that are going in and out of the State budget, through Treasury, from the Commonwealth and through financial assistance grants, and one has to add on the funding which is received from the Medicare agreement. All of that is known to us when formulating the totality of the budget, and it is all available to be spent on patients at the end of the day.

Dr ARMITAGE: I draw the attention of the Committee to the application of funds on page 180 of the Estimates of Payments and Receipts. What is the estimated cost of award increases and other additional expenditures which hospitals may well have to meet from their budgets? In particular, what are the expected cost increases over which hospitals and health services have no control for each hospital in relation to matters like GARG reviews, revenue target increases and award increases for things like SASMOA, nurses, scientific and technical officers, superannuation guarantees, voluntary superannuation, award restructuring, and so on?

The Hon. M.J. Evans: Many of the issues raised by the honourable member have no certainty associated with them. Naturally, at this time no-one is in a position to know what the totality of award rate increases will be during the forthcoming financial year, just as we did not know last year. Such issues can be resolved only at the end of the year. However, they are the same for all in the community. Private businesses must live with those award increases, and so must the public sector. They are negotiated and awarded on a proper and legal basis and must, of course, be paid.

The reality is that, just as private sector managers must manage their budgets, the same is true in the public sector. It is particularly true in the health system where we allow individual health units substantial autonomy in the way in which they and their boards decide the application of funds within their health unit. They must do that within the total budget allocation of funds made to them, and they are aware of that.

A responsibility of being a good manager is to make proper provision for future increases; to make proper assessments of what those increases might be in relation to your particular health unit; and to ensure that your budget is structured accordingly. Indeed, health units have had that responsibility for some two years under the net funding arrangements. They receive the benefit of savings they make, and that encourages good management. However, by the same token, they must bear the responsibility and costs of increases which occur throughout the year. Those increases are known to the community in the sense, as the honourable member has said, that they are under negotiation and discussion, and proper managers, be they in the public or the private sector, must take the right action within their budget to ensure that these cost pressures can be met.

Dr ARMITAGE: I refer to page 512 of the Financial Statement and a sentence in relation to health, as follows:

> The base grants and the bonus pools are indexed for general cost increases (award wages and CPI).

Given that the Commonwealth quite clearly makes an award adjustment, why will the State not pass on the benefits of this to the people who need it in hospitals?

The Hon. M.J. Evans: That misconstrues the nature of the system. We pass on all the benefit. The Health Commission and the health system is administered in the first instance centrally but then, following the disbursement of funds, budgets are allocated to individual health units, and they have all the money bar that required for central administration, the Minister and the like. We do not keep hollow logs. If money is available from the Medicare agreement, it is spent on health services. That is the situation at the end of the day. If

we receive additional funding from the Commonwealth, it is passed on to the health units to the extent that it is not already included in the budget. We do not keep it centrally.

Dr ARMITAGE: The Commonwealth quite clearly acknowledges that in setting a budget or giving a base grant, if there is an award wage increase or a CPI increase, it is impossible to stick within that budget. So what the Commonwealth says to the State Government is, 'We will index, for general cost increases, our base grants and bonus pools.' However, the State says to people managing the provision of health services at the coalface, 'There is your budget. If you get an award rate increase, we will not pass on any extra money. You have to cover that within your own budget allocation.' Why are the hospitals and the providers of health services not given exactly the same deal by the State Government as the State Government gets from the Federal Government?

The Hon. M.J. Evans: The Commonwealth makes an estimate of what it thinks these various increases might be and incorporates it in the grant that we receive. So to that extent it is indexed. However, we have already disbursed that money as part of the overall allocation. It would be meaningless for us to say to a hospital, 'Here is your cheque for $X million; here is a another cheque for what we think indexation will be for CPI; and here is another cheque for what we think the wage increases will be.'

The Commonwealth makes an estimate and includes that in its total funding package. We disburse the total funding package to the various health units. That Commonwealth assumption about wage or CPI increases is built into the money the Commonwealth sends us; that is then incorporated into the budget that we give to the hospitals. We do not break it down to the hospital, because that is its job as a manager. In other words, the total dollars that we receive from the Commonwealth are passed on as total dollars to the health unit.

Dr ARMITAGE: If there is an award increase in the next 12 months, there will not be an equilibrating increase in the base grant and the bonus pool?

The Hon. M.J. Evans: Yes.

Membership:

Mr Hamilton substituted for Mr Heron.

Mr HAMILTON: My question refers to page 500 of the Program Estimates. The Minister would be aware that I have pursued this matter for some time. What is the current situation with respect to waiting lists at the Queen Elizabeth Hospital, and what is being done for people who have been waiting the longest for elective surgery?

The Hon. M.J. Evans: I am well aware of the honourable member's interest in this area and his general concern about the efficient and effective provision of medical services in the west. In relation to this particular topic, at 30 June there were 2 190 people on the waiting list of whom 346 were waiting over 12 months. A number of strategies have been initiated this year to reduce the number of people waiting over 12 months in a wide area of specialities. These include stage one of the funding, and that was 32 joint replacements in orthopaedics for $160 000 and 24 vascular procedures for a total of $45 000. Stage two included pre-operative clinics to the cost of $119 000 and stage 3 additional activity and ENT, vascular, orthopaedics, urology and general surgery, with a total of 464 procedures at a total cost of $1.1 million. In addition we provided the early discharge scheme at a cost of $600 000.

These projects all target long wait patients, and the number waiting over 12 months dropped from 383 in January 1993 to 346 in June 1993. A policy for the management of metropolitan surgical booking lists was released in August this year, and it aims to ensure optimum booking list management across the public hospital system in order to minimise waiting times and maximise patient satisfaction. I have detailed in a previous answer some of the provisions of that agreement.

Mr HAMILTON: The Minister may not have this readily available him, but can he indicate to the Committee what upgrading has taken place at the Queen Elizabeth Hospital over the past four years? What capital works and other programs have occurred at that hospital and what is the program for the 1993-94 budget, both in terms of capital works and other programs at that very important hospital?

The Hon. M.J. Evans: I have some detail in relation to that and the Queen Elizabeth Hospital buildings and equipment upgrade programs. The total level of expenditure on capital works and equipment at the Queen Elizabeth Hospital for the four years 1989-90 to 1992-93 was $30.2 million. These funds have come from within the recurrent budget of the hospital, $6.1 million; private practice funds of $540 000; and the Health Commission's capital works program of $23.3 million. The major items in this period were stage one redevelopment at a cost of $13.95 million, covering the kitchen, obstetrics and gynaecology building and the day surgery area; a CT scanner at $1.65 million; a digital subtraction angiography at $1.27 million; computing equipment totalling $2.57 million; upgrade of the Connor Building for $787 000; and a gamma ray camera for $600 000.

In 1993-94, $3.4 million has been provided for capital works and equipment purchases which include such items as computing $1.26 million; investigation of the concept of a holding bay for the operating theatres with an anticipated expenditure of $267 000, which will allow efficiencies to be made in this area (I was discussing that with the board the other day); and X-ray equipment in accident and emergency for some $300 000. In addition, $100 000 has been allocated for design fees for the second stage of the Queen Elizabeth Hospital redevelopment. The redevelopment has an estimated final cost of $21 million and will upgrade the main building, including air-conditioning.

Mr HAMILTON: There are two issues that are supplementary to that question, one of which is the upgrading of the air-conditioning. I take it that that is in next year's program; is that correct?

The Hon. M.J. Evans: Yes, I have some information on that if the honourable member would like that.

Mr HAMILTON: I would be appreciative of that information.

The Hon. M.J. Evans: With the exception of the theatre suite initial buildings at the Queen Elizabeth Hospital were not provided with air-conditioning, only heating and ventilation, when it was opened in 1959. The new north wing and outpatients extensions were air-conditioned when constructed in 1974. In the period between 1959-74, the maintenance unit at QEH introduced chilled water coils into the forced air ventilation system to provide some tempering effect to the fresh air in summer. The maternity building air-conditioning system was fully upgraded to current standards during the redevelopment project in 1990-92. The kitchen air-condition-

ing was upgraded to current standards in 1991. The Connor Building, formerly the RMOs building, was fully air-conditioned during the period 1989-92. In 1991 the hospitals commissioned SACON to review air-conditioning services in the main building and the accommodation building. The estimated costs of air-conditioning as at 1991 is: main building $5.4 million and accommodation building $780 000.

The upgrade of the main building to modern standards of air-conditioning in all respects is estimated to cost $21 million, inclusive of the air-conditioning. That is the total cost of redevelopment of that building. The commission is endeavouring to establish a major capital works commitment to the QEH in 1994-95 through the Metropolitan Health Services review and by the provision of $100 000 for design fees in this budget that I mentioned earlier.

Mr HAMILTON: I notice from the Minister's response that there is no mention of any provision for additional car parking in that area. I can recall many years ago raising a question about car parking at that particular hospital and indeed the need for a car park to be provided. What has occurred in relation to that matter? Has a report been commissioned and, if so, what does that report say and—particularly for the staff, and those people using the Queen Elizabeth Hospital—have the Minister and the Health Commission addressed this particular problem of car parking, because there are complaints from people about getting caught for parking offences at that hospital.

The Hon. M.J. Evans: Car parking at hospitals in general is a sensitive issue, and I know that the board at the Queen Elizabeth has recently considered this topic. I believe they have had a report on that matter which is before them and not before the Minister or the commission. I understand that the board has decided not to proceed at this point in time, but in general that is an issue which the board will resolve rather than having it resolved centrally. I would caution the honourable member that in most of our other major metropolitan hospitals the car parking has been provided by the hospital or through some self-funding arrangement and has not been provided at the general cost of the health system, but rather through some internal generation of funds such as car parking fees or the like; that has financed the ongoing cost of those car parking facilities.

Mr HAMILTON: I understood the caution in the Minister's response but I want to place on the record that it has been a long outstanding running sore of residents in the western suburbs, and I make no apology for raising the matter. My final question relates to the Hendon Primary School dental clinic, and I suspect that this will impact upon other school dental clinics in South Australia. Can the Minister advise what is happening in relation to autoclaving of dental hand pieces at school dental clinics? I have been asked, in relation to the Hendon Primary School dental technician, what is occurring there and who will be picking up the costs of autoclaving.

The Hon. M.J. Evans: Recent media publicity has been given to the question of autoclaving of instruments in dentistry in general, and certainly in relation to that process I am happy to provide some further information for the Committee. As honourable members would know, autoclaving is a process whereby objects are sterilised by steam under pressure. The possibility, albeit remote, of contracting AIDS through a dental procedure led the NHMRC in June 1993 to recommend that dental hand pieces be autoclaved between patients. This is increasingly the recommendation of similar health authorities around the world. All dental hand pieces used by the SA Dental Service (SADS) are autoclaved between patients at a temperature of 134 degrees for 3.5 minutes. Staff of the SA Dental Service were trained in the new infection control protocols in July 1993. SADS has spent some $600 000 on autoclave dental hand pieces in the past 18 months and expects to spend a further $600 000 to allow the new protocols to operate efficiently.

Many existing autoclaves will not cope with the greater demands of the new requirements, and about 40 replacements are required during this financial year at a cost of $200 000. The Hendon School dental clinic currently autoclaves all handpieces and is soon to receive additional handpieces to increase efficiency to avoid the waiting time for the autoclave cycle. The cost of these handpieces will be met centrally by SADS and will not have to be absorbed by the clinic.

Mrs KOTZ: I refer to the resources summary of the agency programs on page 485 of the Program Estimates. For each department and agency for which the Minister is responsible: how many positions have been proposed to be abolished through targeted separation packages; what is each position; how many persons have so far applied to take the benefit of a TSP; how many TSPs have so far been accepted, and what has been the pay-out for each?

The Hon. M.J. Evans: Regarding individual agencies, the total number of positions identified as surplus to requirements is 470 full-time equivalents, and the total number of separations to date is 193.07 FTEs, which represents 210 employees. Of course, members will appreciate the distinction between FTEs and individual employees. The total cost of TSPs to date is $9.5 million. A breakdown of TSP separations by health units as at 14 September 1993 is as follows: Flinders Medical Centre, 4; Hutchison Hospital, 1; IDSC, 10.53; IMVS, 14.8; Maitland Hospital, .7; Modbury Hospital, 1.4; Mount Barker Hospital, .5; Royal Adelaide Hospital, 39.31; S.A. Dental Service, 4.8; Salisbury Community Health Service, 1; Women's and Children's Hospital, 24.67; SAMHS, Glenside, 1; Noarlunga, 1; St John Ambulance Service, 2; Whyalla Hospital, 14.8; Strathalbyn Hospital, .9; Murray Bridge Hospital and Health Service, .6; Queen Elizabeth Hospital, 16.4; central office of the Health Commission, 7; Julia Farr Centre, 42.56; Clare District Hospital, 1.1; Mount Gambier Hospital, 1.0; and Lyell McEwin Health Service, 2; which produces the total of 193.07 which I gave earlier.

Mrs KOTZ: Again referring to page 485 of the Program Estimates, how many officers are now on contracts of service rather than permanent employment and at what level do they serve—that is, EL1, EL2, etc.?

The Hon. M.J. Evans: I will take that question on notice.

Mrs KOTZ: Will the Minister take into consideration in answering that question the following: are any of those officers subject to performance reviews; how is the performance measured; who measures it; who reviews the performance; what are the consequences of failure to perform; are any performance bonuses paid; and, if so, what are they and how are they measured?

The Hon. M.J. Evans: I am happy to take that question on notice, but it is a fairly safe assumption that we are not into the performance bonus system of the Commonwealth.

Mrs KOTZ: Again with reference to page 485 of the Program Estimates: what are the salary and conditions of service of each of the Minister's ministerial officers and what are the job specifications of each officer?

The Hon. M.J. Evans: I can provide that information on notice, but I think it has already been provided recently in

answer to a Question on Notice; so that information is probably already in the parliamentary system. However, I can have it re-presented in an appropriate form for this Committee. The conditions are quite standard and continue the existing arrangements.

Mrs HUTCHISON: My first question relates to a response given earlier by the Minister regarding capital works expenditure for country and rural areas. Will the Minister provide further details of the plans for the redevelopment of the Port Augusta Hospital?

The Hon. M.J. Evans: On Wednesday 23 June, the board of directors of Port Augusta hospital approved the project definition report for the redevelopment of the hospital for submission to and consideration by the Health Commission. The estimated cost of the redevelopment is $22 million. Stage I of the project incorporated the purchase of a Flinders Terrace property at $580 000 and its refurbishment at a cost of $840 000 for use as a community health centre. It will also incorporate the local South Australian Dental Service Clinic.

Purchase of the property was completed last year and arrangements for its refurbishment are currently being managed by the hospital. The development of the community health centre will also release space within the hospital for the internal rearrangement of services during the redevelopment project. The immediate upgrading of the fire safety systems at the hospital has been approved at a cost of $480 000, and the commission has asked the hospital to undertake more work on the project definition report before it is further considered with regard to the hospital preparing a proposal for the development of a private ward within that facility. Priority will be given to upgrading accident and emergency, medical imaging and operating theatres. A provisional amount of $1 million has been provided for the project for the 1993-94 capital works program, and construction is planned to commence in 1993-94.

Mrs HUTCHISON: I applaud the Government's initiative to place women's health services in country areas because of the considerable geographic disadvantage that women in country areas face in travelling to the city to access services. How much does the Government spend on providing health services to women outside the metropolitan area, and what is the anticipated expenditure for this year?

The Hon. M.J. Evans: There are 13 country women's health services around the State, and they have been set up under the national women's health program. Over the four years of the first national women's health program, $2.1 million has been allocated to country women's health services. These primary health care services offer a range of services including clinical consultations, counselling, group programs and courses, community development activities and the provision of information and resources which promote women's health. These services have been developed along local needs and issues while at the same time they address priority health issues of the national women's health policy.

These services employ staff in a range of full-time and part-time positions, including coordinators, women's health nurses, community health workers, social workers, Aboriginal women's health workers, ethnic workers and clerical officers. All country women's health services incorporate a structure for community participation through the women's health advisory committees. These committees play a key role in ensuring that health services are more accessible, appropriate and affordable to women and help the services to set priorities. These services have a commitment to work closely with GPs and other health and community organisations in their region. This commitment has helped the expansion of clinical services in reproductive health and sexuality.

Women's access to appropriate services could be further strengthened through administrative arrangements that enable the funding of cervix screening pathology requested by nurse practitioners. A Country Health Services Division women's health project officer has been appointed to work with the country women's health services and the country women's health advisory committees.

Mrs HUTCHISON: I refer to page 28 of the blue book, statement 9. From my travels around the Aboriginal lands and the north of the State, it has become increasingly obvious to me that there is a real problem with deafness in Aboriginal children, and that concerns me greatly. I am aware that there was something like a 75 per cent deafness rate a few years ago in the Aboriginal lands. This problem was addressed through the schools, involving children aged five years and onward with some degree of success, which put it down to about 54 per cent. Nevertheless, the problem is still there. What is being done to address the problem of deafness in the one-to-five-year age group, because I am aware that there are some programs with the children at school?

The Hon. M.J. Evans: There is no particular State program at the moment to deal with this problem. However, Aboriginal medical services have developed programs to suit local needs. Generally, a five-point approach is used. Extensive documentation of the extent of ear disease and hearing loss has been undertaken. Standard clinical protocol, such as management of discharging ears, are implemented; health promotional activities, including videos and the like, are presented; and trials of available hearing assistance, such as FM radio and whole-of-room amplification have been conducted. Environmental improvement to reduce the incidence of cross-infection in ear disease has also been undertaken.

There has been quite a deal of collaborative work with the Nganampa Health Council, assisted by the Menzies School of Health Research, the National Acoustics Laboratories, the Northern Territory Hearing Program and the Western Area Centre for Hearing Impaired Children with the South Australian Health Department, which has undertaken a comprehensive screening of 95 per cent of school-age children in the Pitjantjatjara lands, revealing a hearing loss in 54 to 75 per cent. So, it is certainly a very serious problem, in which I know the honourable member shares our concern, and one which we have to continue to address.

The Hon. B.C. EASTICK: I refer to page 6 of the blue book, specifically the lines relating to the Southern Yorke Peninsula Health Service. I know the Minister is well aware of the depth of feeling in the Minlaton area following the closure of the Minlaton hospital. He would also be well aware of commitments made by him that service provision in the area would suffer in no way from these changes and of commitments to ensure the district was provided with doctors equivalent to the situation which prevailed prior to the closure of the hospital. I will quote from a letter written to me by the Chief Executive Officer of the Southern Yorke Peninsula Health Service on 30 August 1993, which states:

> We do in fact have a problem with regard to medical manpower in that the district is short of at least one doctor.

I should also like to quote from a letter written by the Chairman of the board of directors of the Southern Yorke Peninsula Health Service to a constituent in Minlaton, who

wrote regarding his concerns relating to health services on the Southern Yorke Peninsula. Amongst other things, the letter states:

> Firstly, I am well aware that the biggest problem we face at present is the fact that we do not have a stable medical situation.

Further, the letter states:

> This has led to the current situation, where there are obvious deficiencies as you refer to in your letter.

The Minister would also be more than aware of the fact that the three medical practitioners, who were established in the Minlaton practice and who were carrying on an exemplary rural general practice utilising the Minlaton hospital, publicly stated that they would leave the district if the hospital closed. As such I was amazed to read in the letter from the Chairman of the board of directors of the Southern Yorke Peninsula Health Service to the constituent mentioned above that the unstable medical situation:

> . . . stems from the rather unfortunate and, in our view, premature decision of two of the three medical practitioners who were in Minlaton last year to leave the district.

One wonders how more definite doctors in rural areas need to be regarding country hospitals. Given the Minister's comforting statement to people in Minlaton in the Southern Yorke Peninsula prior to his closure of the Minlaton hospital, does he agree with the Chief Executive Officer of the Southern Yorke Peninsula Health Service that the district is short of at least one doctor? Further, does he agree with the Chairman of the board of directors of the Southern Yorke Peninsula Health Service that the medical situation is at present unstable? Does he agree with the Chairman of the board of directors of the Southern York Peninsula Health Service that there are obvious deficiencies in the medical services provided, and does he accept any responsibility for the demise of the exemplary medical practice in Minlaton which dissolved because of his decision to close the hospital, despite the clear warnings of the medical practitioners that that would occur?

The Hon. M.J. Evans: This question really goes to the core of the changes which have taken place on the Southern Yorke Peninsula. Indeed, significant progress is continuing to be made there in the development of a substantial Southern Yorke Peninsula Health Service, based on Yorketown and Minlaton hospitals. One has to look at the key elements of that proposal which involved the rationalisation of health service delivery to Southern Yorke Peninsula to overcome what was basically an over-supply of acute hospital beds and a shortage of aged-care accommodation. That program was tackled with the establishment of a 35-bed—which is a very substantial facility—Commonwealth-funded nursing home at Minlaton, but with the acute accident and emergency services retained as part of the overall development on that site of the existing Minlaton hospital facility; the transfer of the acute hospital services—medical, surgical and obstetrics—to the Southern Yorke Peninsula hospital at Yorketown; and accommodation for community health and domiciliary care services for the whole of Southern Yorke Peninsula on the Minlaton site.

Facilities at both sites require upgrading and refurbishment to suit there new role, and that has been provided for. The alterations to Yorketown hospital have been completed at an estimated cost of $888 000, and the patients are now being referred to Yorketown. Construction has commenced to convert a portion of the Minlaton hospital to a 35-bed Commonwealth-funded nursing home, which is supported by the Commonwealth to the tune $1.255 million. The construction of the nursing home is scheduled to be completed in June 1994. There are, of course, two general practitioners at Minlaton. There were two before; there are two there now.

Doctors leave practices, particularly in the country, for a variety of reasons. Not all of them is it possible to attribute to a single cause such as a change in the provision of those facilities. We are, of course, not unmindful of the fact that an additional medical practitioner should be provided in that region, and certainly the Health Commission is continuing to work with the local medical practitioners, with the Southern Yorke Peninsula Health Service and, indeed, with the AMA to ensure that what assistance we can provide is brought to bear to obtain the services of an additional medical practitioner. However, while that additional practitioner is desirable, I would certainly not agree that the present arrangement is unstable. Indeed, the two doctors who were there earlier are still there. I do not agree that the situation is an unstable one.

The Hon. B.C. Eastick interjecting:

The Hon. M.J. Evans: Well, I am just saying I don't agree with it, wherever the comment came from. The two doctors are quite stable doctors; they do not appear to be giving any evidence that they are not. I have recently visited that service, so I understand the comment that an additional medical practitioner is required; we are certainly working to that end. But, of course, they are private practitioners and work where they wish. The service which is provided at the Southern Yorke Peninsula hospital is quite substantial. It has been significantly upgraded, and it is a regional facility for that district.

A very substantial commitment has been made to the Minlaton community with that nursing home, which again provides for patients from a wider area. There is a two-person practice at Minlaton, and we would certainly like to see additional GP coverage in that region. But that is often an ongoing situation in the country. Wherever one looks in the country regions, it is always possible to be working for additional medical coverage, and doctors move in and out of those areas for reasons best known to them in most cases.

So, while I understand that comment about the additional service requirement, I do not accept that it is unstable. I think that the best arrangement for the region as a whole has been reached with the expansion of the medical acute facilities at Yorketown, the massive development of the nursing home facility at Minlaton, but the provision of GP surgeries in both locations.

The Hon. B.C. EASTICK: I have a supplementary question. Does the Minister accept the link between deficiencies in the provision of rural practice and the closure of country hospitals?

The Hon. M.J. Evans: No, certainly not. I would say that the facilities that will be available when these redevelopment projects have been completed in the southern Yorke Peninsula are very good. The hospital at Yorketown is an excellent facility—I have seen that myself—and I am sure the nursing home when it is completed, along with the domiciliary care service provision (the plans for which I have seen and looked at them on site) will provide an excellent service in that area. I do not think that there is any suggestion such as that which the honourable member is putting forward.

The Hon. B.C. EASTICK: I refer now to page 17 of the blue book. The 1992 actual receipts were $139.098 million. The estimated receipts in the blue book of last year were $113.699 million. What percentage of the extra receipts of $25.399 million were generated by private fees being charged

within hospitals and health centres because of the Health Commission's encouragement to generate such funds; and, if there is some other explanation of this $25.3 million increase, what are those specific details?

The Hon. M.J. Evans: We will take that question on notice. Detail is not immediately available.

The Hon. B.C. EASTICK: I have a supplementary question which the Minister may also care to take on notice. What is the predicted effect of the changed Medicare agreement on the level of receipts within hospitals and health services in this final year, if any example can be taken of the experience of the previous financial year?

The Hon. M.J. Evans: We will take that on notice, but I think it should be understood that the private patient fees are, of course, on the decline in the public hospital system as private patient status and public hospital insurance declines, as distinct from private insurance for private treatment as a private patient in a private hospital.

The Hon. B.C. EASTICK: That is all tangled up with the conundrum of $405 bed days. In Financial Paper No. 1 of the Financial Statement for 1992-93 at page 5.26, in relation to hospital funding agreement, whereby the Medicare base amount is identified as being $422.734 million for 1993-94, why did the Minister sign the Medicare agreement so early, given that New South Wales and Victoria clearly received a better financial deal than did South Australia by playing what might be termed the political game somewhat more smartly; and does the Minister accept any responsibility for the reduction in South Australia's general purpose financial assistance grant of $22 million as a result of funding of Medicare guarantee payments for New South Wales and Victoria, as is identified on page 2.14 of the Financial Statement for 1993-94?

The Hon. M.J. Evans: I would suggest to the honourable member that in fact the Medicare agreements are all on the same basis. The reality is that the new Liberal Government in Western Australia, for example, signed even after that election. New South Wales and Victoria have some basis for talking with the Commonwealth on the grounds of their population numbers, of course, but the Medicare agreements across-the-board are on the same basic principles. I do not accept that there are politically motivated variations between the Medicare agreements.

Mr HAMILTON: My question is in relation to heart disease in South Australia. Can the Minister, first, advise me whether there is a decline in heart disease in South Australia; and, secondly, is he aware of a pro-active campaign that is operating in the western suburbs of Adelaide amongst schools?

I would like to briefly explain that question. Professor Horowitz was requested recently to attend the Semaphore Park Primary School to address 250 students in relation to the problems of heart disease. It was a pro-active campaign, initiated by, frankly, a person who walks with me on my annual walkabout, if you like. I understand that the professor attended that school and received a very, very favourable response from those students. I am also advised that the professor, together with Mrs Alderwood (who is a very active person in the western suburbs), is engaged in talking to principals of various schools in that area about talking to students in other schools about a pro-active campaign centred around heart disease, dietary habits, smoking, exercise, etc.

Would the Minister take this matter up with the Minister of Education—his Cabinet colleague—to assess the value of this particular program, with a view, perhaps, to making this more widespread throughout the community, as it is my belief and that of many others that if we embarked upon a pro-active campaign in schools at a very early age to address the problems of heart disease we may not have, for example, in the western suburbs of Adelaide, the highest incidence of heart disease in the State? The Minister would be aware that South Australia has the highest ratio of heart disease in Australia. So I think the question is a very relevant one and I believe, if we can get the support of the Minister of Health and indeed the Minister of Education, that we could perhaps go a long way towards addressing the future difficulties with heart disease.

The Hon. M.J. Evans: Certainly, I would be prepared to take that up with the Minister of Education to ensure that if there is some value to be obtained from that program that we are able to extend that as far as is practicable and possible. I understand the actual mortality from heart disease has declined—that reduction is quite real—but perhaps the incidence has not declined to quite the same extent. Of course, there are a whole variety of factors which need to be taken into account when looking at the incidence of heart disease, from nutrition to smoking to life-style changes and exercise. Obviously, the honourable member would be aware that it is a very multi-factorial situation. So it is much harder to isolate.

The Health Development Foundation, of course, is also actively working in the schools, as is Foundation SA, in the QUIT campaign and in association with the National Heart Foundation, to try to produce the best possible climate for a long-term reduction in the incidence of heart disease as well. But given the many factors which are at work here, and given the significant changes to individual life-styles which may be required, obviously it will be a long-term primary health care initiative to change that incidence of heart disease in our community. But we are certainly prepared to look at any of those programs that seem to work within the schools, and the Ministers of Health throughout the country and the Commonwealth have agreed that cardiovascular disease is one of our four national goals and targets to adopt in the future, especially given the massive cost to the community as a whole of this kind of disease—and the economic and social costs of that—and the benefits which can be obtained from preventing the incidence before it occurs in a primary health care model and thereby saving even more money, but, more importantly, sparing families and individuals the personal and social cost of heart disease.

Mr HAMILTON: The response from students at Semaphore Park Primary School was rather surprising. Not only were the children concerned about their parents and their smoking and dietary habits and lack of exercise but they were also concerned that they themselves may be left without a parent. It was a sobering response that I received from the principal and staff who were supportive of that program.

The Minister would be aware of concern expressed in the media, particularly the *Messenger Press*, last year and this year, about meeting the accommodation needs of homeless youth particularly in the outer western suburbs of Adelaide. Can the Minister give an update on the current situation? Have those needs been met and, if they have not been, what outstanding needs are to be met in relation to the accommodation needs of homeless youth?

The Hon. M.J. Evans: While the Health Commission has a number of programs in this general area such as the Street Link Health Service and the Hindmarsh Centre, particularly in the western suburbs, it is also true that much of this

program will come under the supported accommodation assistance program (SAAP), which we will be discussing this afternoon under Family and Community Service lines. The honourable member may wish to reconsider the question later. Homeless young people generally have a wide range of demands on our services, quite properly. They range from increased use of the health system to their condition of homelessness, which must also be addressed. Much of that quite properly falls into this afternoon's discussion.

Mr HAMILTON: What programs and assistance, financial or otherwise, are being provided not only to people who have been unfortunate enough to incur head injuries but also their families—parents who have a loving concern for the welfare of their children?

The Hon. M.J. Evans: In 1991 the State Government established the community support scheme with joint funding from the Commonwealth Government through the home and community care program. The community support scheme enables people and their families to receive flexible respite, in-home support and other support services. People with head injuries and in particular their families are a target group for expenditure of funds throughout the scheme.

Total funds available to the scheme in 1992-93 amounted to $4.2 million and people with brain injury accessed about $300 000 of those funds. In 1993-94 there will be additional funding from the Commonwealth and State Governments of $1.3 million. Total funding available to the community support scheme will be $5.128 million. People with brain injury will receive a proportion of those funds.

In 1989-90 the State Government established the 'take 5' respite service, specifically for people with a brain injury, using joint funding from the Commonwealth Government through HACC. Ongoing funding for this service is currently $360 000 per annum. The Commonwealth-State disability agreement has provided for additional funding for the State for disability services and the State has accordingly allocated $300 000 recurrent funding for intensive accommodation support for people with brain injury; $140 000 recurrent funding for day activity options for people with brain injury; $30 000 recurrent funding for a brain injury community re-entry program to facilitate transition from rehabilitation settings into the community; $40 000 recurrent funding for information and advocacy support services to assist families to cope and adjust to brain injury; and $36 000 in one-off funding to develop an information kit relevant to South Australia for people with brain injury, their carers and families.

In addition, $85 000 has been allocated to meet the urgent need for additional communication aids for people with physical disabilities and people with a brain injury. In line with the recommendations of the Disability Services Implementation Steering Committee the State Government will establish an options coordination focus specifically for people with brain injury. The disability services officers currently consult in the field as to whether children and adults with brain injury should each have a separate focus for options coordination.

The options coordination focus will, with the involvement of people with head injuries and their families, assess people's needs, allocate resources and coordinate access to services for individuals. The disability services officers are currently conducting a survey of people with disabilities in South Australia regarding services they receive and the gaps in services and levels of unmet need. This survey is called the disability support needs project and 210 people with brain injury will be surveyed as part of the project. South Australia is represented on the Standing Committee of Social Welfare Administrators, the Commonwealth-State working group, on a national approach to services for people with acquired brain damage. The working group will be making recommendations on the development of a national policy to ensure better and more accessible services and a greater degree of coordination between services for people with acquired brain injury and their families.

Mr HAMILTON: Can the Minister indicate what the local timetable is for the completion of that survey so that I can advise constituents who are interested in this matter?

The Hon. M.J. Evans: Interviews are expected to be completed by February 1994 and the analysis by July 1994, at a projected total cost of $130 000. It is a comprehensive survey. With the indulgence of the Committee I will give some replies.

The CHAIRMAN: You are in order. Will the members of the Committee keep their explanations on questions reasonably brief as that will maximise the number of questions that can be asked.

The Hon. M.J. Evans: In reply to the member for Light's question about capital works expenditure on drug and alcohol services properties I inform the Committee that in 1988-89 most of the expenditure was on sobering-up centres at Murat Bay and Port Augusta, at a cost of $17 000; in 1989-90, $361 000 was spent on further capital works at sobering-up centres throughout the State; in 1990-91, $52 000 was spent to upgrade Joslin and Warinilla; in 1991-92, $35 000 was spent on the Woolshed and Warinilla upgrades, and $54 000 on the Archway rehabilitation service grant to the Salvation Army for fire protection, making a total of $89 000 for that year. In addition, in 1992-93 DASC renovated the methadone reception and clinical areas at Osmond Terrace from recurrent funds at a cost of $60 000.

In relation to the figure of $8 million which the member for Adelaide raised at the beginning of the proceedings today, as I indicated at the time that is entirely due to transfers and rearrangement of expenditure patterns and does not represent any change to the actual policy or any retention of funds by the commission. Some of those changes are as follows: $1.3 million relates to variations to Commonwealth programs; $4.9 million—and these are round figures—relates to the fact that motor vehicles are now reported as a capital item whereas previously they were reported as a revenue item. The same amount of money is being spent, but simply recorded in a different part of the budget. There was a transfer to capital of $1.4 million for the RAH-QEH strategic plan, equipment at teaching hospitals, a mobile mammography unit, theatre waiting at the QEH and accommodation for migrant health. So, they were revenue items which were transferred to capital.

There was also a transfer between the HACC unit of $500 000 and a transfer to capital to offset an expected shortfall in capital spending of $3.5 million, and that has subsequently been recredited. So, when you take the net effect of all those variations—and I can have a further chart incorporated in the record at a later date—it is the amount which the honourable member identified as being different between the two figures. It is entirely due to technical accounting variations as to how the figures are recorded, and that is explained by those variations that I have just read out. It represents no change in health policy or any retention of funding in any hollow log as could otherwise have been thought.

Dr ARMITAGE: The blue book (page 15) contains some lines dealing with specifically funded hospice care, and I want to refer particularly to the one dealing with the Philip Kennedy Hospice. I note that the Estimates of Payments for this year in the sum of $278 000 is $10 000 greater than the figure of $268 000 of last year. The Minister is aware of specific concern relating to the delivery of palliative care in the western region of Adelaide and that the Professor of Palliative Care at Flinders University indicates that the service for palliative and hospice care in the western region is now threatened with major disruption.

The Philip Kennedy Hospice was an enthusiastic innovation of the Knights of the Southern Cross, but people in that hospice were expected to pay their pension to the hospice as if they were in a nursing home at a cost of about $20 a day. That occurred in no other hospice situation. I am told that the Knights of the Southern Cross organisation wishes to reduce the number of beds available for the Philip Kennedy Hospice from 10 to seven immediately, and indeed has indicated its desire to see hospice care facilities provided elsewhere in a more appropriate site as soon as possible.

According to Professor Ian Maddocks, the Professor of Palliative Care at Flinders University, the best solution to the problem is the establishment at the Queen Elizabeth Hospital of a small hospice unit based on possibly eight but preferably 12 beds, which would allow close supervision of inpatients by the hospice director. Close supervision is very important because a hospice is not just a place to die: it is a place of active intervention, and indeed at the moment people at the Philip Kennedy Hospice often need X-rays, further care, etc., and they often have the indignity of going, in the final stages of their lives, in ambulances or taxis to the Queen Elizabeth Hospital which is far from appropriate.

This small hospice unit at the Queen Elizabeth Hospital would also be a particularly good teaching environment for resident medical officers and would be close to all relevant medical services. Does the Minister agree that palliative care in the western region is threatened with major disruption, and what plans does he have to alleviate the problem; in particular has he held any discussions relating to the possible establishment of a small autonomous hospice unit within the Queen Elizabeth Hospital?

The Hon. M.J. Evans: This, of course, is an area in which I have a particular interest given my term of office on the select committee of this House related to death and dying. Members of this Committee, including the member for Newland and the member for Light, and others spent a considerable amount of time investigating this whole area. So, it is one in which I have taken a particular personal interest. The honourable member is correct to identify the difficulties of this particular hospice. Indeed, while I do not agree that there is a major threat to the hospice, because I think that is being addressed at the present time, certainly it does need new arrangements. The honourable member is correct in his assumption that discussions are proceeding with the Queen Elizabeth Hospital in relation to the formation of the unit to which he refers. I think that would be a very appropriate solution if a suitable package of funding and medical and nursing care can be brought together.

The general situation in relation to palliative care I think is one that is worth discussing at this point, because South Australia has a very comprehensive and efficient hospice and palliative care service, which I would suggest is leading in this country. I think that we certainly need to remain on top of issues like the one in the west to ensure that that is provided not only across the State but in every local area where it is possible. I think it is important to note the new funding that the Commonwealth Government is providing in relation to palliative care, because the 1993-94 Commonwealth budget approved funding of $55 million nationally over four years for the expansion of palliative care services. This is in addition to the funding for palliative care services under the previous Medicare agreement, which in 1992-93 netted South Australia nearly $1 million. The Commonwealth proposes to integrate those two funding programs and develop a four-year palliative care program, which covers 1993-94 to 1996-97. That will allow us to develop an integrated network of palliative care services with both public and private sector suppliers.

So, quite a lot of work has been done in the palliative care area. I think that the need is there and the Commonwealth initiatives will allow us better to address that need. In relation to the particular issues in the western suburbs: they are known and are being discussed at the moment with the hospital and the palliative care service, and I am confident we can address the issues that have been raised there.

Dr ARMITAGE: I refer to the Program Estimates (page 487a, the amended page that we received) and the line related to disabilities services. I refer the Minister to the problems being experienced by the Port Pirie Special Needs Training Group, which falls under the aegis of the Mid-North Port Pirie area of IDSC. The particular problem is that that group was given leased space in the Port Pirie branch of what is now the Spencer Institute of Vocational Education whilst room was available, and it did not restrict the operation of the then TAFE programs. This leasing started in 1986. Since then the TAFE or the IVE has expanded and the Spencer Institute of Vocational Education is now paying approximately $17 000 to lease space elsewhere in addition to its present space in Port Pirie. So, it is saying to the Port Pirie Special Needs Training Group, 'You are no longer able to utilise the space.' I am told that the interaction on the campus of the IVE has been extraordinarily good and that the special needs training group does not wish to move, specifically because of the advantages of that integration. Is the Minister aware of situation and, much more particularly, what will he do about it?

The Hon. M.J. Evans: Yes, I am certainly personally well aware of the situation, because I visited Port Pirie not so long ago and had discussions with a number of people there, including the member for Stuart, Mrs Hutchison, Hon. Ron Roberts MLC and Mr Allen Aughey, among others, and we spoke about the particular problems that the honourable member has raised. I understand the needs of that group and the difficulties that it is experiencing in relation to its accommodation. It requires negotiation with a number of groups in the Port Pirie area and I am participating in that process at the moment. Obviously, that negotiation is not yet complete. We certainly hope to secure a favourable outcome for the group, because I am sure that all members would wish it well in its activities and in the very valuable service that it provides. I think that the benefits that the honourable member spoke of are indeed true and apparent, and I will be doing what I can in conjunction with the local members and the local community to see what favourable outcome we can achieve for the group.

Dr ARMITAGE: I refer to the blue book (page 2), which contains the 1993-94 summary. I draw the attention of the Committee to the fact that under receipts, health service fees and recoveries is listed as being $111.3 million. However, on

page 17 of the same blue book, the estimate of receipts is $103.836 million. Where is the missing $8 million? What is the difference between them?

The Hon. M.J. Evans: I am informed that the difference relates to $7.3 million worth of motor vehicle receipts, which are shown in one but not in the other, because of the different nature of the receipts. It is very much the same kind of thing as related to the earlier question.

Mrs HUTCHISON: Before asking my questions I would like to move:

That the proceedings of the Committee be extended beyond 1 p.m.

Motion carried.

Mrs HUTCHISON: I refer to page 493 of the Program Estimates. This relates to a matter that I have raised on a number of occasions with the Minister. When was the Woomera Hospital transferred from the Commonwealth to the State Government? How much funding was provided at the time of transfer; and, importantly, what kind of services will it provide to the Roxby Downs/Woomera area, because there has been a gap in services there?

The Hon. M.J. Evans: I appreciate this question, particularly given that I recently had the opportunity to visit the Woomera hospital and see at first hand the facilities that have been handed over from the Commonwealth. The transfer of the hospital from the Commonwealth to the State was effective on 1 July 1993 for a period of 20 years, with provision for a further 20 year period after that. The hospital has been proclaimed as a recognised hospital and is governed by the board of directors of the Port Augusta Hospital and managed by the hospital's executive. The commission has requested that a Woomera Health Services Advisory Board be established to encourage and ensure the involvement of the Woomera community. As the $900 000 funding for the operating expenses of the Woomera hospital is not part of the normal Medicare grant, the transfer does not impose any financial burden on the rest of the State's health system.

A one-off capital grant of $100 000 was made by the Commonwealth. Agreement has been reached with Medical Operations, the same group providing general practitioner services at Roxby Downs, to provide a resident general practitioner service in Woomera. The two practices will work together in providing improved services to the entire Roxby-Woomera area. The 10 bed Woomera hospital will provide level 1 general practitioner type services, including a 24 hour accident and emergency service, and level 1 medical, surgical, obstetrics and gynaecological services. The provision of an improved hospital service at Woomera should meet many of the needs of the Roxby Downs community. Arrangements are being made by Port Augusta Hospital to further improve the primary health care and community health services to the Woomera-Roxby area in general.

Mrs HUTCHISON: The Minister said that the advisory board is to be set up: is that not yet in place?

The Hon. M.J. Evans: Not yet, unfortunately, but it is in progress.

Mrs HUTCHISON: My second question also relates to page 493 of the Program Estimates, referring to country health services, and it is the vexed question of country medical practitioners. Has the State Government taken any steps to provide support to existing country medical practitioners and to encourage other medical practitioners to practise in the country? This has been a long-standing dispute, and I note that the member for Light raised it briefly.

The Hon. M.J. Evans: The member for Light raised it earlier, and it does touch on that whole issue of country medical practitioners. The commission has established a number of programs to support existing country medical GPs. There is, for example, the continuing medical education program that is jointly funded by the State and the Commonwealth, with the State contributing $231 000 and the Commonwealth $108 000. This program provides for the employment of two rural registrars who act as locums while country GPs undertake continuing medical education. It provides grants to rural doctors for reimbursement of education expenses up to $1 800 per annum for solo practitioners, and a grant of $40 000 to the South Australian Postgraduate Medical Education Association (SAPMEA), which provides specialist visits to country regions to provide education programs for country doctors.

In terms of support for solo practitioners, the Health Commission provides funding for locum cover to enable solo country medical practitioners to take recreation leave. This assistance is in the form of a grant of $1 680 per week for a maximum of four weeks per annum. Travel assistance at standard Government rates is payable to medical practitioners travelling more than 20 kilometres from their surgeries to provide services to public inpatients at recognised hospitals. In addition, the Rural Practice Training Unit has been set up to encourage practitioners to move to the country. It was established in 1992, and runs a number of programs aimed at training practitioners for rural practice and encouraging both medical students and qualified practitioners to consider rural practice as an option.

The current contribution from the Health Commission is $90 000 per annum, which will increase to $280 000 when Federal funding expires in 1994-95. The program currently under way includes: the establishment of a rural surgical registrar's position at Modbury, and currently negotiating additional positions for surgery, obstetrics and anaesthetics in metropolitan teaching hospitals; the organisation of locums for country doctors; assisting with the establishment of rural clubs at universities; visiting high schools (metropolitan and country) and discussing rural practice with students; assisting in the development of curricula and standards by the Faculty of Rural Medicine; and assisting rural communities with the recruitment of general practitioners.

Mrs HUTCHISON: Has the takeup rate on that been successful?

The Hon. M.J. Evans: I am advised that it has been.

Mrs HUTCHISON: My third question relates to the problems of asthma, and there are substantial problems in my own area that have been ongoing over a number of years. It is reported that asthma is causing increasing problems, particularly amongst children. What is the Health Commission doing to help parents with asthmatic children?

The Hon. M.J. Evans: I recently had the opportunity of discussing this when I opened the asthma conference the other day at the Ramada at Glenelg. Asthma is a worrying problem, and there are a number of local and national initiatives designed to identify causes and promote better management. Specifically for families with asthmatic children, we have an 18 month project based at the Munno Para Community Health Service, which will develop and evaluate a self teaching resource pack. The project is being conducted under the auspices of the Asthma Foundation and has Commonwealth support of over $128 000. The Health Commission has committed $30 000 to the project so far. The National Health and Medical Research Council has created

an expert working party with input from the National Asthma Campaign to review all aspects of asthma and to develop guidelines for its more effective control.

At this stage, if convenient, I would like to read an answer to the Port Lincoln question. The member for Light raised the issue about Port Lincoln Hospital. The orthopaedic specialist who visits Port Lincoln provides only minor surgical procedures, for example, arthroscopies, because of the inability to provide after-care for major procedures. According to the Chief Executive Officer, the specialist's operating lists for such procedures are usually booked out for three to four visits ahead. However, there has been no approach from the specialist to hospital management or board for additional operating sessions or to expand the range of services provided.

The hospital would like to provide the opportunity for more major procedures, such as hip replacements, to be performed, and it will ask the medical and nursing staff to prepare a bid for funding from stage 3 of the booking list strategy if the specialist is agreeable and can provide the necessary after care. Port Lincoln Hospital has been given an additional $60 000 for fee for service for surgical procedures in this year's budget, and $30 000 has also been provided for 20 cataract procedures from stage 2 funding under the booking list strategy. A stage 3 submission was requested in a letter sent to hospitals on 1 July. As yet, we have not received a response from Port Lincoln.

Mrs KOTZ: My question relates to page 492 of the Program Estimates which, under 'Specific Targets/Objectives', refers to implementing the efficiency review at Modbury Hospital. I believe the Minister will be aware of a situation that I recently brought to the attention of Parliament about service provision relating to orthopaedic surgery at that hospital. It would appear that the service provision of orthopaedic surgery at Modbury Hospital has been a matter of contention for some time in terms of access to that service and its provision.

I was informed last week that orthopaedic surgeons had negotiated with the hospital to reduce their salaries by about 25 per cent at the beginning of this year to attempt to come to terms with economic and budget measures and to help to provide that very important service to constituents and people within the Tea Tree Gully area. This is of concern not only to the Modbury Hospital but to orthopaedic surgery across the board. I believe that the particular group of medical professionals about whom we are talking need to be commended for taking the steps that they have taken. I also believe that part of that commendation should point out that the salaries received, even though reduced by 25 per cent, do not cover all the hours that these people work in the public interest to provide services to the community. Therefore, it is of concern that the commitments that were negotiated under the salary decrease do not appear to have been undertaken.

The question that is causing anger and frustration amongst not only the people who are attempting to provide that service but the community at large is the one that I should like to put to the Minister. What is the Minister's vision for orthopaedic surgery throughout the State? That also relates to the Health Commission and its vision and policy direction for orthopaedic surgeons. Modbury has for some time had service deficiencies due to budget deficits that have caused extreme concern. Has the Minister any intention at this stage of reviewing the budget within Modbury Hospital, taking into consideration that the extreme deficits have caused service cuts and considerable disturbance to services in the area?

The Hon. M.J. Evans: The honourable member has touched upon a number of issues. I think that the issue that she raised in public earlier this week should be put in perspective. Unfortunately, I am not aware of any orthopaedic surgeon who has offered to take a 25 per cent pay cut. If she knows of any orthopaedic surgeons who are prepared to reduce their fees by 25 per cent, I should be pleased to be put in touch with them, and the Health Commission will certainly have immediate discussions with them about that reduction in their fees. It would be of considerable assistance, and I should be grateful for their names so that we can contact them after the session. Indeed, I could contact them over lunch if she has the names now.

What she is referring to is a reduction in the number of sessions from four to three, which is not quite the same as a reduction in salary because, unfortunately, they reduced the amount of work they did in that period as well. A couple of days ago Modbury came to an agreement with those orthopaedic surgeons because, when the fourth orthopaedic surgeon left, the sessions were distributed amongst the remaining surgeons, taking them from three to four. Of course, it was necessary as part of that increase to reach some understanding that that would result in additional hours of work. When that agreement was reached, those sessions were allocated, so the same number of sessions are still being worked. Unfortunately, their salaries did not reduce by 25 per cent, but I am open to offers.

When a fourth surgeon is again available, the agreement is that the sessions will drop back per surgeon from four to three, but the total number of sessions will be the same as it was before. However, that will provide better cover, with more surgeons available to undertake the work, and that is a better arrangement. That is what is currently being looked at. In global terms, Modbury Hospital has received substantial additional funding this year. Additional funding of $1.2 million from the special Medicare initiatives pool has been provided in 1993-94 for the production of an additional 4 100 public occupied bed days from the opening in early August; and a net additional 16 beds. An extra $500 000, which was provided in 1992-93 for increased patient activity, has been continued again in 1993-94.

I do not think the issue with the orthopaedic surgeons is quite as the honourable member thought it might have been. Orthopaedic surgery generally was a substantial concern in the past in relation to the supply of those services. That has tended to improve in recent years, and in fact South Australia has one of the highest *per capita* rates of orthopaedic surgeons in the country, which indeed has one of the highest rates in the world. I do not think that is still the problem that it was. ENT has probably replaced orthopaedics as the specialty of concern, if one was looking to identify that area.

Mrs KOTZ: I am quite sure that, if the Minister was aware of the situation that I raised in this Parliament, he would also be aware of the name of the people concerned, because that was also a matter of public record, due to the letter that was received by a particular orthopaedic surgeon and read into *Hansard* as a matter public record in this House. The fact that that 25 per cent salary cut was part of those negotiations was also part of the statement made by that individual and, if the Minister has either forgotten that or not read *Hansard*, I am prepared to pass on the letter, the information and the names of the people who brought this to my attention.

The Hon. M.J. Evans: Do you want to make that a supplementary question?

The CHAIRMAN: I think that at this stage the Minister is in order in further responding. I am prepared to count it as a supplementary question.

The Hon. M.J. Evans: I think this is a misunderstanding about the use of the expression '25 per cent pay cut'. The honourable member is interpreting it (I am sure quite genuinely) as a 25 per cent reduction in pay for the same service provided. I understand that there was a statement about a 25 per cent reduction in service, to be accompanied by a 25 per cent reduction in salary; in other words, that is the reduction from four sessions to three sessions. That is not a 25 per cent pay cut. That is like someone working three days a week instead of four days a week and receiving a 25 per cent reduction in their pay and entitlements; it is *pro rata*, and it is perfectly in order to do that. That extra session has now been given back, with the other orthopaedic surgeon leaving. Again, they are not receiving a 25 per cent pay increase—I have not heard the honourable member say that they have a 25 per cent pay increase—but, by the same token, she has argued that there was a 25 per cent pay cut when the sessions were reduced. It is either one or the other. I suspect that it is simply a misunderstanding of the terminology. It is just a reduction in the session; it is not a 25 per cent pay cut.

Mrs KOTZ: I will take that up with the Minister during the luncheon break. I refer to Program Estimates and Information, 1993-94, page 486, and to the Women's and Children's Hospital. With respect to the proposal to extend an open deck multi-storey car park, I believe that the member for Adelaide wrote to the Minister on 21 July relating to this, and the Minister has responded, indicating a number of things. The questions are based on the fact that in the background he provided, the Minister said:

> The proposal has been approved by the City of Adelaide Planning Commission.

It could be assumed that the City of Adelaide Planning Commission would not be asked to approve a proposal unless known funding sources were such that the proposal might be regarded as going ahead. If this is not the case, the Health Commission is obviously just wasting the time of the City of Adelaide Planning Commission.

As such, was the cost of $1.62 million at today's costs included in the original estimate of cost involved in merging the two institutions, and what will be the cost of altering the provision of the energy supply to the hospital, given that the Saltmarsh Building is to be altered in its usage, and were such costs included in the original plan to merge the two institutions of the Adelaide Children's Hospital and the Queen Victoria Maternity Hospital? Who takes responsibility for the statements made previously that the present car park would be sufficient to meet the needs of the merged institutions?

The Hon. M.J. Evans: I think we have to relate this back to my earlier comments about car parking to the member for Albert Park. This proposal is, remains and has always been a self-funded proposal put forward by the hospital itself. There is no Health Commission funding in that proposal. It has never been intended that there would be, and there will be none. It is part of the normal provision of car parking in hospitals which has traditionally been a self-funded proposal. That is quite properly before the Planning Commission awaiting approval or otherwise from the commission. If it goes ahead, following its determination, and that of the board of the hospital, then that proposal will be self-funded.

The existing hospital car park, built at a cost of $4.9 million, was funded by a loan from SAFA which is being repaid through revenue earned as part of the car park. I expect that the same kind of arrangements would apply. For the honourable member's information, but it is not something that touches on our budget, I am advised it would cost about $1.6 million for those spaces for the movement of the energy plant. The honourable member must keep in mind that this proposal will have to be self-funded. That is the basis upon which it is being pursued by the proponents of the proposal. They understand that, and that is in keeping with the usual arrangements. Indeed, it has worked quite successfully on that site already, with the original $4.9 million loan which is continuing to be repaid in the normal way.

Mrs KOTZ: I refer to the Program Estimates and Information, page 491, with respect to teaching hospitals. There is already considerable cross-fertilisation between the Flinders Medical Centre and the Repatriation General Hospital at Daw Park. Given that moves for the Repat to come under the wing of the South Australian Health Commission are well advanced, I believe, is the Minister aware of any major capital expenditure within the past 12 months at the Repatriation General Hospital, particularly on computer hardware and software which, I am informed, is not compatible with South Australian Health Commission computer material? What discussions take place between the Department of Veterans Affairs and the South Australian Health Commission regarding the compatibility of equipment between the two facilities such that ease of transfer is therefore increased? Does the South Australian Health Commission have any staff representation at the Repatriation General Hospital at present to ensure that the best utilisation is made of taxpayers dollars?

The Hon. M.J. Evans: Yes, the honourable member is quite right to identify the Repatriation Hospital as being a very important resource and one which could quite usefully be brought into closer collaboration with the Flinders hospital.

I am afraid I cannot account for or explain any item of purchase of equipment within the Repatriation Hospital since it is entirely a Commonwealth owned and managed facility. I understand that they may have indeed purchased additional computing equipment but I am afraid its compatibility or the nature of it is not something of which I, as State Health Minister, have any knowledge since the Commonwealth Government is exclusively responsible for that facility.

I would wish, as a matter of logic, that they would consult more closely with the State and surrounding hospitals about the compatibility of equipment, and if indeed that equipment is incompatible it would certainly have been much better had they done that. The State is open to such consultation and, indeed, I think Flinders made itself available for consultation, but the offer was not necessarily taken up by the Repatriation Hospital. That comment has to be taken in the general context that I am not responsible for the Repatriation Hospital.

Discussions are under way with the Commonwealth Government about the possible transfer of that facility to the State. That would certainly mean a much closer integration with the Flinders Hospital. That would be highly desirable and quite a useful means of supplementing our health services in this State. However, I really could not say that negotiations were at a point where I would describe them as well advanced. I would say they are simply, in diplomatic language, continuing, and they will continue until the State has either a reasonable deal or they will not proceed.

I do not really think I can add much further to that since some of the things the honourable member seeks are outside

my jurisdiction. I certainly would want to ensure that our health service cooperated as closely as possible with other public services, such as Commonwealth facilities or indeed with private services where that was possible, but we can only offer.

Mrs KOTZ: As a point of clarification, is the Minister then saying that at this point in time, because there is no definite time scale for the transference of the Repatriation Hospital through the Federal area into the State area, it is then of no concern to the Health Commission of South Australia: that if there is a major expenditure into a computer system—which obviously could be of great advantage to the State system and a very necessary one—there is no investigation, discussion or negotiation in that area? I imagine that would be of great benefit to the State as part of the negotiations if we are about to take over the responsibility for that area, considering that we are talking, apparently, about a major capital expenditure in that particular area?

The Hon. M.J. Evans: I understand that in fact we specifically offered the availability of discussions with Flinders but they were not taken up. It is certainly of concern to us, which is why we made the offer, but the offer was not taken up. It is a Commonwealth Government facility; we have no control over what they do, just as I would have no control over Ashford Private Hospital's computer system. I can only offer to have consultations with the State health instrumentalities that are nearby. Certainly had that offer been taken up I would have been very pleased by that. It would have been a logical and reasonable thing to do but unfortunately the offer was not taken up. I cannot force them to comply.

Certainly it would be a desirable thing to have better cooperation among all instrumentalities. Incompatibility of computing systems, for example, is something we live with all the time. The House of Assembly and Legislative Council do not have compatible computer systems.

Mr ATKINSON: My question relates to statement nine in the blue book covering Commonwealth funding for HIB immunisation? What is the level of funding provided by the Commonwealth to the State for the HIB immunisation program? How many children have benefited from the vaccine so far, and what are the effects of HIB?

The Hon. M.J. Evans: The Commonwealth has offered South Australia $557 000 to purchase HIB vaccine during 1993-94 and has undertaken to provide additional funds if required. The estimated cost to South Australia to administer HIB vaccine, excluding the cost of the vaccine, is around $1.4 million and that is equivalent to approximately $10 per injection by local government. The invasive HIB infection caused 37 cases of meningitis in 1992 and a similar number of other diseases such as epiglottis, arthritis and pneumonia. Invasive HIB disease occurs almost entirely in children under five years and effective vaccines have recently become available. The Federal Government's decision to provide free HIB immunisation to children born on or after 1 February 1993 was later extended to cover all children under the age of five years on 1 February 1993.

As of 1 September 1993, contracts having been awarded and national suppliers identified, a comprehensive program to immunise all children under five years began in South Australia. Over 15 000 doses of the vaccine have been distributed so far, mostly to infants under 12 months of age. CAFHS distributes this vaccine via local government to all service providers. CAFHS has been distributing a range of other vaccines free at point of use for four years. CAFHS is planning to increase its role with the provision of immunisation services across the State beyond the service it has provided under contract in Salisbury for the past three years.

Mr ATKINSON: My next question relates to page 499 of the Program Estimates. How much will be spent this year on preventing HIV/AIDS; and how many people does the Health Commission expect will contract HIV/AIDS in South Australia this year?

The Hon. M.J. Evans: In this financial year $6.51 million in specifically funded program costs will be spent on the treatment and prevention of HIV/AIDS in South Australia. In this State we have experienced a drop in the rate of infection since a peak in 1989, although the more recent figures are not so hopeful. In South Australia so far HIV infection has been restricted generally to the acknowledged high risk groups. Between 85 to 90 per cent of HIV infection results from male to male sex. There was a fall in the number of HIV infections and cases of AIDS notified during 1992 but this has not been sustained in the early part of 1993. In some other developed countries injecting drug users contribute a much higher proportion of infection than in Australia.

Internationally the AIDS epidemic continues to grow with two women being infected with HIV every minute worldwide. The control of sexually transmitted diseases is an important part of reducing HIV transmission and involves successful clinical services, including testing and counselling, education programs for health professionals and school students and periodic, carefully targeted campaigns such as the recent safe sex campaign. The STD control branch provides a comprehensive clinical service for 16 000 attendances and clinical staff respond to 20 000 phone calls annually, attendances having increased from 8 300 in 1987. There is 1.5 days training for all fifth year medical students, two day seminars for general practitioners on the clinical management of HIV infection, clinical STD training for 24 general practitioners annually, support for training programs conducted by the Family Planning Association, SAPMERE and other health institutions, and education programs for school teachers and senior high school students. In 1992-93 the branch developed a staff appraisal system, a staff satisfaction assessment system, and an Occupational Health and Safety program for staff and, in addition, the branch maintains on the ongoing systems to monitor syphilis, gonorrhoea and chlamydia and HIV infection in the State, provides a consultancy to general practitioners on the interpretation of diagnostic tests and patient management, and conducts contact tracing for all notifiable STDs detected in the State. There were 800 such cases investigated in 1992. The branch participates in international research projects such as the AZT trials and treatment trials for other STDs, produces technical bulletins for use by general practitioners and others involved in STD control, and in response to unmet demand the branch now provides an emergency contraceptive service.

Mr ATKINSON: I refer to page 491 of the Program Estimates: '1992-93 specific targets—completed the establishment of the Pregnancy Advisory Centre'. The Mareeba Pregnancy Advisory Centre is located at Woodville in the electorate that I represent. Its chief function is to provide legal abortions, especially abortions after 12 weeks of pregnancy. Members of the Woodville and Findon Catholic parish and other Catholics who object to abortion pray the rosary for one hour each month on the footpath on Belmore Terrace outside Mareeba. They recite a series of prayers lasting for about 60 minutes which would be inaudible inside

the Pregnancy Advisory Centre. They do not step inside the grounds of Mareeba nor do they approach or canvass clients of the PAC, most of whom enter by motor vehicle from the Harvey Street entrance.

The Director of the PAC allows a group called The Friends of the Mareeba PAC to meet at the centre. During the August prayers, two women, as yet unidentified, left the PAC, walked through the grounds and outside to the footpath where they verbally abused those who were praying. The two women then ripped from the hands of those who were praying an altar cloth appliqued with the words from the book of Isaiah, 'I have carved you in the palm of my hand.' The women then ran back into the PAC with the altar cloth.

The matter has been raised with the police, but the altar cloth has not yet been returned. Will the Minister contact the Director of the PAC with a view to the altar cloth's being returned to the owners, and will he tell the Director of the PAC that the Government expects that individuals and groups permitted to use the centre ought to respect public prayer outside Mareeba's boundaries that is not otherwise unlawful?

The Hon. M.J. Evans: I understand and acknowledge the honourable member's concern and interest in this area, which has been longstanding: he has often raised matters with me about this area, and I respect his views. The right of citizens to non-violent protest where this does not interfere with the rights of other citizens must be respected whether or not one agrees with their viewpoint. I think it is unfortunate that an incident such as the one the honourable member describes has taken place. However, I would be very surprised if it were sanctioned by the Director of the centre. I am happy to pass on my concerns about the nature of that incident to the Director to see what can be done to ameliorate any views that may originate from the supporters of the centre, because I would expect the same standards of non-violent protest within the law of South Australia as others have shown.

I am sure that this was an isolated situation, and I certainly hope that it will not recur. I assume that the matter is in the hands of the police, who will no doubt continue to investigate and hopefully procure the return of the missing item. In general, I will make known to the centre the nature of the honourable member's request to see whether anything can be done to assist in the matter. I am sure that this matter was not officially sanctioned in any way by the centre.

Dr ARMITAGE: Page 485 of the Program Estimates indicates that the proposed recurrent expenditure for 1993-94 is $1 385 876 000. On the first page of the blue book the proposed estimated recurrent expenditure for 1993-94 is $1 351 201 000. What does the $34 million variation represent?

The Hon. M.J. Evans: I am informed that again this is a technical accounting issue. Notional interest on borrowings by the commission makes up the substantial component of $34.536 million. I am somewhat embarrassed to say that the remaining very small component represents my own salary.

Dr ARMITAGE: I do not accept that answer. These two figures are proposed recurrent expenditure for 1993-94, and there is a $34 million difference. There is no accounting change. Those figures are provided to the House as proposed recurrent expenditure for the year, and the two budget papers show a $34 million difference.

The Hon. M.J. Evans: It is quite true that there is a $34 million difference, and I just explained that. The difference is a notional interagency support service, which is not actually paid for, but for accounting reasons it is desirable that we should notionally set aside the amount of interest on borrowed funds so that we know what that amount is. The amount of money for interest costs is notionally allocated but not actually paid as it is an interagency figure. We would simply be going around in a circle, so there is no point in actually transferring cheques. The notional amount is $34.536 million for interest and a very modest amount for the Minister's salary, which is paid to me but which is not allocated through the overall budget. That accounts entirely for the difference between the two amounts.

Dr ARMITAGE: Whilst I accept that the Minister's salary is indeed modest, I am still unclear as to why, on two summary pages, given all those differences, be they relevant, the same figure was not given to the community to assess the proposed recurrent expenditure. There is nothing in the proposed recurrent expenditure which deals with accounting variations or anything else. This is a bald figure which tells the community of South Australia what the South Australian Health Commission, under the Minister's responsibility, intends to expend in a recurrent manner for the year, and we have two different figures.

The Hon. M.J. Evans: This situation has existed since the original calculation was made. These figures are simply designed to provide information. One represents actual payments, one represents actual cash, because the Health Commission works on a cash accounting basis, and we provide for actual cash. An interagency support cost is not actually paid but is notionally calculated in order that we may know what the interest bill is. It is desirable for the Parliament and the community to know what the interest bill is—and I am telling you that the interest bill is $34.536 million. However, we do not actually transfer that as cash. We spell it out on page 489 of the book. The interagency support service is not paid for, and I would draw the honourable member's attention to it on page 489, which shows that it is done on a cash basis. It shows the $34.536 million figure so that Parliament may know what the amount would be. It would be ridiculous for us to pay the figure in a circular fashion, but we set it out so that you may know what the amount is, plus—as the member and I have agreed—a modest salary provision for the Minister, which I assure the Committee is quite real and is paid to me.

Dr ARMITAGE: A footnote on page 1 indicates that motor vehicles are being treated as capital from 1 July 1992, which we have heard a few times, and as such I assume that in the 1992-93 actual capital column the sale of plant equipment and motor vehicles involves exclusively motor vehicles. That is the first time that has been recorded in any blue book in the past three or four years under that line: sale of plant equipment and motor vehicles has always been in recurrent expenditure. I assume that the $6 888 000 involves motor vehicles. However, on page 3, statement 3, of the blue book, there is an amount which I do not understand, 'variations funded by increased receipts—motor vehicles, $4.731 million'. Are those figures expected to tally? Are they the same motor vehicles, the same sales? What is the explanation for the different figures?

The Hon. M.J. Evans: The $6.888 was from the actual receipts from the sale of motor vehicles, whereas since we have been funded on a net basis the $4.731 figure was a combination of factors, because some health units had a carry-forward figure and wanted to absorb it in their own budget, which they have done. In other cases there was a budget variation and that is why there is a difference between the two: in some cases it was retained in the health unit, while in other cases there has been a budget variation. So, that is

why the figure is less than the other; it is simply a matter of how the unit wanted to treat the figure.

Dr ARMITAGE: I think I need to cogitate on that. I shall do that later. Relating to the Estimates of Payments and Receipts (page 180), I wish to address the question of the resource allocation model utilised by the South Australian Health Commission. In addressing the matter, I draw the Minister's attention to differing sums of money which appear to have been provided to different hospitals: is there any way that principles of equity and social justice are built into that allocation, given that particularly Queen Elizabeth Hospital has considerable difficulties in addition to some of the other demands on other hospitals because of the longer term problems caused by unemployment, and so on, in that particular area—in other words, some of their costs are not borne by other hospitals—and yet, as I understand it, the resource allocation model by which hospitals are given their funding does not take account of those differences?

The Hon. M.J. Evans: It is certainly the case that the output performance model does not of itself incorporate social justice criteria. However, the output performance model is simply a basis on which the calculation can proceed from there. So, the actual outcome in terms of the budget allocated to an individual health unit is then adjusted to take into account the commission's view of the environment in which that hospital operates, and other external factors, such as social justice.

So, the model is not followed slavishly or rigidly without variation. It is used to prepare a base from which other calculations can then be made and it is a very sound and useful base. However, I agree that social justice criteria should be more validly incorporated. It is a very complex issue and some work has already been undertaken on that. I would ask Mr Ray Blight to comment on that work so far.

Mr Blight: This matter was raised formally with the Health Commission's Clinical Case Mix Coordinating Committee and the point being put by the Queen Elizabeth Hospital was that, because it had a higher level of socially and economically disadvantaged clients in its catchment group, this led to a higher length of stay and therefore higher costs, and it sought some recognition of that matter. The Clinical Case Mix Coordinating Committee agreed to set up a subgroup to review that question, and there are Queen Elizabeth Hospital representatives on that group with the other major hospitals having observers, presumably to protect their own interests under the output performance model. The review work so far does show that the Queen Elizabeth Hospital has a high proportion of patients in the very low or low socio-economic status group. For example, approximately 75 per cent of their patients would fall into those two categories.

That contrasts with other parts of the metropolitan area, for example, the catchment for Flinders Medical Centre where only 45 per cent of its patients are in the very low or low category. On the other hand, there are other areas such as the catchment population for the Lyell McEwin Health Service where the proportion of patients in the very low and low socioeconomic group is as high as 87 per cent. Those factors are based on medical patients. The figures for surgical patients are much the same. However, when we look at the average length of stay by the socioeconomic groups, we find that for medical in-patients the average length of stay at Queen Elizabeth Hospital for the very low is 5.8 days; for the low, 5.8; for the medium socioeconomic disadvantaged level it is 5.6; and for those of high socioeconomic status it is 5.8. So there is virtually no difference in length of stay across the socioeconomic groups. Again, this is from medical in-patients and that pattern applies fairly well uniformly right across all of the metropolitan hospitals.

When we look at surgical patients there is wider variation across the various groups but there does not appear to be any correlation between length of stay and level of socioeconomic disadvantage. It would appear to be more a matter of the pattern of surgical procedures undertaken. At this stage it would appear that there is no justification for the Queen Elizabeth Hospital to claim that patients with low socioeconomic status have a longer length of stay than other groups of patients. That conclusion can be applied equally across all the major metropolitan hospitals. The question of whether the resource intensity of patient care within the length of stay is more intensive for those patients of low socioeconomic status cannot be determined as yet and the committee is yet to form a view whether there is further work that can be done on that question.

Dr ARMITAGE: I think I heard the Minister say that adjustments may be made, is that correct?

The Hon. M.J. Evans: I said that the output model produces a certain calculation result. That result is then adjusted up and down to produce a final budget outcome for the hospital in accordance with a range of other factors which would take into account perceived needs in the area as well. All I am saying is that the model is not followed slavishly or rigorously but is adjusted to take account of a wide variety of factors.

Dr ARMITAGE: Could I receive a list of the variety of factors that are taken into account?

The Hon. M.J. Evans: Some are judgment factors; some relate to historical issues at hospitals; some have ongoing funding requirements that have been past commitments and the like; while others would be perceived socioeconomic disadvantage. That was the point I was making: we do not follow a slavishly rigid model. This is about hospitals, patients and patient care. One cannot simply follow—as the honourable member would know only too well—a rigid and unbending pattern in these things. One has to take into account real needs, people's perceived needs and address communities as a whole, which is what we seek to do.

Mr HAMILTON: What is the incidence of prostate cancer and how prevalent is it amongst age groups from 40 years onwards? If one discussed prostate cancer with a sample of men selected from the community, I believe that few men are ever tested by their general practitioner for this disease. It was only in the past five years that I have been tested by a doctor for prostate cancer. When one talks to other men about this particular matter one finds that, in the main, they are not informed and they are ignorant in most cases about what is required for this examination. I am advised that the older men get, the more likely they are to develop cancer of the prostate. Further, what educative program is there for men in the community, carried out by the Health Commission and/or other authorities?

The Hon. M.J. Evans: In view of the technical nature of the question, I would ask Dr Kerry Kirke, who is the Executive Director of the Public and Environmental Health Service, to respond.

Dr Kirke: The honourable member is quite right: prostate cancer is a problem and in fact a growing problem in this State. He is also quite right when he alleges that the older a male gets the more chance he has of getting prostate cancer. The most recent Epidemiology of Cancer report published by

the Health Commission indicates that prostate cancer has the highest incidence of all cancers in men and is second only to lung cancer as a cause of cancer mortality. There is no formal statewide program as yet, although we are certainly considering developing one, and that would involve not only public awareness but also GP training, and I think the honourable member has brought up a good point.

Mr HAMILTON: I am pleased to hear that because I believe there is a terrible ignorance amongst men in relation to this matter. Some years ago, one of my colleagues in the Parliament—I will not mention him but he is now in the Ministry—spoke to me about this particular subject. I thought I was reasonably well-educated in terms of health but I was ignorant of this fact, so I believe there are many people in the community who do not understand what cancer of the prostate is all about. This matter is of critical importance, for obvious reasons. A matter that I know you, Mr Chairman, have a great interest in is the renal unit at the Queen Elizabeth Hospital. What is the waiting list for kidney transplants at the Queen Elizabeth Hospital, and what response is the Health Commission receiving in terms of drivers' licences, where people indicate that they are prepared to donate such an organ? I hope that it has increased.

The Hon. M.J. Evans: We will have to obtain those figures for the honourable member. I do not think that the donor rate is increasing at the rate we would like to see, and no doubt further work will have to be done on that. I discussed that matter with the Kidney Foundation a while ago to see what we could do to assist them with that problem. Certainly the drivers' licence program is one very positive way that we can assist. I will certainly find the specific information for the honourable member and in particular the waiting times for transplants at the QEH.

Mr HAMILTON: All members would agree that the vaccination of children is a very important issue. It is very disconcerting when one reads that there seemingly is an increase in the number of people, parents in particular, who are not prepared to have their children vaccinated against potentially fatal diseases. I refer to an article that appeared in the *Advertiser* of 23 June this year in relation to HIB. What educational programs are in train in terms of normal vaccination procedures and in terms of HIB?

The Hon. M.J. Evans: Australia and South Australia in particular is very fortunate to have very high levels of immunisation. CAFHS estimates that the levels of immunisation cover for South Australian children aged four years is greater than 95 per cent for all scheduled vaccines except HIB. On the other hand, I have also given some very detailed information earlier on about the HIB vaccine. Excluding HIB, in general we have over 95 per cent vaccination rates and, indeed, the national immunisation strategy, which is scheduled for implementation on 1 July 1994, will assist in promoting that, especially to children, and we will certainly have a statewide general immunisation promotion for children, which will certainly include the HIB vaccine in order to reduce any confusion and uncertainty that may exist among parents and medical practitioners about that vaccine.

On the whole, we can take satisfaction from the very high levels of cover in terms of vaccination, but as has been discovered in the United States, the fact that you have very high levels and therefore the threat recedes for a period of time does create windows of opportunity for disease to come back, and there are some terrifying examples from the United States of what can occur if that happens. So we need to maintain vigilance in that area, as the honourable member says, and continue from time to time to stress the need for vaccinations among children with parents and GPs so that we do not grow complacent as a result of our success.

Mr HAMILTON: When would any such educational program commence, and would that encompass boosters for poliomyelitis?

The Hon. M.J. Evans: I understand that a lot of work has just been completed with the Education Department, which work has included a substantial release of books, videos, pamphlets and so on, plus a general promotional campaign through the Education Department. A substantial amount of work has been done and will continue to be done on that area. The honourable member has what was the general campaign theme, I think.

The Hon. B.C. EASTICK: In providing the information that the Minister has promised to the member for Albert Park, I believe it would be worthwhile if the Minister could include some exposé of the effects within the population of South Australia of hepatitis C infections, which follow on from transplant surgery and/or in relation to blood transfusions. That is something which could come at a later stage unless the Minister has the specific information.

My question relates to the Auditor-General's Report (page 330), where the Auditor-General notes comments made by the Director of Government Management from the Office of the Government Management Board, as follows:

> The Health Commission does not have a documented strategic plan for information systems development.

What specific measures have been taken to overcome the absence of this strategic plan, which has been drawn to the attention of the Minister by the Auditor-General?

The Hon. M.J. Evans: I will first give a brief response to a question asked by the member for Spence in relation to the Mareeba Clinic and the incident that he related to the Committee. I understand that the two women were not members of any group associated with the PAC, nor were they using the service. So they were not affiliated with the service. In fact, they did not re-enter the premises: they sheltered on the porch and then made good their escape. So, they did not actually return to the inside of the premises. There may have been a misunderstanding, given that they sheltered under part of the building for a while—on the outside of the building. The Director is very concerned to ensure that such incidents are not repeated. But, certainly, the individuals concerned with that incident were not affiliated with the clinic and did not re-enter the clinic.

I return to the member for Light's specific question. The information resources management strategy, which is otherwise known as Info 2000, is a project aimed at developing new information policies and strategies for the health system to the year 2000. The project commenced in February 1993 and is due for completion in October this year. The key elements of the project are the assessment of the current positioning of information technology, assessment of issues impacting on future strategies, summary of information needs, assessment of strategic options, development of an architecture for future development, strategy for the way forward, management of the change process, and a focus on process, innovation and improvement.

The project will provide a framework to ensure that individual health units' strategic information technology plans are developed on a consistent basis and correspond with overall system plans. The firm of Ernst & Young was selected to provide consulting assistance following the issue

of a brief to seven firms. Ernst & Young has undertaken similar studies for other States. A policy and strategy committee has been established as a steering committee for the project, which includes membership of CEOs from a range of units, executive directors of the commission, senior clinicians and representation from the Information Policy Unit of the Premier and Government Management.

The Hon. B.C. EASTICK: I refer to page 3 of the blue book. Will the Minister explain the variation in Commonwealth funded programs in relation to highly specialised drugs, which appears as a negative figure of $3 277 000?

The Hon. M.J. Evans: I understand that the original amount was included in our budget based on the estimates in the Commonwealth budget and the white paper on high cost drugs, but we were funded on actual use. Because these areas are difficult to estimate in advance, when the actual use was tallied up at the end of the year there was a variation to be made. So, the original estimate was based on the Commonwealth's own estimate, and that turned out to be higher than necessary. When the actual use figures were determined at the end of the year, a variation in the amount had to be produced because we were funded on the actual use costs.

The Hon. B.C. EASTICK: The Auditor-General's Report at pages 330 and 331 deals with the altered arrangements for workers compensation, and states:

> The purpose of the exercise was to remove the inherent disincentives that existed in previous administrative arrangements. . . and lowering the overall cost of workers compensation in the health sector.

The Auditor-General's Report indicates that the commission received the findings from the Auditor-General's review into the management of workers compensation in August 1993, and this review was further to one in 1992 which suggested that, while progress has been made in certain areas, further action was still needed to achieve the full benefits of the internal audit's initial recommendations.

The August 1993 report indicates the need for improved reporting of timely, relevant and accurate information; regular reporting of liabilities for outstanding claims; and regular reporting of statistical data to the commission. It states that the target set by the commission of limiting workers compensation claims to 2 per cent of total salary was not achieved. In fact, it was actually 2.7 per cent. What progress has been made further to the report of the Auditor-General's finding, and why was the commission's target for workers compensation claims as a percentage of total salary not achieved? What were the 'inherent disincentives' that existed in previous administrative arrangements to which I referred earlier?

The Hon. M.J. Evans: As members would know, the Health Commission is an exempt employer under the Workers Rehabilitation and Compensation Act. There are about 120 health units representing 24 000 full-time equivalent employees involved in the commission's workers compensation program, each with its own chief executive officer who is responsible under the legislation for workers compensation and occupational health and safety.

In 1992-93, workers compensation claims paid to employees of the health system reduced by $1.6 million to $23.6 million; the total cost of the program reduced by $5.1 million to $28.5 million; the number of new claims opened reduced by 374 (or 7.9 per cent) to 4 053; and the estimated outstanding liability for workers compensation claims remains static, which represents a reduction in real terms.

In 1992-93 there were 196 stress claims under the commission's workers compensation program—10 fewer than the previous year. There has been a total of 945 stress claims since WorkCover began in 1987 at an average cost of $9 000 per claim, and stress claims account for 10 per cent of the total cost.

It is relevant at this point to turn to the Auditor-General's Report, because he conducted an audit of the Health Commission's workers compensation program during 1992-93, and a summary of the findings was included in the Health Commission's section of the annual report. The Auditor-General drew attention to the need for improved reporting to the commission of timely, relevant and accurate financial and non-financial data. The commission accepts the criticism that the reporting needs to be better, but the reality is that we are reliant on others, our insurers, to provide that information.

The Leader of the Opposition, in a recent speech in the House, chose to quote from volume 1 of the Auditor-General's Report, on which I have just commented. He went on to make the accusation that the Health Commission and I, as Minister, had been supplying false, incorrect, untimely or irrelevant information to the Auditor-General on both financial and statistical matters. That totally misunderstands and in many ways misreports what took place. The need for improved reporting was to the commission from the commission's insurers, not the information which I, as Minister, or the Health Commission was providing. Therefore, that misunderstanding on the part of the Leader of the Opposition needs to be cleared up. I totally reject any allegation that the data were false, incorrect, untimely or irrelevant as provided to the Auditor-General. That is not the case and it does not represent the facts that the Auditor-General was reporting. He was merely commenting on the need for improved reporting of that data, with which we certainly agree, but that is the responsibility of our insurers.

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

[Sitting suspended from 1.28 to 2 p.m.]

Department for Family and Community Services, $151 624 000.

Departmental Advisers:

Ms A. Dunn, Chief Executive Officer, Family and Community Services Department.

Mr J. Barrett, Director, Agency Services.

Membership:

The Hon. D.C. Wotton substituted for Dr Armitage.

The CHAIRMAN: Before the Committee proceeds, I make the point that members may see a television camera or cameras in the galleries behind me during the afternoon. This results from a request that was made from the media to the Speaker that they be allowed to film from a position which is not normally allowed when the House is in session. The Speaker has taken advice on it and is in the process of issuing a statement which indicates that this is not to be taken as a precedent for the sittings of the House; but, while the Committee is in session, for general background material, the cameras can occupy the gallery for a very short period of time. That matter will be looked after.

The Hon. M.J. Evans: We are living and working in times of great change and great challenges and agencies in the public sector find themselves at the centre of a number of reform agendas. While the restructure of the State's economy

to achieve international competitiveness is certainly at centre stage, agencies such as Family and Community Services are also key players in achieving reforms which will take South Australia into the next century.

Traditionally, and in many respects by stereotype, agencies such as Family and Community Services have been seen as the economic liabilities for the State, least concerned with or attuned to the economic focus. On the other hand, agencies with direct links to the economic agenda have been seen as important assets.

It is time for Government in South Australia to acknowledge that such a perspective is both inaccurate and unhelpful: unhelpful, because it is out of step with the international trend away from the primacy of economic rationalism. Social development agendas are now taking their rightful place alongside economic and urban and regional development strategies. Inaccurate, because agencies such as Family and Community Services have actively and fruitfully undertaken structural reform based on economic imperatives to achieve better customer outcomes. It is a matter of record that the department, through its restructure, is doing more with less and that staff have embraced change positively and refocused themselves.

As a Government and as a community, we must recognise the work of the department as value added activity. We only need to look at the profound effects of violence on families, the significant costs in providing human services for the victims of domestic violence and the resources consumed in terms of the police and the criminal justice system to understand the value that prevention programs add to our communities both socially and economically.

The estimates for 1993-94 for the Department for Family and Community Services must be understood in the context of the recently released strategies document. That plan is underwritten by three very important principles of best practice:

1. Refocusing planning and policy on the areas where people live and work through a reaffirmation of district centres as the key players in a local area planning context;

2. Constructing new partnerships and alliances within Government and the community sector based on improving customer service outcomes thus making the fundamental distinction between means and ends; and

3. Reshaping programs to reflect the changing expectations of communities.

In service delivery, the theme is very much one of achieving balance. In services to families and children, there is more program focus on early intervention and prevention. This is a reflection of the worldwide trend towards family preservation balanced with the State acting on its responsibilities to intervene to protect children. Getting the balance right is one of the most consistent messages coming from the community and one of the most important challenges facing welfare agencies around the world.

In its work with adolescents at risk, the department seeks to balance supporting families with the need to provide alternatives for young people when staying or returning home is an impossible option. Crisis financial services are balanced with the need to develop prevention and community development projects which will ensure more enduring and more dignified outcomes for those at risk of or in poverty. The department also seeks an appropriate balance in its responsibilities to the aged, frail aged and people with disabilities and their carers. The focus is not about defining them into disadvantage but into recognising that in some cases they are vulnerable through violence, through poverty and through loss of family and community support.

As we prepare for the next century, the essential challenge is to move away from the crisis orientation and the stigmatisation of welfare services. The future is about locating them in an inclusive framework which supports the role of all families and builds on the strengths of our communities to care and respond. That challenge must be balanced with the need to maintain crucial safety net services for the disadvantaged and the vulnerable. The corporate approach of the department for 1993-94 fully reflects that balance of responsibilities. It remains a key player in the Government's social justice strategy with some $109 million of this budget, an increase in the order of $8 million, identified as directly providing services to these most disadvantaged.

There is clearly no retreat from the department's commitment to dealing with the day-to-day issues of disadvantage. At the same time, the department is promoting new and different approaches which will galvanise individual and community strength to fight the structural disadvantage which sustains the cycle of poverty, isolation, disruption and despair. The corporate approach taken by the department is evidence of a revitalised and refocused team striving for best practice and able to take up its role as one of the lead agencies in shaping the focus for South Australia to mark the International Year of the Family.

The Hon. D.C. WOTTON: This budget shows a reduction of between 2 per cent and 3 per cent in funding available for some community services. This is despite the Premier's assurances that services would not be cut as a result of a reduction in resources. Those people hardest hit are from the country and the north-eastern region of the metropolitan area—the areas with the greatest need, with people in the country facing extreme pressures and in desperate need of all forms of community services at this time.

Child abuse workers are understandably concerned because victims of child abuse are not receiving the attention they deserve purely because there is not the staff to deal on a day-to-day basis with basic child protection needs. Is it any wonder that they are threatening strike action. All of the non-government agencies are continuing to report unprecedented demands on their service with less and less support from Government. The Adelaide Central Mission now operates Lifeline entirely at its own expense due to the withdrawal of Government funding in the mid-1980s. Now that Crisis Care operates for only limited hours, the recorded message on its answering machine refers callers to Lifeline. Without Lifeline to share the burden of responding to crisis both Crisis Care and local officers of the Department of Family and Community Services would be overwhelmed.

It is an anomalous situation that this organisation, which during the course of 30 years has provided 10 950 days of continual service and dealt with over 360 000 telephone calls, in addition to over 75 000 face-to-face counselling appointments, should be sharing this Government work with no funding support at all from the Government.

Other agencies such as the Salvation Army and St Vincent de Paul, to name just two, are also experiencing massive increases in demand. St Vincent de Paul received 2 008 calls in August in comparison with 1 431 in August 1992. Many of these agencies are now finding it necessary to make inroads into their limited reserves which, in most cases, are certainly not extensive.

People affected by adoption have had their post-adoption services stopped due to a lack of ongoing Government

funding. DOME (Don't Overlook Mature Expertise) has continued to provide what is essentially a welfare function in that it entails a very intensive one-to-one handling of people who are emotionally distraught as a consequence of unemployment. Despite the fact that 648 returned to the work force in 1992-93, many with the help of DOME, it has been informed that FACS cannot see its way clear to further fund it.

In 1988, 1 321 people sought financial counselling from non-government services. Last year 6 011 sought assistance. Funding from the Government for this service increased only in line with the CPI. The client case work numbers have increased by 360 per cent. The Government has promised a paltry $2 million to rehabilitate gambling addiction as a result of the introduction of poker machines in hotels and clubs. Community service agencies have been told that they will have to prove the need for funds before they become available to help these people. Funding needs to be made available now to ensure that a rapid response can help to prevent the development of another huge social problem rather than wait to respond to one which will have already blown out.

The Government, to a very large extent, has abandoned the very people who have depended on it most. This further cut in community services this year will mean that this Government has reduced by $10 million the money available through Family and Community Services to the underprivileged in the past three years. Up to now these cuts, to a large extent, have been met by efficiency savings within the department. Additional cuts will mean a reduction in departmental staff and further cuts to voluntary agencies.

People working in community services are only too aware that at times when unemployment is high the demand on welfare support is also high. Unemployment and economic recession takes a very heavy toll on families. In this opening statement I have referred to only a few of the many concerns that have been expressed to me by both Government and non-government agencies. I will address many more by way of questions to the Minister.

I am informed that a considerable amount of funding has been provided to cover the cost of the re-organisation of offices and staffing in the department's central office. Can the Minister advise how much has been allocated for this purpose or spent and why? I am informed that the amount is about some $600 000. Bearing in mind the concern that I expressed in my opening statement regarding the lack of resources for areas such as child abuse and the lack of financial help for the non-government sector such expenditure would be a disgrace.

The Hon. M.J. Evans: Substantial work has been undertaken in relation to the city centre or head office building, the total cost of which was $534 000. However, I think that should be seen in the context of why that work was done and what savings it will permit. Often it is necessary to spend some funds to reshape buildings that are no longer relevant for the purposes for which they were first acquired, in order to allow additional staff to be relocated from other areas. For example, the city centre alterations have allowed the Children's Interest Bureau to be accommodated within the city centre with resultant rental savings in the Da Costa Building; the combination of units previously occupying fragmented accommodation within the building and the establishment of the two new divisions into contiguous space; the more effective utilisation of space while improving working conditions for staff; the partial separation of FACS and the Health Commission to dedicated levels within the city centre; and the potential for further rental savings to be achieved by relocating additional units to the city centre.

We expect that this will be a cost-effective change and that we should be able to recoup much of, if not all, the costs incurred to date. So, that work has been undertaken, but it has been undertaken in what is expected to be as cost neutral a framework as possible to improve service delivery, staff effectiveness and staff working conditions within that framework of no overall impact on revenue.

The Hon. D.C. WOTTON: I question the expenditure of that money at this time. I do not believe that the information the Minister has provided to the Committee makes it any easier to understand how $534 000 can be expended in that way when there are so many needs within the department.

The Hon. M.J. Evans: If the $534 000 was spent on its own without any regard to offsetting advantages, I would understand the honourable member's concern, but it is perfectly reasonable in this climate of change and structural reform to seek to make changes to accommodation where people can be relocated from other rental accommodation for which ongoing rental costs are having to be paid, to bring those people back to head office, to consolidate the department's operations and to improve staff effectiveness. I think this is not a case of simply large expenditure with no balancing offsets, and I think it is important that those long-term balancing offsets are kept in mind.

The Hon. D.C. WOTTON: I understand that a light plane was chartered in I think late March this year to enable the Chief Executive Officer and members of the senior staff to travel around the State visiting regional managers. I further understand that this followed soon after a one day briefing of many of the same managers at Patawalonga. Will the Minister provide details of the officers who were on this charter; the cost of the exercise, including the cost to charter the plane and the accommodation cost; and will he indicate the reason for this exercise?

The Hon. M.J. Evans: I understand that the trip which the member detailed took place. It is essential that chief executive officers, especially those who are relatively new to the department, familiarise themselves with the department's operations throughout the State to allow staff to meet with them, to allow staff to talk with the CEO about changes which are occurring, and this has taken place in the context of a period in the department's history of substantial change. It is vital that the CEO, who is to provide leadership in these matters, is able to meet with the staff concerned, the staff are able to speak with her in this case to satisfy the information needs of the staff, and that the CEO is fully apprised exactly of the conditions, particularly in the country areas of the State. I am sure that country people, in particular, would be very concerned if CEOs remained in Adelaide and did not venture out into the country areas of the State to find out exactly what is happening out there.

As Minister I have sought to travel extensively through the country areas, visiting hospitals and FACS units throughout the State. It is essential that Ministers and CEOs do this to familiarise themselves with the process. In order for that to be achieved in as cost effective a manner as possible, bearing in mind that the CEO's time is very valuable, it is essential that this is done in an effective and expeditious way. Quite often, the chartering of an aircraft, especially a light aircraft, within South Australia is far more cost effective than taking separate commercial flights where you wish to travel to a number of different country centres. That is certainly what was done in this case. Indeed, select committees of this

House often travel in that manner, as did members of the Juvenile Justice Select Committee. They were able to see far more, meet with far more people and save on staff time because the CEO was able to return to Adelaide much more quickly. That trip needs to be seen in that context.

The people who attended in addition to the CEO included the Manager of Aboriginal Advocacy, the industrial relations officer, the Director, Family and Community Services, staff counsellor, the Executive Director, the Deputy CEO and administrative support. Those people all had essential roles to perform in this process. I would not expect it to occur frequently, but in the context of the appointment of a new CEO and in the context of the changes taking place, that was the most cost-effective means of honouring our obligations not only to rural South Australia but also to the department's staff and clients.

The Hon. D.C. WOTTON: Will the Minister provide the details associated with both the costs of the charter and the costs of accommodation, and so on?

The Hon. M.J. Evans: Yes.

The Hon. D.C. WOTTON: The officers and the managers whom the Chief Executive Officer and those other people visited were not the same in many cases as those with whom she had the opportunity to meet just prior to that trip at a one-day briefing.

The Hon. M.J. Evans: Certainly, I understand that some managers had been present at that one-day briefing. But the managers are not the people we are principally concerned with here: the managers often have contact with the CEO. A lot of staff in the country areas are not managers. The whole idea, of course, is that you have field staff who are providing direct service provision, as distinct from managers of district offices who would have had contact in any case with the CEO in head office. It is very important—indeed, more important—that the CEO and the Minister, for example, have contact with the staff at all levels, particularly with field service staff who provide that service directly to the public, that the CEO meet with these people and they meet with the CEO, and that conditions on the ground are able to be observed.

So, while it is certainly the case that the CEO would have met some of those managers at these regular briefings, they were not the group to which this was principally directed. The managers are frequently in contact with the CEO and to visit them alone would have been an absurd exercise. This is principally about the staff of the department and the communities in which they live and work. For example, all the local councils were also visited in that context. As I said, the communities in which they live and work were an equally vital part. The fact that some of the managers would regularly meet the CEO, in any event, I understand and acknowledge.

The Hon. D.C. WOTTON: I understand that a number of people from the department are on leave without pay. Who are these people? How long has each been on leave without pay and why? Which of these people has been offered voluntary separation packages and why? Will the Minister provide details regarding such voluntary separation packages?

The Hon. M.J. Evans: We will take that on notice, given the detail required by the honourable member. I assume that the honourable member would not want us to provide the name of the staff in a public forum such as this.

The Hon. D.C. WOTTON: I would like the names provided.

The Hon. M.J. Evans: Given those reasons could be quite personal and involve family circumstances as to why one would be on leave, to publish that information with the names would be a matter of concern. I could provide that information privately. One could provide the general statistical data for the Committee, but I would be concerned if we were seeking to publish the names and personal circumstances of staff members in a public forum such as this. However, I will certainly liaise with the honourable member to seek that, but I would indicate to the Committee that I would have some difficulty in doing that in a public forum in relation to the personal circumstances of staff members.

The Hon. D.C. WOTTON: Can I just indicate to the Minister that I would be perfectly happy to discuss that matter personally with him as far as the names are concerned.

Mr ATKINSON: Page 515 of the Program Estimates refers to the juvenile justice program. The broad goals of this program are to minimise re-offending and to protect the public through a range of strategies. One of the specific targets for 1993-94 is to develop alternative detention options. What is the department doing to provide suitable alternative forms of secure care for offenders?

The Hon. M.J. Evans: The honourable member is quite right to draw attention to this. Indeed, a number of alternative forms of detention are currently being developed by FACS implementation during 1994, and I will list a few of those. First, a home detention program is being developed that is based on the experience of successful overseas programs as well as that of the Department of Correctional Services. It includes elements of electronic monitoring, personal phone calls and face-to-face visits. Where the offender's family is unable to provide the necessary support, INC families may be arranged. This alternative will be available to the courts as a sentencing option upon proclamation of the Young Offenders Act, which was approved by Parliament earlier this year, and will also be used as part of an early release package.

Secondly, there are the outdoor challenge programs. Some wilderness programs have been very successful in providing challenges for young offenders and facilitating changes in behaviour and attitudes that are likely to impact on their offending. An outdoor challenge program is being developed for youths currently on detention. The goals for that program are for the youths to learn new skills in a constructive way within a challenging environment; to develop new behaviours with guidance from youth workers with the aim of transferring these behaviours to the community upon their return; to develop social skills and increase self confidence and esteem; and to gain an increased awareness and ability to take personal control over individual behaviour and destiny. A key component of the outdoor challenge programs will be the preparation and post-program transition process. This will maximise the positive effects of the camp and ensure the transfer of the skills.

A further example is work camps. One of the emphases of the Select Committee into Juvenile Justice was the importance of reparation to the community. This not only gives the sense of 'putting back into the community' or restoration, but also provides the community with a more tangible punishment than incarceration. The work camps provide a more concentrated penalty than spending months in detention, and may have beneficial side-effects such as skill development and a sense of achievement. The key elements of a work camp program are: the possibility of a shorter period of incarceration than detention, labour intensive work and a high level of structure. This program better suits the older (say, 15-plus), more entrenched offender rather than the younger adolescent and may be particularly

effective with the entrenched offender who may no longer see incarceration as a deterrent.

Mr ATKINSON: I have a supplementary question. Does the home detention for young offenders require the young offender to wear an electronic bracelet, as is the case with adult offenders on home detention?

The Hon. M.J. Evans: Yes, that is an option. Home detention has come about as a result of the recommendations of the Select Committee into Juvenile Justice that the range of penalties be extended, and home detention was particularly mentioned in the sentencing options provided in the Act and approved by the Parliament. One option for home detention would include the electronic monitoring, which would be subcontracted through Correctional Services, but of course the other alternatives are telephone calls or personal face-to-face visits, because it would depend on how long the period was, and one cannot assume that the programs would be identical to those at Correctional Services because, of course, we are dealing with young offenders here and one has to be more innovative about the nature of the programs and one has to make allowances for education and other possible work options. So, certainly one option is negotiation with Correctional Services about their technology, but there is a wide range of other options and the department would want to tailor the solution to the individual and their social needs, as well as their previous offending and the very nature of the offence for which they were sentenced.

Mr ATKINSON: On the same line of the program, the broad goals of the program are to minimise reoffending and protect the public. What measures have been taken to improve security in the youth training centres?

The Hon. M.J. Evans: The central tenet of our security remains good quality supervision to prevent absconding. That is the very definition of the security process at the training centres. However, physical design factors are important influences on both residents' behaviour and their ability to abscond. As to the sites that continue to be in use, Magill, which is the South Australian Youth Training Centre (SAYTC), the perimeter makes it difficult to monitor outside intruders, and the site is unsuitable in that respect. The size and nature of the perimeter fence make it difficult to monitor that. Changing population criteria, due to the opening of Cavan, rule out expensive high technology security modifications at SAYTC. However, significant improvements are being made by upgrading external fences and making relatively minor internal modifications, which include the upgrading of the security wiring or tiger tape on remaining fences and roofs. Stricter security monitoring has been instituted for all out of door activities and hospital activities. There is wire mesh on additional windows, for example, at the education centre and replacement of glass windows and other breakable materials in vulnerable areas.

As an alternative to that we can look at the new centre at Cavan. Construction of the new facility provided an opportunity to design a building with much better protection against attempted absconding and external infiltration than the existing centres because, of course, it is purpose built. This has been achieved without having to resort to highly visible security measures such as razor wire fences. All aspects of the building were designed with security in mind, such as an interior courtyard roof design to inhibit anyone jumping out onto it. Security measures at the centre include reinforced walls, ceilings and windows, electronically controlled sensors, alarms, lighting and camera recording, personal duress alarms and sensors, computerised security systems operating in all units concurrently, enabling all staff to be aware of what is happening in another part of the centre. But good staff supervision remains essential to complement these physical security features. While the possibility of absconding cannot be ruled out completely, Cavan's features will have a much greater deterrent and retardant effect than either of the existing two facilities.

Mr ATKINSON: At page 508 of the Program Estimates is reference to community development and planning, in particular the administration of grants through the Home and Community Care program. Has the additional funding provided to the Community Support Scheme Inc. during 1992-93 and the restructuring of the administrative and financial systems of CSI resulted in more or better services for young people with a disability and their carers?

The Hon. M.J. Evans: As the honourable member will know, CSI has an important role to play in the provision of services for people with a disability and for their carers. There was concern earlier about the position of the Julia Farr Centre in relation to its clients who have been on the CSI program and who presented with more needs than were originally anticipated. The Health Commission made available an extra $157 000 which, after approval from the then Federal Minister, resulted in a total of $409 000 in additional funds when matched with the HACC program for the 1992-93 financial year. That package has been fully taken up during the 1992-93 financial year, which allowed not only the resumption of services for affected consumers but also for additional people with severe needs to participate in the scheme. During 1993-94 approval has been given to increase the level of State funds to $500 000, resulting in total matched additional funds of over $1.3 million being available through the Community Support Scheme.

Several other sectors within the disability field are also looking at putting forward the State's share to further increase the funding through the CSI scheme during 1993-94. The South Australian branch of Disabled People's International recently ran a phone-in for consumers and carers using the scheme. Over 100 consumers responded and, although many had concerns about their access to and level of funds previously available, the majority felt that the flexible supports offered through the scheme were extremely beneficial. The report of the phone-in is now available to the public.

Over the past six months, the interim administrator who was seconded to CSI has reorganised administrative and financial management structures for the scheme, which allows for the participating specialist disability agencies to arrange longer and more flexible support contracts with consumers, and for more comprehensive and accessible financial and activity reporting for the specialist disability agencies and funding bodies as well as for each consumer. Service agreements have been arranged between CSI and each of the participating specialist agencies, and they detail such issues as eligibility criteria, level of funding, data collection and reporting.

Mrs KOTZ: In his opening address, the member for Heysen mentioned that the Government had promised $2 million to rehabilitate gambling addicts as a result of the introduction of poker machine licences in South Australia. It has been stated that the money will be provided to welfare agencies if a need is proved. Recognising that the then Premier, Mr Bannon, made a similar promise in 1984 when the Casino was established, what form will this assistance

take, and is $2 million adequate? Can the Minister provide any other details in respect of this matter?

The Hon. M.J. Evans: As honourable members would be aware, poker machines are not yet in place in this State, although the implementation date for that has been approved by the Governor in Executive Council. I believe that an announcement was made last week about the operational date, and it is quite soon: later this year in relation to the Casino and a month later for the clubs in general. It will take a while for that mechanism to build throughout the community and for individual clubs to be licensed for the use of the machines, and indeed for the use of those machines to become more common.

Naturally any program associated with the rehabilitation of chronic gamblers would be associated with a gradual build-up of that program. The department is discussing this with the relevant authorities in the gambling and gaming area as well as the non-government sector, because we would like to see the programs developed through a range of agencies: not simply through the department, but also through the non-government sector. We will continue to work with Treasury and those non-government agencies on the implementation of that program. I see no reason why that should not proceed as indicated. Of course, it will build up as the level of usage of the machines in the community builds up.

Mrs KOTZ: As a supplementary question, I realise that the question was directed specifically to the term 'poker machine', but I am quite sure that the Minister recognises the fact that the machines in place at the Casino at the moment are also of a nature that establish gambling addiction habits. Given that Mr Bannon, the then Premier, made that comment in 1984, I am quite sure that the machines that we have at the moment that have established this gambling addiction would have been a predilection for the statements that were made about the $2 million. I again ask the Minister to confirm that at this stage he is saying that nothing at all has been done in this area in relation to the initial $2 million that was talked about or in relation to any programs or strategies looking at gambling addiction because of the introduction of these machines into the Casino.

The Hon. M.J. Evans: That is not the case. The Central Mission already maintains a gambling counsellor, for example, who is able to assist people in this regard, and that position is funded through the department. Presumably the use of such machines is not yet as widespread as it will be one day. Therefore, the programs will expand to match the demand available to them and also the source of revenue to fund them, because until the machines are in widespread use the revenue does not come through.

Clearly, if no-one picked up the option for the machines, there would be no need for support services in relation to them, because the commitment was specifically in relation to poker machines. However, in the interim, given the current level of usage at the Casino, a gambling counsellor is available through the Central Mission, and that position is funded by the Government.

Mrs KOTZ: I refer to a Government announcement made during the second half of 1992, in as much as it would initiate an aged health strategy for older South Australians. I would also like to mention that, in the SACOTA *Update* of June 1993, this initiative has been mentioned under the aged health strategy, as follows:

> In our State budget submission last year we called for the development of an aged health strategy to deal with the many issues affecting the health needs of older South Australians.

It goes on:

> The Government told us that they agreed with this proposal and work on it would be initiated in the second half of 1992. Several of our other health recommendations were to be included in this strategy.

It concludes:

> Despite apparently getting very close on several occasions, nothing has yet happened. The aged health strategy is lost somewhere in the Citi Centre! We hope it will be found soon, so that the Government can avoid once again being 12 months behind in its promises.

What stage has been reached in the preparation of that strategy, what form will it take, and what are the main issues that it will address?

The Hon. M.J. Evans: I am informed that significant work on this is under way. Indeed, the Health Commission agreed to develop a health of older persons policy on 8 February 1993. Work on the policy is being undertaken jointly by the Health Commission and the Office of the Commissioner for the Ageing. A steering committee chaired by the Commissioner for the Ageing has been formed to oversee and coordinate the development of the policy. The membership of the committee includes representatives from hospitals, general practitioners, consumers, the mental health sector, the tertiary education sector, country regions, the non-government sector, home support services, disability and the future directions planning for health services.

It is proposed to conduct three consultations in country regions, one major metropolitan consultation, a phone-in and also to allow service providers and consumers to provide written responses to a preliminary issues paper. A series of focus groups are planned to provide more detailed information on specific issues to be included in the policy and the strategic directions document. Some of these focus groups could be on issues such as health promotion and illness prevention, mental health, community-based care, medication, hospital discharge, education and training for health workers, issues for people from non-English speaking backgrounds and for Aboriginal people. Work is certainly under way on the preparation of that policy. It is one to which the commission and certainly the Commissioner for the Ageing are committed and to which the Government remains committed.

Mrs KOTZ: Part of the question that I posed related to what stage had been reached in the preparation of that strategy. The Minister has stated that policy is being developed, and apparently that began in February this year. However, I take it that he is saying that that is as far as the development has gone at this time; that all other moves he is talking about are yet to be implemented—they are still at a projected time scale rather than at implementation or further advanced than the February development of the initial policy.

The Hon. M.J. Evans: It is expected that work on the policy will be completed by about March next year, which is roughly the 12-month time frame that one would expect for something that involves as much consultation as this. Of course, consultation is a two-edged sword. I believe it is a vital and essential part of forming a policy such as this, which affects such a wide and vital part of our community. Many people are involved, many interests have to be examined and many special interest groups wish to put a case. Consultation is necessary over a lengthy period but, of course, at the same time the consultation provides us with input from the community and ensures that all those affected by the policy will have a chance to have their say. It also ensures that

groups are allowed to own part of the policy, and it gives the community a much greater commitment to the policy as a whole.

Whilst I agree that it would be possible to generate a framework in this area more quickly, the reality is that to do it without the kind of extensive consultation and the detailed investigation that are proposed would be to leave an incomplete policy at the end of the process. With a completion date of early next year, I can assure the honourable member that it is well developed, but the more public phase of that project will necessarily come towards the end of the process.

Mrs KOTZ: The organisation DOME (Don't Overlook Mature Expertise) has been informed that Family and Community Services cannot see its way clear to fund that organisation further, which will mean that people most in need of that essential service will no longer have such services available to them. DOME has been particularly successful in this area, and I believe that, of the 648 persons returned to the work force in the 1992-93 financial year, the major part of this number have received the services of the DOME organisation.

I believe that DOME is the only community based organisation providing a service to the mature aged and disadvantaged unemployed and operates as a hands on results oriented group. Why has the Government made this decision which, quite obviously, will be to the detriment of our older unemployed?

The Hon. M.J. Evans: I understand that no decision has been made to discontinue funding through the Family and Community Services Department and, in addition, DOME (which provides quite a valuable service) also received significant funding through DEET SA. So, I am not quite sure to what the honourable member is referring. Certainly, no decision has been taken by us to discontinue that funding.

Mrs KOTZ: A letter has been received from DOME which states that it is concerned because it has been informed that Family and Community Services, in the words of the letter, 'cannot see its way clear to further funding of DOME'.

The Hon. M.J. Evans: I understand that it is not possible for it to have received a letter from us saying that funding is being discontinued, because it has not been sent. However, it has not yet been advised of its ongoing funding, although it soon will be. The answer is very clear: it has not received a letter discontinuing funding because no such letter exists. It does not exist because we will not discontinue funding. Funding will be continued. DOME has not yet received the letter that tells it that. I agree that it is awaiting its letter, but the absence of a letter does not imply a negative result. It will not receive a letter discontinuing funding, nor has it to date.

Mrs KOTZ: I want to thank the Minister on behalf of DOME, because I am sure it will be extremely pleased to know that its funding will not be cut. Talking about where DOME relates to the unemployed (and the initial question was a concern that funding was being cut), I would also like to relate to other organisations such as St Vincent de Paul. I know that many of these organisations are having considerable problems at the moment because of the nature of their service, which requires extra funding.

One request that was made from such an organisation was the suggestion that, with regard to the expenditure side of these organisations, the Minister could perhaps look at some exemptions to assist where statutory payments are concerned. One that was brought to our attention was to look at stamp duty on building transactions and vehicle purchases and registration. Has the Government thought about those exemptions as an assistance measure to these organisations that are providing a very valuable service to our community?

The Hon. M.J. Evans: I hope that we shall not be going through every community-based organisation and checking them one by one, because that would be a fairly long process. No decision has been taken to defund St Vincent de Paul. They will continue to receive their grant, as does DOME. There is no threat to either organisation.

Mrs KOTZ: That was a specific question.

The Hon. M.J. Evans: The answer is that they will continue to receive their money.

Mrs KOTZ: Will you consider those areas?

The Hon. M.J. Evans: That certainly is an option to be considered. My view is that it is better for the community as a whole that organisations should receive direct grants. Our contribution to direct grants to non-government bodies has continued to increase. The grant funding component of the department has continued to increase over the years as a percentage of the overall payment, and that is a good trend. I believe that as a whole it is better for organisations to know what they are receiving from the Government as direct grants. They then continue to pay the costs which organisations meet in the community. They often do that out of their grant funding. In some cases, where they pay tax or the like, it means that the money flows back into the system. However, everyone then knows where the totality of the budget stands and where the allocations are going. In my view, it is a healthier practice for people to receive an appropriate grant and then meet the normal ongoing expenses that an organisation has to meet. If an organisation had a need for a certain amount of funding, that would be justified in the context of the grant for that funding and it would be judged in competition with other agencies at the appropriate time.

I know this is done in certain circumstances, but as a general policy, if we are discussing this across the board, when you grant exemptions you are not able to judge them on merit against other organisations, because you bias the marketplace towards particular exempt transactions rather than general service delivery. For example, you might, by stamp duty exemption, encourage people into the purchase of property rather than some other provision of service delivery because rental does not incur stamp duty but purchase does. Therefore, you would bias the direction of the association. I think it is more satisfactory on the whole, from a management perspective, that they receive a grant for the service that they provide, which they justify in competition with other agencies and services on an ongoing basis. Exemptions tend not to give you that equity and level playing field. I acknowledge that there is a place for them and if particular cases are made we can examine them.

Mr HAMILTON: Before asking my question I should like to place on record my support for the Minister and his staff for going into the country and meeting country people. I lived most of my life in the country and I know that there is a perception, rightly or wrongly, that city folk forget about country people. I believe that the attitude of the Minister and of his staff in going out and meeting country people in regional and other locations is to be commended, rather than the cheap shot for political reasons that we have seen today in the Committee. I reject that sort of nonsense when we are dealing with the concerns of country people. I just wanted to place my concern on record, having mixed with country people for most of my life and since coming to this Parliament, as people know from my trips into the rural sector.

My first question relates to homeless youth. What services and funding are available through the restructured SAAP program for homeless youth in the western suburbs? Last year and again this year there was considerable discussion in the local *Messenger Press* about the aims and goals and, indeed, the amount of funding that was necessary for homeless youth, particularly in the outer western suburbs of Adelaide.

The Hon. M.J. Evans: I understand the honourable member's concern with respect to homeless youth in the western suburbs. The establishment of new services in the western suburbs is part of an overall restructure and reallocation of resources in the metropolitan area to ensure a more equitable and effective service delivery to homeless young people. The process of establishing these services has been through consultation with local community organisations. The new services will be administered by the Port Adelaide Central Mission and will provide a range of services from 24-hour supported shelter accommodation to outreach support for young people having difficulty in maintaining independent accommodation.

There has been an increase in funding to the western suburbs of $21 000, bringing the total to $510 530. Specific services funded are the Indo-Chinese Refugee Association, the Offenders Aid and Rehabilitation Services, Port Adelaide Central Mission, West Care 'The Lodge' and Red Cross 'Dunant House'.

In addition, there are metropolitan-wide services available to homeless youth and agencies working with them, which offer crisis accommodation, assistance in locating emergency accommodation, counselling, assistance to resolve family conflict and material assistance. These include St John's, Joyce Schultz, Westcare Crisis shelters in the city, Trace-a-Place, StreetLink and Inner City Outreach.

Mr HAMILTON: My second question is in relation to the grant for services for the aged. What is the Government doing for the aged in general and in particular with reference to the Age Line service and the Seniors' Car? In newsletters I put out in my electorate on a regular basis I make mention of the Age Line service, because it is an excellent service and I understand it is reflected in the number of calls received by that agency. Further to that, what discussions are going on between the Government and Consumer Affairs in relation to those people who set aside funds through different organisations for their funeral expenses? What protections are or will be provided for those people who have set aside that money in different private organisations for their burials? It is a critical issue, which I raised earlier this year with the Minister of Consumer Affairs, but it does impact on the aged in our community in particular.

The Hon. M.J. Evans: Age Line is a free and confidential telephone inquiry service for older people. Two full-time staff are available to provide information, to make inquires on behalf of the caller or refer the caller to a more appropriate agency. Age Line had a 13 per cent increase in inquires in 1992-93, as against over the previous year. The nature and volume of the inquires during 1992-93 was broadly broken down into areas such as accommodation, finance service, pensions and benefits (concessions was by far the major one), legal and health services, community-based services and leisure and recreation. The total number of calls was 3 670. Further information could be provided to the honourable member if he was interested in that.

Age Line staff presented 90 talks and visits to community organisations in the city and country during 1992-93, and promotion of the service was also achieved this year in two home safety and security expos during Law Week at four suburban shopping centres and at a two day retirement lifestyle expo. In relation to the prepaid funerals matter, that is primarily the responsibility of the Minister of Consumer Affairs. However, I understand that a working party has been established by that Minister to examine the issues associated with prepaid funerals. The committee is examining the issue now; a report is not yet available but is expected.

Mr HAMILTON: I take the Minister up on his kind offer to provide me with information. Again, in relation to Home and Community Care programs, what has the HACC program done to achieve its effectiveness and to allow it to consult with consumers and service providers about the direction and utility of HACC services?

The Hon. M.J. Evans: Discussions have taken place with the SA Health Commission and the Local Government Association resulting in the development of service agreements which will be entered into by the HACC program with each of its funded projects. The service agreements will contain information about the outcomes to be achieved by the project, the implementation of the HACC national service standards and the collection of service and financial data. It is expected that all HACC funded projects will sign a service agreement during 1993-94.

In order to rationalise and provide more flexible services, the HACC program has been involved with the Health Commission in discussions with its major HACC funded projects, the Metropolitan Domiciliary Care Services and the Royal District Nursing Service, in terms of their colocation, integration and amalgamation. Domiciliary care services have been encouraged to adopt alternative styles of service delivery using such options as purchase of services and brokerage.

The HACC support unit in conjunction with the HACC advisory committee has also undertaken extensive consultations regarding the current status and future directions of the HACC program in South Australia. They were conducted with consumers, both the frail aged and younger people with disability, their carers, PEAK community representatives, health and welfare bodies, public sector planners, major service providers, smaller service providers and with local government.

The HACC support unit now participates in the Family and Community Services regional planning and consultation process so as to provide more local and relevant linkages with service provision agencies and consumers. This will allow the unit to further address social justice and equity issues in its needs-based planning approach to funding. A major focus of the program over the past year has been the introduction of the HACC national service standards and guidelines with consumers and funded service providers. Certainly, I hope that the implementation of the standards will lead to better access to services, more effective and flexible service delivery, and the development of responsive processes to deal with complaints and disputes.

The Hon. D.C. WOTTON: With respect to compulsive gambling problems, I wish to pick up from where the member for Newland left off in her question asked of the Minister. The Minister indicated that he is aware of a person working with Central Mission to deal with compulsory gambling problems. The Central Mission is one of the organisations that has made contact with me and has asked me to ask the Minister what action he is taking to ensure that the service that is provided and the funding that is to be provided can

commence at the beginning of this year so, as I said earlier, a rapid response can help prevent the development of a huge social problem rather than waiting to respond to one, which by that time may have already blown out.

Can the Minister answer that specifically, because there is a need to be looking at that now rather than perhaps at the end of the financial year. Also, I understand that a parliamentary committee was appointed in May 1992 to report within 12 months on matters relating to compulsory gambling problems. Has that committee actually met? I understand that the Chairman has been replaced. Has that committee brought down a report and, if not, why not?

The Hon. M.J. Evans: The department funds the financial counsellors at the Central Mission, one of whom is the gambling person to whom I referred earlier. I am sure that additional funding would enable them to provide further services as and when the poker machine industry continues to expand. As yet, of course, the infrastructure is not in place. As the funding from that source of revenue occurs, then revenue will be available to spend on the services to which the honourable member alludes. When that occurs we will work with non-government agencies and Treasury to ensure that there is a flow of cash, as previously promised, to fund those services. That, of course, will be done in conjunction with the industry as it evolves.

While I acknowledge the issue of pre-emptive strike, which the honourable member raises in this area, the other reality is that the industry is not in place. The proclamation of the dates has only just occurred and we really do not know yet how that industry will evolve and what impact it will have. So, I think to design your services well in advance—while one should have in place a bit of a framework in that area and, as I say, we already have the counsellor there—the reality is that there is much to be gained by allowing the social support infrastructure to evolve at the same time so that we can actually respond in tune with the developments in the community.

I am not sure about the parliamentary committee to which the honourable member refers. Parliament is responsible for its own committees, and certainly as Minister I would have no authority over a select committee of the House, and nor would I want to have or seek any such authority. When and how a committee of the House reports is a matter for the committee. If that is the Social Development Committee (a standing committee) then, of course, that has charge of its own destiny. I am not aware of any other select committee of this House which is specifically established to deal with poker machines.

The Hon. D.C. WOTTON: As I said earlier, in May 1992, when this matter was before the House, it was indicated that a committee would be appointed to bring down a report on compulsive gambling problems, at a time when debate was in progress on this issue. Is the Minister aware of whether that committee was formed and whether it has met? I am informed that it was set up. I am informed further that the Chairman has just been replaced but we have seen no report from the committee.

The Hon. M.J. Evans: I understand the select committee of the Upper House may in fact be taking submissions on that matter at the moment. I really have no control over another place in relation to its select committees and I am afraid I cannot give a commitment about that. The honourable member may be better advised to discuss that with his colleagues in another place to seek information about their program.

I think it would probably be a little presumptive and inappropriate for me to comment on the proceedings of that committee, and probably contrary to Standing Orders. I understand the point which the honourable member makes is addressed by the current work of that committee.

The Hon. D.C. WOTTON: Further to that, I know that the matter is being addressed in the Upper House but I understand that a separate committee was established. I will seek more information about that. The Premier has indicated that he wants to see the new structure—and I am not sure what the new structure will involve but the structure that will eventually take in community services—in place by the end of the year or early next year. Has the budget taken into account any proposed savings or increases that may come as a result of the establishment of the new structure and, if so, where is it referred to; and, if not, why not?

The Hon. M.J. Evans: The budget does not take into account any possible changes to the structure of the department: that is a matter for the Premier to determine. It falls to Premiers to determine the structure of Governments, and any comment about the structure of Government would need to come from the Premier. I can assure the honourable member that the budget is drafted on the structure as it exists now and, of course, until any change is made naturally the budget will continue to be structured on that basis.

The Hon. D.C. WOTTON: I find it interesting that if a new structure is to come into place within the next 12 months the budget would need to address that particular issue. I understand what the Minister is saying, that the Premier has responsibility for the new structure, but some rumours have been circulating regarding the future structure. One of the claims being made is that CAMHS will be placed under the control of the Department for Family and Community Services along with other community based and driven organisations. Will the Minister provide some information on that matter?

The Hon. M.J. Evans: As I indicated, any change to a Government department would be determined by the Premier. A budget, of course, is effectively a snapshot of Government as it exists on the day the budget is handed down. If the structure of Government changes during the course of a financial year, as happens from time to time when administrative units are relocated or moved for greater efficiency or effectiveness, it is a relatively easy matter: the Public Finance and Audit Act provides for the change of administrative units and the relocation of the funding for that. Of course, members would be familiar with the annotations that appear in budgets each year saying, 'This unit was formerly funded through [such-and-such a line].' Those changes will always be made from time to time.

If the structure of Government is changed, it is relatively easy to reallocate the funds to different lines in the budget. Parliament then has the opportunity to review that when the next budget is presented. I am aware that there were a variety of rumours about a variety of things following the last restructure. These occasions for restructuring always provide the opportunity for such rumours; however, I think that people should not lose sleep over those kinds of issues.

The Hon. D.C. WOTTON: In the 1982 election policy speech an inquiry into poverty was promised to ensure that South Australian welfare services could most efficiently meet the needs of people in poverty. I do not think that that inquiry was ever carried out. If it was I have never seen a report, so I wonder whether that is the case. Does Adelaide still have the highest rate of poverty of any Australian capital city, and

what statistics can the Minister provide regarding this matter? A report, 'Having their say', prepared by the South Australian Youth Network, found that in June last year an estimated 48 per cent of young homeless people came originally from the country. How many young people are currently considered to be homeless and what percentage initially came from the country; what percentage of the homeless aged between 16 and 25 receive an income; what percentage are receiving some form of community service benefits; and what percentage receive no income at all?

The Hon. M.J. Evans: I have some difficulty in accounting for things that occurred two years before I first entered the Parliament. However, I will endeavour to find some information for the honourable member. The department has an extensive anti-poverty program that is based on the various field offices and, combined with the financial counselling services, it is quite effective in addressing the needs of people in this kind of situation.

Much of what the honourable member spoke about impacts on Federal Government income security and income maintenance payments and I will see what I can do to provide the relevant information for him. I am not into keeping statistics about whether Adelaide has a higher or lower level of poverty. It is a difficult issue to manage: one must take into account the different accommodation costs. What a level of income would provide you with as far as reasonable housing in Adelaide is concerned would not be applicable in Sydney. Clearly, income levels and actual costs must be taken into account. The variations between capital cities would make it difficult to determine that, but we will do what we can to provide the specific information requested by the honourable member regarding homelessness.

The Hon. D.C. WOTTON: I specifically asked the Minister how many young people are considered homeless in South Australia. I would have thought that the Minister would have that information. How did the Minister come to that determination of the numbers?

The Hon. M.J. Evans: Certainly, an exact census of people in that situation is very hard to determine because it depends on your definition of 'homeless'. For example, does one include homeless by choice or homeless by force of circumstance? A variety of factors need to be taken into account. Also, the period of time that a person is homeless and what one defines as homeless in terms of the nature of the accommodation are also important. There is some accommodation which I would define as homeless but, indeed, those who find themselves in difficult circumstances may not.

So, I am not quite sure that anyone will ever be able to provide the honourable member with the kind of precision that he is seeking. But I can say that there are about 150 young people in Supported Accommodation Assistance Program Services (SAAPS), who are mostly in transition from what amounts to homelessness but who may have left home for a variety of reasons, and one might find numbers of the order of 100 who are actually literally homeless, for one reason or another, and on the streets. But it is a very difficult thing to define, and the nature, reasons and purpose for their situation are not things that are easily determined. So, while we have some general parameters about this, one has to be very careful in interpreting the figures. In speaking with those concerned, it is not easy to determine just why that condition is as it is.

The Hon. D.C. WOTTON: Does the Department of Family and Community Services not have an official definition of 'homeless'? If it does, what is it?

The Hon. M.J. Evans: In a sense, the definition that we use speaks for itself: if you do not have a home, you are homeless. There are those who live in inadequate accommodation, which is what I spoke of earlier, such that the circumstances might well include accommodation of some kind but it may be of a standard which almost amounts to homelessness, and then there are those on the street who are literally without a home. 'Houselessness' is the in word for such things. I do not know quite what turns on a definition of 'homeless', because quite literally it is as it says.

Mrs HUTCHISON: I refer to the Program Estimates, pages 510 and 511. With regard to the recent large number of unexpected retrenchments which occurred in Port Pirie from Pasminco Metals BHAS, understandably that was a very traumatic time for families because of the way in which the retrenchments occurred. I am aware that concerns have been expressed about whether the level of counselling required could be provided. What counselling support did the department provide following those retrenchments?

The Hon. M.J. Evans: The social worker allocated to coordinate counselling support at Port Pirie has been actively involved in assisting a community group in organising a phone-in, which was conducted over three days in August. There has been a reluctance on the part of the people affected to seek help. The social worker is now home visiting in an attempt to both support these people and work with them in identifying their needs.

The office has been active in providing financial advice to retrenched workers and has assisted with the renegotiation of debts. A low budget video has been produced and will soon be available. It is intended that the video will be loaned individually and will also be shown as part of group activities. A booklet containing information about eligibility for benefits, available through Family and Community Services, the Department of Social Security and the Commonwealth Employment Services, has also been compiled. This book contains a lot of practical hints on what, when and how to do things. The social worker working in conjunction with the community group expects to establish an unemployed persons' support group in the near future. It is envisaged that this group will have an educative, job-seeking and support focus. Family and Community Services has encouraged a community response to this problem and is working closely with the community group that has representation from the union, Red Cross, Central Mission, Port Pirie City Council and the community at large.

Mrs HUTCHISON: That leads to my next question. I am constantly getting requests in my electorate offices in both Port Augusta and Port Pirie with regard to financial counselling. Can the Minister give the Committee an indication of what particular services are available in both Port Augusta and Port Pirie (and I realise he did to some degree give some information in that last response)?

The Hon. M.J. Evans: The services available in Port Augusta and Port Pirie include: the FACS Department providing financial counselling and emergency financial assistance at Port Augusta, Port Pirie, Roxby Downs, Leigh Creek, Yorke Peninsula and Mid North areas; the Spencer Gulf Financial Planning provides a financial counselling service on a fee-for-service basis; the Port Pirie Central Mission provides a budget advice service; the rural financial counsellors are based at Kadina and Clare; and emergency

financial assistance is also provided by a number of non-government agencies. Financial counselling training is being planned to increase the number of financial counsellors in Port Pirie and Port Augusta. In particular, four non-government agency workers will attend training in October. The training is being funded by FACS and will be provided by the Adelaide Central Mission, with the workers being supervised by FACS' senior financial counsellors for the first 12 months.

Mrs HUTCHISON: My final question deals with counselling for young Aboriginal people. One of the matters that arose during the Select Committee on Juvenile Justice was the fact that the families complained about a lack of counselling for children at risk, to prevent them from getting into an offending pattern. What assistance and counselling does the department actually provide to young Aboriginal people?

The Hon. M.J. Evans: This is a very important area and the services, in the way of counselling and assistance for young Aboriginal people, are provided through a number of means. The Applied Learning Centre is a joint FACS and DEET(SA) job training facility targeting Aboriginal adolescents at risk and offenders. Training includes workshop and environmental programs focusing on work experience, work ethics, employment processes, career options and ongoing training. The Country Aboriginal Youth Team is a diversionary program located at Port Augusta, targeting young Aboriginals. This program assists and supports the younger children to access existing mainstream youth programs as well as organising specific Aboriginal programs; and it provides positive adolescent role models for the children through an intensive adolescent support program and a young positive staff team.

The Metropolitan Aboriginal Youth Team offers Aboriginal offenders individual support and counselling while they are in secure care and through the transition from secure care back to the community. To assist the youth to settle back in the community they organise appropriate life skills programs, an intensive personal support person and substitute care (INC support) if needed. There is also a visiting officer to secure care centres, which provides for Mr George Tongerie to visit offenders in secure care, offering individual and group counselling. There is a variety of funding for non-government agencies, such as the Aboriginal Child Care Agency, Offenders Aid and Rehabilitation, the Aboriginal Youth Action Committee, family support programs and family care programs. The programs that are available in the non-government sector are also particularly important.

The Hon. B.C. EASTICK: The last report of the department indicated that there had been a fourfold increase in the past 10 years with respect to families seeking emergency financial help. In other words, we have grown from $499 000 in 1981-82 to $2 043 000 in 1991-92. The report indicated that more than 40 000 people were seeking emergency financial assistance. What are the most up-to-date details in respect of the number of people now seeking financial assistance, the amount paid out during the past 12 months and the amount budgeted for the next 12 months to provide emergency financial assistance?

I ask that against the background of the information provided on page 188 of the Estimates of Payments and a series of areas relative to financing under headings which do not altogether fit into emergency financial assistance. There is payment of emergency financial assistance of $1 869 000 estimated for 1993-94 and a series of other payments, including family maintenance orders of $5 million. Is that family maintenance through the Federal Family Court? Is there integration of these features? Burials are also a form of emergency assistance, and for some reason that area amounted to $327 575 (actual) in 1992-93, while the sum is reduced to $219 000 for 1993-94.

The Hon. M.J. Evans: The honourable member has covered a range of areas in the general topic of general emergency financial assistance. An important part of the department's program is the demand for emergency financial assistance payments. The number of people requiring emergency financial assistance only once remained about the same as the for the previous year, but there were significant reductions in the total number of payments made as a result of reduced repeat applications. The reduction in the repeat applications can be attributed to comprehensive assessment and response to the customer situation and the use of interventions with a mix of payments, loans, financial counselling, education and supported access to goods and services.

The more thorough and flexible approach to the provision of financial support has provided better outcomes for the customers or clients by resolving their financial difficulties rather than continuing their reliance on direct assistance. To provide more detail, there was a 25 per cent reduction in the total number of repeat applications and a 70 per cent reduction in the number of people requiring more than three payments during the year. The planned approach about which I spoke earlier is the major cause of that. As to the emergency financial assistance line, as can be seen from the program performance budget for 1993-94, it is $3.68 million, but a range of programs has to be looked at in that context, including the concessions program of about $60 million; the financial counselling program of $1.3 million, which has concentrated on the reductions about which I spoke earlier; and the family maintenance program of $7.2 million which, as the honourable member alluded to, is part of the Family Court mechanism paid by the Commonwealth through the department.

The honourable member also raised the question of funerals and burials. A number of proposals to improve targeting and reduce expenditure in the funeral assisted program are being considered. For example, cremations are to be undertaken for all destitute funerals, unless specific cultural reasons exist for not doing so or unless it is known that this would be against the wishes of the deceased. Portions of the DSS bereavement payment can be taken into account in determining the level of assistance and examining options with respect to leases on plots. A variety of those things need to be examined and taken into account so that we are sensitive to the needs of the people with whom we are dealing.

There is some scope to make changes. A wide variety of programs is tied up with the emergency financial assistance payments program, and it is important to note the improvement that has been recorded there because of better planning and a more coordinated approach to tackling the needs of families and steering them towards better reliance on financial planning, management and budgeting rather than on continuing emergency assistance grants.

The Hon. B.C. EASTICK: Following the discontinuation of the post adoption service on 30 June due to a lack of ongoing funding, what provision is being made to support alternate services for the people affected by adoption, recognising that such alternative services are dealing with

increased numbers of people following the greater community awareness created by the work of the now defunct post adoption service?

The Hon. M.J. Evans: The honourable member refers to the post adoption service grant, which operated under the auspices of Lutheran Community Care and which was funded by the department on the basis of a one-off grant. The grant was for some $80 000, and the participants were aware at the time that it was given on a one-off basis and there was no certainty—in fact quite the reverse—that the grant would continue to be available. The service was reasonably valuable in that context, and I am sure that the people providing it gave a strong commitment to the needs of adoptees. However, the reality is that, in assessing the availability of funding, we were not able to procure additional funding for people in that situation. The one-off grant was provided in the hope that something would become available during the year, but unfortunately that was not the case.

The department does provide funding to ARMS (Australian Relinquishing Mothers Association) and to Jigsaw, and we are having some discussions at the moment with non-government agencies about continuing a post adoption-post guardianship service, and I hope to be in a position to make further announcements about that later. However, the negotiations are in a preliminary stage. I appreciate that there are difficulties in one-off grants, whereby you generate an expectation which you may not subsequently be able to meet. On the other hand, the service provided during that period was quite useful, and it would have been unfortunate had we not taken the chance to provide that one-off funding.

The Hon. B.C. EASTICK: The national executive report of the annual general meeting of the Murray-Darling Association at Wentworth on 18 and 19 August indicates under the heading Seniors' Privileges that it was agreed that State Governments be asked to consider the circumstances of senior citizens living adjacent to State borders, for example, the Murray River, who only have access to services in another State, and subsequently cannot use the existing Seniors Card, etc. The report suggests that this is being followed up in the three States through various channels, including the State Ombudsman. Is the Minister's department aware of these difficulties, and is any action contemplated to give an element of equality to all residents of our State, even though the service cannot be provided by the State?

The Hon. M.J. Evans: South Australia is not in quite the same position as New South Wales and Victoria where there are substantial towns such as Albury, Wodonga and so on right on the border, so the cross-border traffic within the one community is not so great here.

The Hon. B.C. Eastick interjecting:

The Hon. M.J. Evans: Certainly we are, but the reality is that Victoria and New South Wales have major population centres right on the river boundary, whereas the river simply enters South Australia and both sides of the river are within South Australia. In addition, there are no substantial communities right on the river boundary entrance point with New South Wales. While I understand the point, I do not think it is quite the same situation as applies between New South Wales and Victoria. However, I am certainly concerned about national recognition for the Seniors Card because quite often South Australians holiday interstate—in Queensland or wherever—and interstate people, such as those from Broken Hill, visit Adelaide, and we need to ensure national reciprocal rights in this area.

South Australia, Victoria, New South Wales and Western Australia have all adopted the common blue and gold seniors card symbol and Queensland and the ACT are looking to adopt it. While we have no reciprocal rights at the moment, attempts are being made between the interstate seniors card administrators to have national recognition of the card, and I think that will be quite important. It is not yet available but we are certainly working towards that end, and I support the honourable member's viewpoint that reciprocal rights are very important. However, I do not think we fall into quite the same category as has been argued in States where there are towns that literally straddle the border.

Mr ATKINSON: In the juvenile justice program referred to in the Program Estimates (page 515), it is stated that funding is provided for modifying the South Australian Youth Training Centre at Magill. Are the new plans for SAYTC likely to result in an unhealthy mix of young offenders and, in particular, what will be the impact on girls?

The Hon. M.J. Evans: The Magill facility of SAYTC will now accommodate all girls, all boys under 15 and boys over 15 years who are either serving first time remand or detention orders or who are less serious offenders. The most serious male offenders will be held at Cavan.

SAYTC is currently being upgraded and renovated for $1.2 million to ensure that suitable facilities exist for this mix of young people. The key factor in managing this diverse group is separating them into age and sex appropriate groups so that day-to-day activities are suitable for them and so that the more serious offenders do not contaminate younger children.

The centre will operate with five living units so that both the young women and the younger boys have their own unit. The other three units will group the older males according to the type and length of their sentence. Programming the education centre will ensure that different age and sex groups will be involved in activities suitable to them.

Additional funds have been set aside for after school hours programs to ensure that young people have activities relevant to their own interests and developmental needs. Facilities for girls will be greatly enhanced in comparison with current facilities at SAYRAC, where girls and the younger boys share a co-ed living unit.

The new young women's unit at SAYTC, currently under construction, will provide sleeping accommodation and living areas that are self-contained and physically separated from the young men's units. The unit includes kitchen and laundry facilities plus areas for study and recreational activities similar to Cavan's living units. This unit will enable the young women to have separate activities within the unit and to develop skills in independent living.

Mr ATKINSON: Maintaining an effective response to disasters is a broad objective of the program entitled 'Support for individuals and families' (page 510 of the Program Estimates). What was the FACS contribution to flood relief during the past financial year?

The Hon. M.J. Evans: Members will know that serious flooding occurred in the Gawler River district and parts of the Adelaide Hills between 29 August and 9 October last year. Further major flooding affected these areas and the region bounded by the Adelaide Hills, Murray Bridge, Strathalbyn and Milang from 18 December through January 1993. FACS coordinated the welfare response and recovery and the personal hardship and distress provisions of the National Disaster Relief Arrangement (NDRA). NDRA emergency

assistance and temporary living expense grants were immediately available for families inundated by the floods.

A central assessment panel was formed to investigate and process claims for the re-establishment grants. Applications were responded to within a one-week time frame. Public donations of over $19 000 and a Rotary Club donation of $20 000 were also administered and distributed.

Extensive involvement in counselling and advocacy was provided to victims and community groups by staff from 12 FACS district offices and Citicentre. Following the third major flood, a flood recovery team consisting of seven social work and financial counselling staff, assisted by two administrative staff, was created to assist all aspects of the recovery process. All families seriously affected by the floods were contacted and provided with material and counselling services.

In respect of the first two floods, if one totals all the various amounts of money the grand total is over $673 000, and for the third flood the total was $856 000, giving a grand total of over $1.5 million, which is a very substantial contribution, some of which is part of the Commonwealth Government's assistance program.

The Hon. D.C. WOTTON: I understand that in December of last year there was an investigation into the administration of Community Support Inc and to consider whether there was any need for changes. What was the outcome of that investigation?

The Hon. M.J. Evans: The honourable member is correct in that there was a review—I think that is a better word than 'investigation'—of the activities of the organisation. As a result of that review, we put in place some new accounting systems in accordance with recommendations from the department's senior officers and Treasury and a new Chief Executive Officer took over. While a number of problems were identified with the financial systems, which were rectified by the new systems, there was no evidence of any fraudulent or other misappropriation of funds. That was able to be discounted, but there was room for significant improvement in the way in which the organisation was administered, and that has been put in place successfully. I draw attention to the fact that, despite these difficulties, clients and consumers of these services and their carers continue to tell me that it is probably the single best thing that the Government has ever done for people in this area by providing them with support through an organisation like CSI and the type of services and support that it provides. Honourable members should keep that in mind and the fact that it was a new organisation with a new type of service provision.

The Hon. D.C. WOTTON: As a supplementary, what funding will be available for Community Support Inc for this coming year? I am not sure when Community Support Inc was established, but I should like to know how much funding has been provided in the past on a yearly basis and how much is to be provided in the next 12 months.

The Hon. M.J. Evans: The budget for this financial year is $5.1 million, which is a very good amount. We are looking to maximise the amount that we can obtain there. It was $3.84 million last year, for example, and it will be $5.1 million this year. I do not know whether the honourable member wants to go further back in history. I hope those two figures are satisfactory.

The Hon. D.C. WOTTON: I refer to the INC scheme. I have been receiving a fair bit of representation from INC parents, as the Minister may be aware, and there is concern on the part of those parents about what they see as possible changes that would mean that they come more under the umbrella of the court system. It has been suggested that this might come about at the same time as the new youth court legislation comes into force and the new youth court comes into being. There is also concern that the supervision programs associated with INC no longer exist. It has been put to me that the support programs for those children and care givers have been decimated to the point where they are either nonexistent or unrecognisable.

The Hon. M.J. Evans: There is no firm proposal to include INC parents under the supervision of the court. I think the idea may have been floated by sources external to the department, but certainly that idea is not being proceeded with. INC parents do a very good job and we will continue to support them in their work.

The Hon. D.C. WOTTON: INC parents have put to me that the new funding policies have been very poorly explained, incompetently instituted and inconsistently administered, to the point where many valuable and experienced INC parents have become extremely frustrated and disillusioned with FACS and have resigned. Does the department recognise this as major issue; is this the case; are a number of FACS parents resigning; and, if so, could the Minister provide some detail regarding that situation? If that is the case, who is taking up the role of those INC parents who are resigning?

The Hon. M.J. Evans: I understand that the total number of parents has not changed over the period of time when this change has taken place. A few individuals have left the system, but others have come into the system and, of course, that happens from time to time in any event. So, although some INC parents were concerned about the changes, I think the vast, overwhelming majority have accepted the change—it has been quite reasonable—and have continued to perform very good work for the community. Individuals will always disagree with particular policies and will come and go from the scheme, but I think the scheme remains very strong and viable and a very important part of our overall care package.

Mr HAMILTON: What programs have been put in place to ameliorate domestic violence, and what is the level of cooperation between Government and non-government agencies in tackling this very real problem?

The Hon. M.J. Evans: In its corporate plan, effective from July 1993, the department identified a number of key strategies which are aimed at reducing domestic violence in the community and at supporting victims in order that they can re-establish themselves in a safe environment. There is a renewed focus on services provided through district centres to identify support and provide appropriate referral for clients. In addition, the centres will liaise with local action groups and develop culturally appropriate programs to address the needs of perpetrators. Community concern about the increasing levels of family violence is reflected in the 1993-94 budget; a joint Family and Community Services and Health Commission initiative to integrate Statewide domestic violence services will be boosted by increased funding.

An additional $70 000 will be injected through the FACS budget into the domestic violence unit. This complements the $200 000 increased funding which the Health Commission will provide for local area prevention, education and therapy programs run by community health centres. FACS will also maintain the focus on providing support and assistance to victims seeking to re-establish themselves in a safe environment, through supporting women's shelters and outreach services, including grants of $100 000 in 1993-94 to fund much needed services in Coober Pedy and Ceduna.

Protocols now established with the Housing Trust ensure that victims of domestic violence can receive emergency financial assistance at the first point of contact. An annual allocation of $10 000 has been made to the Marriage and Family Centre through the Family and Community Development Program as a one third share of the funding of a program to assist families where domestic violence has occurred. The national campaign focused on violence against women has been allocated funding for major initiatives in the period 1993-95. The FACS domestic violence and child protection units will combine resources to produce a training film on family violence. The units will also coordinate key initiatives to mark the International Year of the Family.

Mr HAMILTON: Given the evidence of increasing need for community based aged care services, as opposed to residential care, what is the Government doing to ensure that resources in this sector keep pace with demand?

The Hon. M.J. Evans: In relation to home and community care, there are several aspects to the issue. By far the most important single funding source for community care is the HACC program. The program provides financial assistance for services which support frail older people, people with a disability and their carers so they can remain living in the community. The costs of the program are shared between the three levels of government. The ratio of Commonwealth/State/local government funding is currently in the proportion of about 61:38. National financial growth targets in HACC are set annually by the Commonwealth, with the amount of Commonwealth growth funding allocated to each State being determined by each State Government's own effort.

The South Australian Government is committed to improving support to older people living at home, to people with disabilities and to their carers by providing funds to attract the maximum annual growth offered by the Commonwealth in matching funds under the HACC program. The Commonwealth has offered to match funding provided by the States to provide for real growth of 6 per cent for HACC in 1993-94, and a further 2.44 per cent indexation. This will provide a capacity to increase HACC funding by $3.977 million in 1993-94 to a total of $51.1 million.

I have written to the Federal Minister of Housing, Local Government and Community Services (the Hon. Brian Howe) confirming that the offered growth in program funding will be taken up in South Australia. Of course, if financial effort in other States does not extend to this 6 per cent growth, there may be an opportunity further to increase the South Australian growth factor this year. It is proposed that the real funding growth in South Australia be applied to an expansion in services to younger disabled people through the CSI program of $0.893 million and to the expansion of home assist services and other enhancements to existing local government services involving the commitment of $1.934 million of expenditure.

Mr HAMILTON: I refer to the training and expertise of Family and Community Services staff. When I first came into this job in 1979 and went out doorknocking, one of the common criticisms I picked up was allegations that the then Department of Community Welfare staff were not sufficiently trained, that they divided the family, and that they encouraged young people to leave their homes. I do not believe that any organisation is perfect, nor do I believe that Family and Community Services is perfect when we are dealing with people and their desires and frustrations. I raise this question first to put it in the *Hansard* and, secondly, to give the Minister the opportunity to respond, because in my dealings with the Family and Community Services Department and with the old DCW I have received tremendous support for both my constituents and staff.

What ongoing training programs are there? The Minister may want to respond to allegations that the Department of Family and Community Services is breaking up families and allowing 13 and 14 year olds to go out into the community seemingly willy-nilly and supported by the department.

The Hon. M.J. Evans: I think the honourable member is quite right to identify the very high standard of service and the very high levels of training and expertise that are available through the Department of Family and Community Services. The staff conduct themselves in a very professional way and, indeed, that is reflected in the substantial commitment which the department has to the training and support of staff. Indeed, the department provides training to its staff at a level twice that required by the training guarantee levy and, of course, training in that context amounts to some 3 per cent of our budget. That is a very substantial commitment and is on top of the professional qualifications which the staff bring with them when they enter service in the department.

The honourable member correctly identifies the department as providing that very high level of expertise. Certainly, the occasionally floated stories in the media about the department's staff encouraging young kids to leave home are not the case. That is completely contrary to the ethic of the department, which in fact is one of family preservation and support for families, except where it is entirely inappropriate or not possible for a young person to live at home for obvious and understandable reasons. Clearly, there is a balance to be drawn. The department's basic premise is that young people are best cared for in their own family environment. I think the honourable member is right to draw attention to the expertise of our staff. That has improved substantially over the years and will continue to improve with that very high level of commitment to training.

Mr HAMILTON: Where a 13 or 14 year old, and particularly a young girl, leaves the family nest, what procedures are set in train by the Department of Family and Community Services to address those types of circumstances?

The Hon. M.J. Evans: Of course, as the member would understand, it depends on the reason for the child leaving home. If it is for reasons of abuse, neglect or inappropriate family circumstances then the legislation, both current and proposed, allows the department to make application to the Children's Court or the Youth Court to see that the child is in need of care or protection if the parent is unable to control, supervise or provide for that child. If that is the case then substantial provision exists to provide for foster care, for temporary or permanent guardianship by the department and the Minister and the child can be looked after in that way. In other situations, of course, it will be possible for the department to go into the home to work with the parents and the child, and to resolve the problems which exist in that family to the extent that we are able to do so, and allow the child to continue to live in their own family environment. Certainly, children will continue to live with their family unless it is inappropriate that they do so. If that is the case then there are adequate mechanisms in both the proposed and existing legislation to allow the department to provide alternative care—in most cases foster care—for that child, either on a short term or long term basis.

The Hon. D.C. WOTTON: I want to pick up the same subject that the member for Albert Park raised in regard to the

qualifications of the members of the department. I am not even sure these days whether we are able or supposed to refer to officers as social workers but, if we are, how many social workers are currently employed by the department, and of this number how many are Aborigines, and how many are persons of ethnic background? Can the Minister indicate how many have less qualifications than the minimum recognised by what was, and I presume still is, the Australian Association of Social Workers or an equivalent of that association?

The Hon. M.J. Evans: Certainly we can provide on notice the specific details that the honourable member has sought. It is sometimes not easy to know from the personal circumstances of staff members what their national background might be. That information is not always obvious or known to the department because it may not be relevant to their employment criteria, of course. However, if that information is available we will acquire it. In respect of Aboriginal employment, as at the last pay day in June 1993 a total of 88 staff were employed by the department.

The Hon. D.C. WOTTON: The non-government sector has expressed grave concern, as I mentioned earlier, about the lack of Government support for financial counselling services. It is felt by these agencies that, in recent times, the Government has expected the non-government sector to play a much greater role in the provision of these services without providing funding support. From what I can gather, there does not seem to be much joy for the non-government sector in the 1993-94 estimates.

What steps does the Government intend to take to ensure that the non-government sector will continue to provide this much needed service? I am amazed at the statistics that have been provided to me that point out the massive increase in the four regions in client case work numbers. Noarlunga, Norwood, Bowden-Brompton and the Adelaide Central Mission have all recorded an extensive increase in the number of clients who have sought assistance in this way. I believe it is an important service, particularly at this time.

The Hon. M.J. Evans: I challenge the assumption behind the honourable member's question that the proportion of the department's commitment to non-government services is not increasing. In fact, the proportion of grants allocated to non-government agencies has increased from 31.7 per cent in 1989-90 to 37 per cent in 1993-94. Our partnership with non-government agencies has continued to increase. We often enter into new and innovative arrangements with the non-government sector—for example, the family preservation program—to provide that partnership between Government and non-government areas which I think can best deliver services to the general community. So, we have continued to increase that area of involvement, and I would expect that to continue in the future. It is a viable and important way of delivering services in a most cost-effective and socially effective way.

With respect to financial counselling, I draw attention to the following grants for 1993-94: the Aboriginal Legal Rights Movement-financial counselling program, $31 000; Adelaide Central Mission—financial counselling program, $35 900; Bowden-Brompton Mission Inc.—financial counselling, $25 300; Noarlunga Community Legal Service—financial counselling, $25 300; Norwood Community Legal Service—financial counselling program, $25 300; and SACOSS-financial counselling program, $20 350. Those specific purpose programs for financial counselling and others which impact on that area are important, and we continue to support them.

As part of our anti-poverty program, the Financial Counselling Service has been responsible in substantial part for the reduction that I spoke of earlier in repeat applications for emergency financial assistance. So, even in these difficult times, while the number of one-off applications has remained fairly constant, the number of repeat requests for emergency financial assistance has declined significantly, due at least in part to the financial counselling programs offered through the department and the non-government sector.

The Hon. D.C. WOTTON: The Minister said that he believes that these non-Government agencies are being well-funded in this area. They have experienced an increase of some 360 per cent since 1988 and really, if you look back over that time and compare it with the projection for the next 12 months, you will see that the Government is simply keeping up with the CPI. Assistance is not being provided by the Government to keep up with the requirements and the workload that is being experienced by these agencies. In Noarlunga in 1988 there were 246 clients and 983 in 1992; in Norwood, 225 up to 1 021; Bowden/Brompton, 78 up to 1 264; and the Adelaide Central Mission, 772 up to 2 743. Overall that is a total of 1 321 in 1988 to 6 011 in 1992—a significant increase.

The Hon. M.J. Evans: As I indicated, our grants to the non-Government sector have increased substantially over time. If we look at the ball park figures over the period that the honourable member mentioned, we see that in 1989-90 there was some $44 million in external grants, while in 1993-94 it is some $78 million. That is a very substantial increase over that period and involves real growth—not just, as he said, sliding along at the CPI level—in our commitment to those programs. Financial assistance by way of emergency relief in the non-Government sector is provided mainly by the Commonwealth department, whereas financial counselling services in the non-Government sector are provided by both the State and Commonwealth Governments.

The State allocation for financial counselling in 1993 from the Family and Community Development Program is over $111 000 for direct services and $25 000 for policy development and training. Indeed, a number of preventive projects have been put in place which will assist that to be a more permanent solution. Simply handing out cash on a financial assistance emergency basis is not the best way of assisting families in the long run. In the preventive project area, about $123 000 has been provided for the funding of 52 projects. Examples of these projects include the purchase of white goods to be loaned to people in need to allow them to save for the purchase of their own goods, without entry into costly hire-purchase arrangements; funding for the establishment of a consumer credit cooperative as a joint initiative with the Salisbury council and local community agencies; and a family empowerment project at Elizabeth, which brings together the network of essential services to provide intensive systems to a small number of disadvantaged families.

These services include: health; education; Anglican Community Services; United Way; Para Districts Counselling Services; FACS, which will provide financial counselling; money management; debt consolidation; and other direct financial support as needed. A very important part of this is that the project will eventually be evaluated by the University of South Australia. The non-Government sector funding of anti-poverty through the Family and Development Program within FACS is currently being reviewed. The non-Government agencies, which are currently funded to provide financial counselling services, have previously written to me

requesting that the level of funding for financial counselling be increased. They have been informed that they will be consulted as part of the review process in respect of the development of new policies in this area.

I suppose it is those possible changes that may have prompted some of the concerns that have been raised by the member for Heysen. I can assure him that, while we have a strong commitment to the non-Government sector in this area and the provision of financial services which will allow people to develop their own skills and not simply revolve around a cash hand-out mentality, those areas will be developed fully in future years. Our commitment has been demonstrated by the real growth that has been shown in the grants area to non-Government funding units. Certainly the statistics, which I do not wish to repeat but which I draw attention to, for repeat clients seeking financial assistance grants are declining substantially. I think in those areas we can see the outcome of that policy of providing real assistance and helping families to grow in this area, rather than simply providing them with small cash payments on an ongoing basis.

The Hon. D.C. WOTTON: I was not surprised to see in the *Advertiser* this morning concern being expressed by people in the departments dealing with child abuse. Certainly, I had been made aware of the concern in this area over a period of time, and I pick up the point that was made in the *Advertiser* this morning on Tony MacHarper's behalf that, with child abuse notifications being up 300 per cent, they find that they do not have enough staff to deal on a day-to-day basis with the basic child protection needs and that members of the PSA (in other words, members of the department) are finding it impossible to cope adequately with the number of child abuse notifications. Can the Minister provide for the information of the Committee the official figures regarding the increase in child abuse notifications over the past 12 months and how they compared with the previous 12 months? Can the Minister provide details of the availability of staff to deal with those issues; and also can the Minister on a region by region basis indicate the delays in dealing with the notifications that are being experienced currently?

The Hon. M.J. Evans: There are a lot of figures in there and I will try to work through those as best I can. I have also seen some of these figures canvassed in the media which reflect increases from anything up to 300 per cent. I am not sure; it was not clear over what period of time they were discussing that increase. I am sure it is true over some period of time. But if one looks at the notifications in the past 12 months one sees that they have increased by something of the order of 4 per cent as distinct from this figure of 300 per cent which is being bandied in the media. One needs to look at these figures very carefully because the official statistics show an increase of about 4 per cent.

If we look at some of the detail: in 1992-93 the Department for Family and Community Services received 6 239 reports that children had been abused or neglected and determined that 5 736 reports involving 4 796 children should be further investigated. This compares with 5 950 reports received in 1991-92, in which it was determined that 4 542 reports involving 3 946 children should be further investigated. This does represent an increase of some 26 per cent in the number of matters which the department considered required further investigation, as distinct from the overall level of notifications, which increased by only some 4 per cent.

In relation to the staffing in the child abuse area of the department, there has been a reduction of about six in the number of middle management positions over last year, but we have taken on some 17 family preservation positions which are all new and which, of course, substantially add to the people available to deliver services to families. So, while there has been a reduction in that management level, in fact we have been substantially increasing the number of officers who actually provide services in this area—quite a significant increase, in fact, in a very exciting new program.

Mrs HUTCHISON: My question relates to the area of the ageing. The department's financial support program, listed on page 511 of the Program Estimates, contains a broad objective of providing concessional financial support as the key component of the anti-poverty strategy. What is the impact on the State Government of extending concessions and fringe benefits to part pensioners (and I believe this actually took effect from 1 April 1993)?

The Hon. M.J. Evans: As in other States, the South Australian Government provides concessions for energy costs, municipal and water rates, public transport and motor vehicle registration. In addition, South Australian pensioners receive a number of health care concessions (ambulance subscription fees, for example) and concessions on various licences. The estimated total cost to the State Government of these core concessions in 1993-94 will be some $72 million—a very substantial commitment.

The cost of extending these benefits to part pensioners and older long-term beneficiaries from 1 April 1993 will be an estimated $11 million in the current financial year. Under the Commonwealth-State agreement negotiated on this point the Commonwealth will contribute $9 million in 1993-94 towards State costs. This figure is based on the number of pensioner health benefit card holders and is indexed for growth both in pensioner health benefit numbers and in the consumer price index. In addition, and separately from those core concessions I mentioned earlier which are common to all States, the South Australian Government will extend its other concessions to part pensioners at an estimated cost of $4 million in 1993-94.

Mrs HUTCHISON: I have had numerous applications through my office, as I am sure other members have, for the seniors card. How has business in South Australia reacted to that new seniors card?

The Hon. M.J. Evans: I am pleased to report that the reaction to the new seniors card by both business and the older community has been overwhelmingly positive. When the Premier launched the new card on 29 July, over 200 businesses were listed in the first directory of benefits being issued to card holders. Many of these businesses have multiple outlets throughout South Australia. The Government has decided that the seniors card should, over time, generate an increasing proportion of its own revenue to cover the costs of the scheme.

The net revenue of $73 000 from advertisers in the 1993 directory was only just short of the first year revenue target of $75 000. A random survey of businesses listed in the 1993 directory has produced a very positive response from nearly all those contacted. Businesses are already reaping the benefits of targeting their goods and services to the older market. As evidence of this, since the end of July, 55 additional businesses have registered their interest in participating in the scheme from 1994 onwards. This new interest represents a growth of more than 25 per cent in the number of interested participants in the scheme in less than two months, which must surely be seen as a strong vote of

confidence in the card. Some areas of business warrant a particular marketing effort in 1994.

Country and ethnic businesses, for example, are under-represented in the 1993 directory, despite concerted efforts early this year to generate interest from them through contacts with chambers of commerce and country councils. The Seniors Card Unit in the Office of the Commissioner for the Ageing will be mounting an extensive marketing campaign in these areas in the forthcoming 12 month period.

Mrs HUTCHISON: I can see that I will have to start lobbying businesses in the country. One of the specific targets mentioned in the Community Development and Planning Program (page 508 of the Estimates) is the implementation of new arrangements for personal care subsidies, a service for the aged in the community. Given the Commonwealth's emphasis on helping older people to stay at home, is it becoming easier or more difficult to obtain a nursing home bed? I have heard it is becoming more difficult. What is the State Government doing to help older people and their families in this regard?

The Hon. M.J. Evans: There are two parts to this question. The Nursing Homes and Hostels Inquiry Service is a two person unit in the Office of the Commissioner for the Ageing which provides information and advice to the public on matters relating to accommodation for the aged when an element of care is required. The service also coordinates registers of vacancies in nursing homes and of applicants for nursing home beds and helps people to locate respite beds in both nursing homes and hostels.

During 1992-93 the service registered 1 020 people seeking nursing home accommodation, a 33 per cent increase over 1991-92 registrations. The average waiting time between registration with the service and placement in a nursing home also increased, although only slightly; an average waiting time of 9.5 days compared to 8.9 days in 1991-92. However, this modest increase should be seen in perspective. The average waiting time for a nursing home placement in 1991-92 was 13.5 days, so it seems the overall trend is for it to become easier for nursing home placements to be achieved. The number of requests from the community about the procedure for entry to nursing homes, what to look for when shopping around for a placement, and so on, has also increased. The service received 262 calls of this kind in 1992-93, a 14 per cent increase over the previous year.

Providing information to older people and their families at a time when they will often be anxious about this major change in living arrangements is a complex and sensitive task. I would like to think that the increase in requests for information to the nursing homes and hostels inquiry service reflects not only the rapid aging of the older section of the aging population, but also the services credibility in the wider community. I am very pleased to report that an evaluation undertaken of the information functions of the service during 1992 confirmed that it was well regarded by its users, both individuals and families in the community, and users in the nursing home and hostel industry as well.

Mrs KOTZ: In answer to a question asked earlier this year the Minister advised that the Department for Family and Community Services owns seven boats, including a 15-foot fibreglass runabout, a 15-metre houseboat and a 23-foot timber yacht. What are these boats actually used for, and what are the costs and maintenance costs of each of the seven boats?

The Hon. M.J. Evans: Yes, in the main the boats are used as part of programs, so the boats at cost are allocated to a program rather than to a boat service if you like. Therefore, the use of the boats and the cost of them are tied together, but we will try to extract some figures for the honourable member in view of her interest. At least two of the boats were donated to the department for use in these particular programs, which range from use with young offenders to the Duke of Edinburgh scheme, and obviously if there is a maritime component to that scheme some sort of boat is essential. Do you want details of the nature of the boats and so on, or have you already got them?

Mrs KOTZ: I believe we only have three descriptions out of the seven boats.

The Hon. M.J. Evans: The seven boats are as follows: a 15-foot fibreglass runabout known as the *Maid Marion*; a 15-metre houseboat, which is leased to the Education Department, known as the *Queen Laura*; a 23-foot timber yacht known as the *Blade Runner*; a 16-foot fibreglass runabout, a 17-foot fibreglass runabout, an 18-foot fibreglass runabout and a 16-foot timber runabout, all of which are unfortunately and sadly unnamed.

Members interjecting:

The Hon. M.J. Evans: I am sure that the honourable member is not disparaging the Duke of Edinburgh program which is a very valuable program for young people in this State and indeed which has found acceptance throughout the Commonwealth of Nations as a worthy award program for young people. One component of that program often includes a degree of training with boats of this kind, and given the modest size of some of these boats in that context I think the program is quite useful for young people as part of that Duke of Edinburgh Award scheme. As I said, at least two of those boats were in fact donated to the department given that context. While I understand the honourable member's interest in these areas I do not think it quite constitutes that order of magnitude.

Mrs KOTZ: I appreciate that the Minister will in fact determine the cost implications in the programs if it is at all possible, and I thank him for that. Why is the 15-metre houseboat leased to the Education Department?

The Hon. M.J. Evans: It was originally constructed as a young Aboriginal employment program many years ago. It has subsequently been leased to the Education Department for its outdoor education program.

Mrs KOTZ: The gap between the cost of services and concessions provided to those eligible is continuing to grow significantly in the aged area and the aged and those on pensions recognise that this is an injustice. What action, if any, do you believe should be taken to address this injustice?

The Hon. M.J. Evans: I assume the honourable member is referring to areas like municipal rates, for example, and so on? Is that correct?

Mrs KOTZ: Yes.

The Hon. M.J. Evans: I gave some details in response to a question from the member for Stuart which I will not repeat and which showed that the total cost of those concessions programs is very substantial. Although, I am that sure all members would like to see an extension of those programs, the cost of doing so is quite significant. Indeed, they have been extended this year as part of this Commonwealth/State agreement, which has been negotiated at substantial cost to the State as well as to the Commonwealth. The expansion of that program is worth millions of dollars.

Of course we would like to extend it further, and no doubt over time, in subsequent budgets, that will be possible. However, I believe the expansion of the concessions area this

year alone is quite significant and represents a multi-million dollar investment. So, while I understand that it would certainly be appropriate if we were able to fund further increases, I believe that the millions of dollars contained in this budget alone for increases in concessions as part of the Commonwealth/State agreement are a very substantial demonstration of our commitment to concessions in this area.

Mrs KOTZ: The select committee report on the juvenile justice system made a series of recommendations in areas such as crime prevention programs, drug and alcohol programs, Aboriginal death in custody initiatives, mental health care and alternatives to detention. I am sure the Minister will agree that there was considerable concern amongst the members of the select committee at the time they were receiving evidence from certain Government-funded agencies.

The submissions from those agencies appeared to be far longer on rhetoric than they were on substance. I refer to the evidence relating to initiatives taken in some of those areas. Although some submissions were presented as initiatives taken, I think it was determined that in fact they had not been implemented as they were being presented to the select committee as evidence. Will the Minister provide details of any initiatives implemented or being implemented aimed at meeting these key prevention recommendations from the report?

The Hon. M.J. Evans: The honourable member is quite right in relation to the report of the committee; it was a very comprehensive document. I hesitate to praise the committee too much, as I was a member of the committee, as was the member for Newland. However, I am sure it has been widely recognised as a substantial document in that area and it has made a significant contribution to the work in juvenile justice.

Of course, the principal recommendations related to reform of the legislation. That has in fact been done and Parliament has approved the new legislative scenario in relation to juvenile justice. There was alongside that a number of key recommendations, as the honourable member correctly identifies them, in relation to education, young Aboriginal people and the like. The Education Department is making substantial efforts to pick up a lot of those recommendations within the scope of the department. I am sure that if the honourable member asks the Minister of Education, Employment and Training she will be only too pleased to detail those efforts, because I believe that the department is making progress there.

In relation to a number of other areas, I think we would need to look at the specific examples to which the honourable member is referring to match them up. However, I have certainly referred to the department the area of the report that covers each of the departments, and unfortunately it is cross-departmental. There is also an inter-agency committee looking at the implementation of those various recommendations and it will be reporting to the Justice and Consumer Affairs Subcommittee of Cabinet.

Given the enormous range of those recommendations and their depth, I think it is not unreasonable that the Government is implementing them over a period of time. Indeed, the principal recommendations have already been implemented and others continue to be so, either by individual agencies or by the system as a whole through the Cabinet subcommittee. However, I think the honourable member will need to identify particular recommendations and we will follow those up separately for her. I have no doubt that some recommendations will not be capable of implementation in the long run, but I think most will be, and I think it was a useful contribution to our body of knowledge in that area.

Mrs KOTZ: As a supplementary question. The Minister has stated that he has already passed on to his department some of the recommendations in that report that quite obviously affect the Department of Family and Community Services.

What resources will be made available to fund specific initiatives that will be undertaken in 1994, keeping in mind that it is the International Year of the Family, and what forms will those initiatives take?

The Hon. M.J. Evans: Of course, it is a matter of identifying which recommendations we are talking about. The department has a substantial role in the reform of the legislation, and that has already passed through the Parliament. The department is responsible for managing the secure care centres, and much work is being undertaken there to prevent deaths in custody, to ensure that training is available and appropriate and to ensure that the range of services available to young people is as broad as possible.

In addition, there are quite a number of crime prevention programs such as the Bank Street Youth Support Group, the Country Aboriginal Youth Team, the Shed project at Salisbury and Aboriginal youth action committees, and a variety of those recommendations have also been looked at by the Education Department, as I indicated earlier. While I can take on notice a request to be more specific about the department, I think the honourable member will find that the principal recommendations of the committee in relation to the legislation have already taken place, and many of those other areas will be looked at progressively over time. The department's commitment to secure care is very substantial. An enormous change in resources has occurred as a result of the changes to the legislation.

Mrs KOTZ: Can I clarify that the Minister is actually saying that there are no specific areas that have been identified through his department and therefore there are no specific initiatives?

The Hon. M.J. Evans: No, certainly, the Minister is not saying there were none; the Minister just went through a whole list of the ones which he thought relevant and which immediately came to mind, and agreed to take on notice an examination of the other areas that he may not have been able to bring to mind today.

Mr HAMILTON: How will the SAAP youth sector restructure benefit homeless youth?

The Hon. M.J. Evans: The number of organisations funded in the metropolitan region will be reduced from 23 smaller organisations to 11 larger ones as a result of the restructure. In this process, several organisations have amalgamated. The majority of them will lose SAAP funding after 31 December 1993, but have indicated that they intend to continue operating in some capacity. As part of the restructure process, the level of funding to youth accommodation services in the metropolitan area has been increased by $676 000 to a total of $5.2 million.

Services to young people will, therefore, increase as a result of the restructure. There will be less duplication and a more equitable distribution of services and service types across Adelaide. The new structure will increase the number of SAAP funded beds available to homeless young people in the metropolitan area by a minimum of 50 to a total approximately 330.

An industrial protocol to guide the implementation of this restructure has been successfully negotiated with the

Community Employers Association and the Australian Services Union (as the representative bodies of organisations and employees affected), which will maximise employment opportunities for persons in the sector and service delivery during the restructuring, and minimise the disruption to service delivery and the potential level of redundancies. Every effort will be made to ensure the minimal disruption of services to young people.

Mr HAMILTON: What commitment has the Government made to funding the expansion of support services for the frail aged, the younger disabled and their carers under the HACC program?

The Hon. M.J. Evans: A number of points have already been made this afternoon about the HACC program, but I can summarise by saying that the quantum of funds for the HACC program 1992-93 was $47 million. The Commonwealth, as I indicated earlier, has provided additional funding which, together with matching State funding, has allowed an increase in the program to a total of over $51 million dollars.

Many of the other details have already been provided to the Committee. It is important to understand that the Government remains committed to making the maximum possible use of the HACC program because of its importance not only to the frail aged and younger disabled but to their carers and the community at large.

Mr HAMILTON: What specific programs are available for those males who are perpetrators of domestic violence?

The Hon. M.J. Evans: The range of programs has been increased recently, and an additional $190 000 was made available this year through the Health Commission budget. That provides extra services at community level for the perpetrators of domestic violence and seeks to address the problem at its core. If the honourable member requires further information, we will see what we can provide on notice, but that mostly comes through the Health Commission.

Mr HAMILTON: If it were available, I should like the statistical data on the number of men participating in those programs. Are they on the increase, decrease, or are they stable; and what are the results of such programs?

The Hon. M.J. Evans: I will seek to obtain that information through the Department of Health, Family and Community Services and, where appropriate, the Health Commission.

Chairman:

The Hon. J.C. Bannon substituted for the Hon. D.J. Hopgood.

The Hon. B.C. EASTICK: Under '1993-94 Specific Targets/Objectives', at page 514, there is the statement, 'The unit will conduct training in preparing children who must give evidence in child abuse cases'. One of the issues which frequently comes before a member from the parents of a child who has been abused is their grave concern about the further trauma to a youngster of going into a court where they are to be interrogated by solicitors acting on behalf of the accused, even where in some circumstances the accused has admitted being the abuser. Can the Minister indicate from evidence available through the department how many cases of abuse are called off because of the reluctance of parents to allow a child to go into court to give the necessary evidence? Will he also indicate whether further discussions have been held with the Attorney-General's Department, which made a public statement about the possibility of presenting video information relative to the child and removing the child from being subject to cross-examination by the legal profession?

The Hon. M.J. Evans: I understand that the legislation has been changed to allow the video-taping of evidence. This, of course, will substantially address the problem that the honourable member correctly identifies as having been of serious concern in the past. It would be very hard to obtain statistics about parents who have previously turned down the opportunity for a child to appear in court. It is not within my province as Minister of Health, Family and Community Services; it is within the Attorney-General's province. However, I understand that the video-taping of evidence is part of the Evidence Act changes.

The Hon. B.C. EASTICK: As a supplementary question: why then is there a need for the unit to be schooling people to give evidence in child abuse cases if in fact such evidence is no longer procured in open court?

The Hon. M.J. Evans: Evidence still has to be given, be it by videotape or whatever, so the evidence will still be required; it is just that the manner of its transmission to the court may be varied.

The Hon. B.C. EASTICK: On many occasions during the course of the Select Committee into Juvenile Justice, the committee was advised specifically by mothers that when they perceived that a child was on the point of engaging in or was on the fringe of illegal activity, they cried for help from FACS and none was forthcoming. The Minister will have been present on a number of those occasions. This fear was specifically expressed more by Aboriginal or ethnic mothers than by Anglo-Saxons. What action has the Minister taken during his tenure of office and will any programs within the reorganised department seek to offset some of these grave criticisms?

The Hon. M.J. Evans: I certainly recall evidence being giving to the committee in that regard, but it was isolated. I do not know whether the committee heard about more individual circumstances than any across the board statistics in relation to that, but it does reflect a real problem, particularly for communities where English is a second language with ethnic communities and with the Aboriginal community, where that issue of contact with FACS is not always straightforward in some cases. That problem is certainly real and needs to be identified, even though I do not believe it is as widespread as the honourable member may be suggesting.

Certainly, some people have unreal expectations of what the department might be able to do in relation to young people whom they consider are at risk of further offending. The department is not able to prevent children from further offending. Some people hold the view that they can be preventively locked up to avoid further or possible offending behaviour. I have had that put to me, but it is not a realistic option in our judicial system. However, what is feasible and what the department is doing is working intensively with families as part of our family preservation program and the intervention program where there is a crisis in a family that needs assistance. It is working with the family and the young person to ensure that their behaviour is more appropriate, that the family responds better to the needs of the young person and that the young person understands the responsibilities that being a member of a family unit imposes on them.

That work with the family is the best possible response one can make to that kind of situation because, if the young person is not actually offending, really what we are seeing is a social crisis situation—a family crisis—not a criminal event, and therefore it needs to be responded to in that

context. That is what the family preservation programs seek to do, and they will address the problem which the honourable member raises in a much more positive and dynamic way than anything which the juvenile justice system could do. As a supplementary point, I draw attention to the Evidence (Vulnerable Witnesses) Amendment Act 1993.

The Hon. B.C. EASTICK: The Minister may well be aware from letters which have been received from the South-East of the case where a mother expressed grave concern when her natural daughter was found to have been raped over a period of time by the son of the child's stepfather. Over a period of some weeks the mother was unable to obtain any assistance from FACS in the South-East, with people either being too busy or not returning calls, and the mother gained a very clear indication that FACS was more interested in the future of the child who had been the perpetrator of the difficulties and less interested in the plight of the victim.

The mother claimed that the only assistance that she had of any real value, other than some verbal abuse from FACS workers in the South-East, when she persisted in wanting to know what they would do to assist her, was from the Victims of Crime organisation in Adelaide. I can give the Minister additional information if he wishes, but a number of members of Parliament have received information from the parent, and a number of members of the Opposition have received additional information from the mother when they queried the detail of her assertions.

The Hon. M.J. Evans: This is an individual case and obviously the member is making some very serious allegations against departmental officers in relation to which I think one needs to take a balanced approach. One should look at both sides of the equation, and the honourable member has chosen to repeat some very serious allegations against officers of the department without having the opportunity to present the alternative viewpoint in defence of that action. This individual case is under investigation at the moment and I will be writing back to the member for Heysen, since he has taken it up directly with me, and since the member for Light is interested in the outcome of this case, I will also give him a copy of the reply. That may be more appropriate, given the individual circumstances of the case, than providing a public analysis of that. That is intertwined with some substantial allegations of criminal conduct as well, so no doubt others beyond the department will need to be involved if that turns out to be the situation. Given the nature of this individual circumstance, it would be better to handle it in that way.

Mrs HUTCHISON: I refer to the juvenile justice program on page 515 of the Program Estimates. A serious issue has come up from time to time with respect to petrol sniffing on Aboriginal lands. What are the Government's plans to address that problem?

The Hon. M.J. Evans: Petrol sniffing on Aboriginal lands is a serious problem. Cabinet as a whole was made aware of that during its recent visit to the Pitjantjatjara lands. In July, Cabinet endorsed a coordinated strategy for the problem of petrol sniffing on Anangu Pitjantjatjara lands, including endorsing the AP Law and Trouble Committee as the local reference group for petrol sniffing rehabilitation program implementation; and with the Law and Trouble Committee to report to the Social Development Committee of Cabinet, the Department of Family and Community Services, the Health Commission, the Drug and Alcohol Services Council, and the Department of State Aboriginal Affairs, to implement the recommendation of the AP report 'Children of Disposition', in conjunction with the Law and Trouble Committee.

In 1992-93 the department administered funds of $137 000 on petrol sniffing programs in the AP lands. These funds were expended mainly on programs run by committees and employing local people, to provide a range of educational, health and activity based alternatives for young petrol sniffers. The department will continue to be committed to working with local communities to develop strategies relevant to the local needs of those communities and will work with other major providers of services to ensure Cabinet's decisions of July are fully implemented.

Mrs HUTCHISON: As a supplementary question, was the Minister aware of the project carried out at Yuendemu which was one of the communities in the Northern Territory which actually did wipe out petrol sniffing? I believe it was carried out through the women's committee.

The Hon. M.J. Evans: I have heard reports of that project during discussions with Aboriginal communities in the Pitjantjatjara lands. I think one has to be very careful in looking at these programs and their results in other areas because, with different groups of Aboriginal people, with different environmental circumstances in each case, it has proved very hard to replicate success in one area in another.

Local conditions, local attitudes and circumstances change so dramatically. So, while one looks with interest at successful programs elsewhere and tries to learn what one can in relation to them, I think that success has to be interpreted cautiously. It is not a straightforward process to translate one program to another area, particularly across such a significant cultural gap as exists in that area.

Mrs HUTCHISON: In relation to the support for individuals and families, appearing on pages 510 and 511 of the Program Estimates, what special programs are being provided, if any, for Aboriginal people in the Coober Pedy area?

The Hon. M.J. Evans: There is quite a range of support programs for Aboriginal people in Coober Pedy. The school is currently conducting a lunch and homework program, which targets Aboriginal primary school children. There is a home-maker program, which operates daily in the area; and a youth centre is presently being used as a drop-in centre, which offers recreational activities and trips away for football carnivals and the like. There is a deafness program. Aboriginal Health reports a high rate of partial deafness within the Aboriginal community, believed to be the result of childhood injuries and conditions. It is reported that 10 to 15 per cent of the Aboriginal population suffer from partial deafness. There is an Aboriginal women's group. The program targets Aboriginal women and aims to increase knowledge in areas of domestic violence, child abuse, health, budgeting, home-making skills and child care.

The community is presently lobbying for a child-care centre. An Aboriginal child care-centre does exist, but there is a wide range of community issues in relation to that. There is out-of-home care, and nine Aboriginal families are registered caregivers. There is intensive adolescent support, and two Aboriginal people are presently registered. There is a FACS youth group involving a wide range of suitable activities, and an employment skilling program based on a partnership between FACS, the Umoona Community Council and the Department of Correctional Services. There is an Aboriginal anti-poverty group, involving FACS, the Umoona Community Council, Aboriginal Health, Aboriginal police aides and community representatives. There is also an Aboriginal meals program. So, quite a range of activities is presently based in the area for Aboriginal people.

Mrs HUTCHISON: I refer to the juvenile justice program at page 515 of the Program Estimates. It was mentioned during the Select Committee on Juvenile Justice—and I am sure that the Minister would remember this—that, once young offenders leave detention, there are very few follow-up programs to help them reintegrate into the communities. What is the department doing in that area?

The Hon. M.J. Evans: All young offenders released from secured care are placed on a closely supervised release program endorsed and overseen by the training centre review board. Each program is tailored to the individual and draws upon a range of community based services and support systems. Community service order commitments, as a component of the release program, have continued to be a feature of early release initiatives during 1992-93. The use of those CSOs provides intense supervision and the opportunity for young offenders to repair the damage they have caused.

Another feature has been the use of work camps in remote areas of South Australia as an early release initiative. Secure care staff have also worked closely with the Adolescent Forensic Psychiatry Unit on the development of innovative responses to young offenders, and a work force training program has also been a feature of the post-release area in 1992-93, including a Federal Government Land Care Environment Action Program for young offenders recently released from secure care centres. In 1992-93, 79 per cent of all youths released from SAYTC successfully completed their conditional release periods in the community.

The Hon. D.C. WOTTON: Older people when discharged from hospital frequently are not provided with appropriate support in the community. When will the existing discharge and admission guidelines be reviewed, and when that review takes place will the needs of older people be given special attention? I refer to a statement that the Minister made in his capacity as Minister of Health, Family and Community Services on 10 August under the heading 'Increase in health budget for 1993-94' when he announced $400 000 funding for a nursing convalescent unit at Flinders Medical Centre. Does this relate in any way to a submission for an extended care nursing service prepared by the Director of Nursing at Flinders Medical Centre?

In this extensive submission it is proposed that a comprehensive extended care nursing service be established and incorporated under the one umbrella with common infrastructure systems and processes, the service to enable patients who suffer acute episodes of illness and who require complex nursing to be cared for in their home environment by specialised Flinders Medical Centre nursing staff under the direction of the patient's consultant to facilitate the transition of patients from hospital to home by providing continuity of care with an emphasis on pre- and post-discharge planning. This area has been brought to my attention on a number of occasions when I have met with older people.

The Hon. M.J. Evans: The Health Commission is committed to reviewing those guidelines as part of its annual program for 1993-94, and that will take place this year. I do not think that the dependency nursing unit which the honourable member mentions in relation to the Flinders Medical Centre is related to the submission by the Director of Nursing. The unit at the hospital, which I opened approximately six months ago, is a low dependency unit where people are in transition from a serious illness or operation. They no longer require intensive acute bed care and are able to progress to a half-way situation where they live in a more domestic environment but within the hospital, so that in the event that there is a relapse in their condition or an emergency occurs they are but moments away from intensive acute care support. I suspect that that is a different program from the one to which the honourable member alludes, which has yet to be approved.

I also draw attention to the early discharge scheme that has been developed by the Queen Elizabeth Hospital in relation to Commonwealth booking list funding which should provide substantial support to people in the circumstances to which the honourable member refers. Early discharge schemes are an integral part of our health care planning. They help both the patient and their family; society through early return to work, if appropriate; and the health care budget itself, because of the release of valuable acute care beds. I accept and agree that this is an important area. The guidelines will be reviewed and commitments are being made through individual projects in the health care system.

The Hon. D.C. WOTTON: When will an adequately resourced strategy be developed to properly address the rehabilitation needs of older people? Rehabilitation linked to discharge planning is of critical importance to older people and significantly impacts on their quality of life. This matter has been raised on numerous occasions. Further, can the Minister indicate, recognising that this is more a responsibility of his colleague but one which as Minister responsible for older people in South Australia he would have an interest in, when the Access Cab scheme will be extended to provide a realistic level of service to disabled older people, while realising that it must be extended to provide access to more older people as well as a greater number of trips for those currently in the scheme?

The Hon. M.J. Evans: Obviously, rehabilitation services are very important. They are, indeed, provided through the health system at the moment. I recently opened the Alfreda Centre in the western region. The member for Albert Park was there and welcomed the development—a very substantial service—and of course that will benefit not only those with work-related injuries but also older people in the community, and rehabilitation beds are provided elsewhere throughout the health system. Rehabilitation beds, though, are in relatively short supply. It is a growing area, and unfortunately it is a relatively new area in that respect. The needs, in that context, have always been there but have not been addressed as adequately as they might have been. Those services are continuing to expand. For example, apart from the Alfreda Centre, which I mentioned earlier, St Margaret's Hospital has proposed the establishment of a specialist 10 bed in-patient rehabilitation unit, and that is being considered.

The Health Commission has made available $300 000 for operating costs and has set aside $213 000 for capital works to enable the establishment of the service in 1993-94. So, there is a range of initiatives in that area, but I acknowledge that more work is yet to be done. The Access Cabs area, as the honourable member said, is more particularly the responsibility of my colleague the Minister of Transport Development, but I do believe that some seven additional specialised vehicles are being brought into the system this year. No doubt the Minister will be able to expand that service as and when circumstances and funds permit.

The Hon. D.C. WOTTON: I am pleased that the Minister realises that there is a desperate need in that area, as I am sure he does. I refer to representation which I have received, and which I am sure the Minister has also received, also from aged care organisations. They make the point that the not-for-profit industry is concerned with the high WorkCover

premiums imposed in the State in comparison with charges incurred by the industry in other States. This high cost to member organisations is exacerbated by the methodology being applied by the Commonwealth with respect to reimbursement on an industry average rate versus full reimbursement.

Also, with respect to the supported residential facilities legislation, there is concern that, on many occasions, they are being assured that the industry—that is, the Commonwealth funded and monitored nursing homes and hostels—would be exempted. As I understand it, the draft regulations advise the procedure through which exemption may be granted by the Minister. It is noted that if exemption is granted inspectoral staff, which is yet another body entering into and overseeing the industry, may enter the organisation to ascertain whether the organisation does have an exemption.

The industry would suggest that, if the nursing homes and hostels that are funded and monitored by the Commonwealth Government are given a class exemption, this action would negate any costs associated with staffing resources supposedly required to monitor approximately 400 facilities. Members of the industry are also concerned with the impact on the aged care industry regarding the institutionalisation of mental health organisations. They consider that the aged care industry will be required to care for these persons now placed in the community and, because of the lack of options, these people will seek the appropriate provision of services in hostels and nursing home care in mainstream Commonwealth-funded institutions and, in turn, will place additional stress on industry staff and resources. A number of issues are contained in that representation, and I appreciate that some advice from the Minister may need to come as a result of the matter being placed on notice. Considerable concern is being expressed, and I would appreciate it if the Minister could provide a response to some of those concerns.

The Hon. M.J. Evans: Certainly, in relation to the WorkCover matters I am happy to refer them to my colleague the Minister of Labour Relations and Occupational Health and Safety. I am not quite sure of the nub of the point the honourable member was making in the second half that discussion: it seemed to relate to a whole area of registration, and so on. I am happy to go through the *Hansard* report of that and find individual points to see whether additional information can be provided. I certainly did not quite gather the central point that was being made. It is certainly true that those inspections can take place under the Act, and so on, and the Act was passed through here with a relative degree of bipartisan support, which I appreciated. I am just not quite sure of the concern being expressed by the honourable member.

The Hon. D.C. WOTTON: Rather than take up the time of the Committee at this stage, I would appreciate it if the Minister would have a look at *Hansard* and provide a response.

Can the Minister inform the Committee how the negotiations are proceeding with acute hospitals regarding the establishment of conjoint geriatric units with other community services in the Domiciliary Care Service and the RDNS? Also, can the Minister indicate when the proposed amalgamation of the RDNS and the Domiciliary Care Service will take place? Recognising that discussions about the amalgamation commenced some time ago, I would like to know what progress has been made in that area.

The Hon. M.J. Evans: Of course, much of this falls under the health provisions, but I understand that approximately 72 per cent of the RDNS clients also receive assistance from Domiciliary Care Services. The Metropolitan Health Services Division of the Health Commission has initiated a process of collocation, integration and, if appropriate, amalgamation of these services. Part of that matter is also subject to consideration by the Health Administration Select Committee of this House, so I do not want to pre-empt any decisions that that Committee may come to or any recommendations which it may make.

Obviously, that is an important issue. I support the collocation and the integration of those services. If amalgamation turns out to be an appropriate step at some point, that can certainly be considered, but significant gains are there to be had through integration and collocation, which has already occurred in some situations.

There are certainly no plans afoot to enforce amalgamation or to implement that in the short term. As I said, that is a matter which needs longer-term consideration, in particular by a select committee of this House at the moment. But the collocation and integration objectives are very worthwhile and will be pursued with individual regional agencies as and when that is appropriate.

The ACTING CHAIRMAN: I understand there are no further questions from the right of the House, so I will call on Mrs Kotz.

Mrs KOTZ: We talked earlier about the discontinuation of the post-adoption services, and I am quite sure that the Minister realises that there are many areas where young people do suffer because of abuse and neglect which they have experienced, particularly when they are reaching that age of adolescence. They may be harbouring an accumulation of emotions, particularly anger and sadness, which causes them to act inappropriately.

The only way of expression they have is indeed to express those negative feelings, which may be anti-social and put the young people themselves at risk as well as other members of the community. With the restructuring of youth supported and assisted accommodation programs, no facility is available specifically for young people with challenging behaviour, if I can put it in that manner. This means that adolescents with behavioural problems who cannot be supported in foster care have few alternatives available and are at risk again. Has the Minister and the department considered this area of need; and, if so, what specific program has been designed to accommodate these young people?

The Hon. M.J. Evans: No centre as such is provided for young people with challenging behaviours, but the problem is recognised through the provision of overall support services, so that where such a young person presents in relation to a particular service they are able to buy in the contracted services which they need. For example, Lochiel Park is also available as a community residential care centre where children with challenging behaviours who are under the guardianship of the department are able to be accommodated and assisted. However, in relation to those from outside the department's care the policy is to provide funding for services to be purchased in relation to individual young people rather than to have a centre which is the focus of activity for young people with challenging behaviours.

Mrs KOTZ: Obviously the Minister recognises, as I stated earlier, that in attempting to purchase these services it is a limited area. You mentioned one area at Lochiel where apparently there is appropriate accommodation, but what other areas are we specifically talking about? Where are we looking to purchase these requirements? At this stage do we

have a list of youngsters with whom the department is dealing as to these terms and needs?

The Hon. M.J. Evans: Young people concerned with challenging behaviours can live in any of the supportive accommodation program centres or opportunities, including the INC parents scheme and, wherever it happens to be that they are accommodated, additional services can be purchased for the extra cost which their challenging behaviour causes the organisation sponsoring them. The idea is not to provide a one-off location, which is the focus of activity in this area, but rather an integrated approach where these young people can make use of the mainstream services but, where they do that and that has an impact on the cost of that service, there is provision for young people to have the extra services that they need brought in for them.

Certainly, we need to work more closely in the future with CAMS as well because it has a role to play in that area. It is better that these young people are accommodated as part of the broad community service and community accommodation programs rather than seeking to create an institutionalised environment where only these kinds of young people are accommodated.

Mrs KOTZ: I believe the serving communities project is seen as clear recognition of the commitment to real partnership between all levels of Government and the non-government sector. Will the State Government commit funds to offset the cost of reforms in those areas that have been identified through the serving communities project as being unable to absorb any additional cuts or reduce the deficit to meet existing demands? Will the Minister provide details of the serving communities project and the difficulties that they obviously have identified in being unable to absorb any additional cuts?

The Hon. M.J. Evans: I am having difficulty with the question because there has not been any substantial change to funding to the serving communities project. The honourable member may be referring to something that she has not mentioned in her comments. As to the community services sector review, which is the serving communities project, a memorandum of understanding was agreed between the Deputy Prime Minister, the Minister of Health, Family and Community Services, the President of the Local Government Association and the President of SACOSS. Five think tanks were established at the end of 1992 and they met their reporting deadline of 31 March.

There has been a plenary session as a result of that, and the task force has developed a work plan and time frame for its implementation. Funding arrangements for peak bodies are being reviewed and a proposal for restructuring is being developed in consultation with relevant organisations. Serving communities has convened three meetings of unions, employees and funding agencies to deal with the applications of new industrial awards and, in particular, the social and community services award.

We have discussed broad-banding feasibility studies and conducted those studies in the southern and northern metropolitan LGA areas and in the Riverland. A model service agreement based on a set of explicit principles has been developed and work will commence soon on its application to a particular program area. A two-day community management seminar is to be held today and tomorrow, and a half-day information technology seminar was held on 13 August 93. Numerous reports have been published of their work. However, I am not sure what the honourable member is referring to in relation to funding cuts.

Mrs KOTZ: I believe that the area in question was in the case of certain reforms that apparently were to be undertaken that would initiate costs that would not have a further reallocation of budget.

The Hon. M.J. Evans: Funding has been guaranteed until July 1994. There is a clear commitment to that: it was agreed at the beginning of the project. Part of the reform is often the generation of savings as well as extra costs, so there are often offsetting savings as a result of reform and structural change; for example, that has occurred in the SAAP funding program. I do not understand the nature of the question given that that funding has been guaranteed until the end of this financial year, when the position will be reviewed.

Mrs KOTZ: The introduction of the Social and Community Services Award will have significant implications for the non-government sector. What provision has been made to ensure adequate funds are available to relevant departments to enable them to properly resource the implementation of a Social and Community Services Award, enabling community service organisations to maintain a level of service which accords with the escalating needs of the community?

The Hon. M.J. Evans: Negotiations are continuing between employers and unions over a classification structure and rates of pay for the Social and Community Services Interim Award. It is anticipated that these matters will be resolved by the end of the year. There is no current award covering the majority of workers in the support of the accommodation sector. When the full costs of award introduction can be more accurately costed, consideration can be given to how agencies may be assisted to deal with any increased labour costs. At the same time the Government remains committed to encouraging management in service restructuring, which will increase efficiencies, reduce the costs of providing services, and improve outcomes for customers. Following the review of funding commitments through the Family and Community Development program, agencies will in the main be placed on three-year funding agreements which will increase security and enhance agency planning. So, at the moment we do not have the details that are required to provide that commitment, but when they are available we will be able to work through the implications for the agencies.

The Hon. B.C. EASTICK: Does the increasing emphasis on case-mix based funding at major hospitals address adequately the needs of older people, particularly those with multiple diagnoses and/or psycho-geriatric problems, which is an area of increasing involvement in the community with Alzheimer's disease and similar geriatric problems coming more and more to the fore?

The Hon. M.J. Evans: Case-mix funding in the health sector is still very much an objective. The new Victorian Government has proceeded enthusiastically down those lines. We have held back slightly in that area given the implications such as the ones to which the honourable member has correctly drawn attention. The impact of case-mix funding is dependent on the social mix in the community. We discussed this morning the implication of social justice costs in hospital funding and I think the point to be made is the same one that we drew this morning: that one cannot follow formulas slavishly in these areas but one must develop a range of responses to them and determine funding formulas based on case-mix, on social justice criteria and on the age and other profiles of the communities to determine a balanced approach to funding.

No one formula will ever be the magic equation where you simply put the equation to work through a computer and get the exact answer at the end. It is a matter of refining the model—and case mix is a good model—that produces an outcome, but then you must judge that outcome based on other criteria, including the age profile, the social justice profile and so on, of the community that you are addressing, and it will always remain the responsibility of Government to make that final adjustment based on the input from the various mathematical models that we can establish with increasing certainty, but without the human touch.

The Hon. B.C. EASTICK: Can the Minister indicate whether the Office of the Commissioner for the Ageing is taking part in an assessment of Alzheimer's disease and its ramifications, or is it looked upon as a health initiative without direct impact upon the activities of the ageing sector?

The Hon. M.J. Evans: Of course, quite substantial research and work is being done on Alzheimer's disease through the Health Commission and the health units. There is also an Alzheimer's support service, which is a substantial voluntary effort and which puts considerable resources into assisting sufferers and their caring family to cope with the problem.

I think I should draw attention to the fact that the Office of the Commissioner for the Ageing is not a service delivery agency in that sense and certainly not a health services delivery agency: it is a small unit and not able to respond in that way. But, of course, the Commissioner would be very interested in issues affecting older people, and Alzheimer's is certainly one of those. Therefore, the Commissioner would retain an interest in that, but I think the primary service delivery role would have to be through the commission.

The Hon. B.C. EASTICK: Certainly the information coming to the Commissioner from those in the aged area is likely to be of tremendous advantage to any detail that the health sector might be looking for. Not infrequently, some small area of activity can sometimes pinpoint or foresee certain aspects of a problem that the bigger picture of the direct health-based approach might miss. That is the basis upon which I approach the matter.

The Hon. M.J. Evans: That is exactly what the health care for older people policy is all about. That will help us to identify those areas and, of course, the Commissioner retains that brief across the board to interface with the mainstream agencies to ensure they are taking into account the special needs of the older community in areas of health care or public transport, etc. However, in particular, this one topic upon which the honourable member has focused is very important. The Commissioner would retain a strong interest in that and, where relevant input can be had through the policy, for example, or through the individual service agencies, the Commissioner would certainly take that step.

The Hon. B.C. EASTICK: Earlier this afternoon there was a number of questions in relation to HACC and delivery of service in that area. One of the voluntary organisations makes the claim that there is a no-growth situation from the viewpoint of the service area for post-acute treatment and rehabilitation for families in stress and in palliative care in relation to the overall HACC program. Can the Minister indicate whether such a no-growth circumstance has been identified within the department and what action is being taken to address it?

The Hon. M.J. Evans: The current HACC funding agreement with the Commonwealth does indeed provide that that is a no-growth area. However, for example, the palliative care recommendations will receive a substantial boost from the Commonwealth palliative care funding, which we discussed this morning. So, while the present agreement does designate the general area—the statement the honourable member made was correct; that was a designated no-growth area—I would draw attention to the special provisions that will be made in the palliative care field, arising from both from the Commonwealth initiatives and also from the select committee report in which the honourable member participated.

The Hon. B.C. EASTICK: The Minister will be aware that palliative care is not necessarily a situation peculiar to the aged, and that there is an increasing likelihood of palliative care being required, for example, for AIDS sufferers. One of the submissions presented to the select committee on death and dying mentioned renal failure, myocardial problems and, indeed, a batch of further medical conditions affecting younger people, indicating that this may alter the original concept of HACC for the aged and dilute the benefit.

The Hon. M.J. Evans: I am not quite sure where the question came in there.

The Hon. B.C. EASTICK: I understood that the original concept of HACC was more for provision of needs for the aged in the community rather than for younger people, and the greater use has certainly been for people in the aged field. If we are to have, as statistics and medical evidence would suggest (and I am talking now from the care point of view, not the health point of view), an increasing number of younger people requiring the type of assistance HACC can give, will there be a diminution or dilution of the effort available to the aged, and is that a problem?

The Hon. M.J. Evans: One needs to keep in mind that the original target groups for HACC were the frail aged, young people with disability and their carers. There were three target groups in that area, so it has never been exclusively a frail aged area or exclusively a younger disabled area but shared between the two. There is a balance to be struck there and, obviously, that is an ongoing policy area where each interest group would have its own viewpoint to put forward.

The honourable member correctly draws attention to the fact that palliative care is not just a function of the older community but needs also to be seen as a separate issue. Quite substantial funds for palliative care are now being provided both through the State and through the increasing Commonwealth initiatives. South Australia, as we noted this morning, probably has one of the highest standards of palliative care available in this country. Funds provided for hospice and palliative care services increased by nearly 25 per cent in 1990-91 and have been maintained in 1991-92 and 1992-93.

We have some dedicated hospice bed units in the north and in the southern districts, as well as in the central Adelaide region, which provide a very high standard of service, and we can expect to see that grow as the Commonwealth funding initiatives take effect. So, one needs to look at the HACC program not in isolation but in the context of the broader palliative care services that are provided and the expansion in funds that is being enjoyed in those areas.

The HACC program itself has also enjoyed significant growth, and I detailed that in response to earlier questions. There has been quite substantial growth in HACC as a whole. So, when you put all those factors together I understand the points the honourable member is making but I think that they are addressed by the growth in HACC funding and by the growth in palliative care funding.

The Hon. B.C. EASTICK: Does the Minister have any statistical information (or will he make it available in due course) as to whether there has been a change in the percentage of HACC funds going to particular aged groups?

The Hon. M.J. Evans: I will seek to obtain what information I can. While some people obviously fall into one category or the other, there are grey areas at the margins. The definition problem is not without its difficulties, but I will ask the department to generate what statistical data are available to differentiate those two categories.

The Hon. D.C. WOTTON: On page 190 of the Estimates of Payments and Receipts, dealing with intra-agency support service items not allocated to programs, referring particularly to 'Goods and services—Administration and operating expenses, minor equipment and sundries', the estimated sum is $3 642 000. What does that sum represent?

The Hon. M.J. Evans: That has gone from an actual expenditure in 1992-93 of $2.147 million to an estimate in 1993-94 of $3.6 million. The savings in 1992-93 were the result of underspent funds in agency services and executive areas of $297 000. Departmental reserve funding placed under intra-agency support services and estimates but transferred to other areas as required was $221 000. Savings from the restructuring of the central area and the February reallocations for 1993-94 reflect restoration of the base reserve provisions and carryovers. Quite a few commitments which were incurred in the previous year have been carried forward into this financial year. The funding there represents a restoration of the original base because the savings which were available last year are not available this year. That line has also been used to fund commitments which were made in the previous year but which had to be paid for in this financial year.

The Hon. D.C. WOTTON: I am intrigued about the reduction in the maintenance costs of buildings. We seem to have gone down from $536 000 to $475 000. What is that about?

The Hon. M.J. Evans: Some savings were made during 1992-93 and they were carried forward to 1993-94. We have one-off funds resulting from the sale of the Gawler office in 1991-92, and a 1 per cent savings target was applied which was offset by savings carried over from 1992-93. Most of the impact has been from the smaller number of buildings now owned by the department. As a result of the restructuring process, we have been able to reduce the number of buildings owned by the department. When that is added to the one-off savings, it means that we have been able to reduce costs. It is not so much a case of less maintenance for the same buildings as the same maintenance for fewer buildings.

The Hon. D.C. WOTTON: I note that, under 'Grants—Family and community development', the estimate last year was not reached. The estimate for 1992-93 was $549 000 and the actual was $472 000. This is a very important area. Why was that estimate not reached?

The Hon. M.J. Evans: Some of the result of transfers of funding from operating to grants, and minor variations are the result of reallocation within the family and community development grants area across the program. So, there has been some reallocation of some grants from one line to another, which explains part of it. There was a slight underexpenditure in the grants line in 1992-93; that base was restored in the 1993-94 estimates. It has only changed from $4.8 million proposed for 1992-93, as against a $4.744 million actual; so the difference is very small, given the total program, and this year we are proposing a $4.787 grant line, taking into account that some programs have actually moved lines. I do not think the variation there is terribly significant.

The Hon. D.C. WOTTON: It is a variation from the 1992-93 estimate to the actual expenditure.

The Hon. M.J. Evans: The proposed expenditure was $4.8 million; the actual expenditure was $4.744, so the variation is only $50 000 out of $4.8 million.

The Hon. D.C. WOTTON: Will the Minister provide for the information of the committee the list of grants that are being made available?

The Hon. M.J. Evans: We can obtain that print-out and make it available to the Committee. That is for the 1993-94 financial year?

The Hon. D.C. WOTTON: Yes. I want to raise an issue that I referred to previously, relating to the matter of the department's involvement in taking a person to court when that person is a parent of a child or a youth who has turned 18 but who still requires maintenance to be paid by that parent. It is a matter that I have discussed, and I appreciate the frankness with which the senior officers have discussed this issue, but I find it pretty hard to accept that the department needs to be involved in taking persons to court over such an issue. I realise that the department has a responsibility to do it under the Family Law Act. In the House the other day I raised a matter where a parent, who had never seen his child and who had paid the maintenance up to the age of 18, had in recent times in fact been asked to increase that maintenance.

He had done so, on the basis or in the belief that when that child turned 18 there would no longer be a responsibility, but then was absolutely staggered to find that he was taken to court by the Department for Family and Community Services, which insisted that that maintenance be continued because that young person wanted to go on to tertiary education. I understand that that matter has now been addressed and is out of court as a result of payment being made, but, at the time about which the agreement has been reached with that payment of some $3 000 to the son, the young person was living away from the family with a grandmother, was receiving $118 weekly through Austudy and had signed an affidavit that his expenses were no more than $104 a week (and that included a fair percentage of that amount which apparently is being paid to the grandmother for rent). Yet it has been determined by the court that that father should pay to his son the sum of $3 000.

However, it has been determined by the court that a payment of $3 000 should be made to the son by the father. How many people are in that situation? It would be interesting to know how many times over the past 12 months the department has found it necessary to take a parent to court over this issue. The time taken and the resources required by the department to deal with this before the court would be quite extensive. With all the other priorities that the department has, I find it difficult to come to terms with the department's having to be involved in such an issue.

The Hon. M.J. Evans: I will deal with the last point first. Whatever the merits of the proposition, we are spending Commonwealth money in this area because we get full cost recovery from the Commonwealth.

The Hon. D.C. WOTTON: This is not State departmental resources being used?

The Hon. M.J. Evans: No, because they are repaid by the Commonwealth. At no point do we draw on State resources to provide this service. It is not done at the expense of other State services, and I understand the honourable member's

concern there. This is funded by the Commonwealth. We get full cost recovery from the Commonwealth. It is not done at the expense of other State initiatives which one might deem to be of greater importance, because the program enjoys full cost recovery. However, that is not to defend the program *per se*. It does need to be looked at in the context that this has a great deal of history.

The legislative authority for this provision is contained in the Family Law Act of the Commonwealth, and it has been there since the Family Law Act was implemented. Prior to the introduction of the Family Law Act in 1976, the department enforced the same kind of principle under the provisions of the Community Welfare Act in South Australia. This is a long-standing provision. However, times are changing, and circumstances are not what they were.

I have also received correspondence from the person to whom the honourable member refers, and I have taken note of his comments in the House. I have asked the Chief Executive Officer to review the circumstances of these payments to see whether we need to make an adjustment in our philosophy. I point out that it has a longstanding legislative history, enacted many years ago in the State and in force since 1976 as a result of Commonwealth legislation. We do get full cost recovery, but there is a philosophical issue behind it which needs to be reviewed in the light of modern circumstances and in the light of the many benefits and payments that are available generally. We will certainly have a look at that. I think the honourable member should be aware of the other factors that I have mentioned this afternoon.

The Hon. D.C. WOTTON: In the past 12 months, how many times has it been necessary for the department to take a person to court over this issue?

The Hon. M.J. Evans: We will try to obtain more detailed information, but I do not believe that the number is very large. The number is increasing as economic times affect the ability of young people to go to university, and the costs of that increase. So, there may well be increased demand in the future. While the absolute numbers now are quite low, it is an appropriate time to review it to see what the circumstances are. We will try to obtain some more detailed figures for the honourable member. The philosophy of it may be a significant issue to look at. I do not think that the absolute numbers of young people involved are such that it is a problem.

The Hon. D.C. WOTTON: The State Disaster Plan is mentioned on page 510 of the Program Estimates under 'Welfare Services, Individual and Family Care, Support and Protection'. I realise this was referred to earlier. It states that the 'State Disaster Plan (Welfare) and Standard Operating Procedures will be updated.' What is the process under which that will occur? Who are the people involved, and what are the anticipated changes in the disaster plan?

The Hon. M.J. Evans: The Chief Executive Officer is a member of the overall coordinating State Disaster Committee, and an officer of the department is consulting with relevant non-Government agencies to ensure their involvement in the review. That will take place over a period and will be coordinated with the State Disaster Committee through the CEO.

The Hon. D.C. WOTTON: How does that relate to the national disaster needs analysis?

The Hon. M.J. Evans: The State Disaster Committee will work with the National Disaster Committee to ensure that the two plans are complementary.

The Hon. D.C. WOTTON: Is there any time scale in regard to that?

The Hon. M.J. Evans: Given the involvement at national level and the magnitude of the task, I do not think one could expect definitive changes in that area in under a year. It is being worked on on a continuous basis, but we are talking about liaison between committees at State and national level, involving coordination between non-government agencies and Government sectors at local level; and a Senate committee inquiry is proceeding as well. When you put all those factors together, I think that we should look forward to at least a 12 month time line.

The Hon. D.C. WOTTON: Does that mean that you really have not got off the ground yet?

The Hon. M.J. Evans: We have a State operational disaster plan. That is in place. I do not think one needs to underestimate the significance of having that in place. What is occurring now is the national coordination of the various plans. Obviously it is a very complex area because a disaster covers such a wide range of responses and agencies. When you link that into the Federal level and add in a Senate inquiry as well, I am being conservative about my time estimate. Given that we have our own plan in place, it is probably better to take the time and trouble to have the consultation and get it right at the national level.

The Hon. D.C. WOTTON: Yesterday, the Minister launched National Foster Parents Week. I understand that there is some difficulty, and I would be interested in the Minister's comments on this, in recruiting foster parents. First, is that the case? I notice in the Specific Targets for 1993-94 that the media section will design and implement a print and electronic media campaign to recruit foster parents as part of National Foster Parents Week. Is that the case?

The Hon. M.J. Evans: We have the same number that we had last year, so there is not a crisis situation in that regard but, if we looked at identifying areas where we are in need of extra support from the community, it would be in the area of teenagers and children with disability. Those would be the two target groups where there is most difficulty in obtaining foster parents. The foster parents to whom we have access on the system are enough to cope with the immediate demand, but clearly it would be desirable to have more parents in those two categories to ensure greater flexibility and adequacy of supply.

The Hon. D.C. WOTTON: Yesterday I had discussions with some of those foster parents. I would be most interested to know the average length of time that foster parents spend with children. I know that that would vary considerably.

The Hon. M.J. Evans: I had discussions with them as well. For example, I met a constituent of mine who has been a foster parent for nearly 22 years and who has had nearly 1 000 children in her care. Others have had children in their care for a very short period. I am not quite sure what would turn on an average. I think that an average would be misleading in that context. Some are emergency parents; some are long-term parents. We would be combining different groups and obtaining a mathematical average which, I suspect, would be of value only to a mathematician. I do not think that an average means anything; it is of no significance.

The Hon. D.C. WOTTON: What is the Government doing to recruit new parents?

The Hon. M.J. Evans: We have Foster Care Week in which we highlight the value of foster care parents. That provides publicity and information. We constantly talk to suitable people through the department and its officers, and

people come and go from the program all the time: new parents are signed up, and parents who have been in the program for a while drop out. There is bound to be a turnover in those areas. We have placement teams in each region which have a quota for that region and which recruit from interested people who make inquiries of the department.

I do not think one should interpret from my earlier comments that there is a massive difficulty in that area; it is simply that if we are targeting any groups at all we are looking for people in those two areas. There is a constant turnover of foster parents, and new people are coming on stream all the time. The non-government sector is of considerable assistance in providing candidate foster parents for the department to talk to.

The Hon. D.C. WOTTON: Over the past two years how many new foster parents have been recruited and how many have dropped out of the system? I would like to know how that relates to INC parents as well.

The Hon. M.J. Evans: Historically I am advised that we have a 20 per cent turnover of INC parents each year, but it is a difficult job and people are under stress. So clearly one would expect a turnover of people.

The Hon. D.C. WOTTON: I request that the information be provided under the normal time scale in response to the following questions. For each board, committee and council for which the Minister is responsible: who are the members; when does each member's term of office expire; what is each member's remuneration; who appoints the members; on whose nomination or recommendation is the appointment made; and what is their role and function?

In respect of contract officers, how many officers are now on contracts of service rather than permanent employment; at what level are they serving; who, if any, of those officers are subject to performance reviews; how is performance measured; who measures it; who reviews performance; what are the consequences of failure to perform; are any performance bonuses paid; and, if so, what are they and how are they measured?

For each department and agency for which the Minister is responsible: how many positions have been proposed to be abolished through targeted separation packages; what is each position; how many persons have so far elected to take the benefit of a TSP; how many TSPs have so far been accepted; what are the salary and conditions of service of each of the Minister's ministerial officers; and what are the job specifications of each officer?

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

ADJOURNMENT

At 6.6 p.m. the Committee adjourned until Tuesday 21 September at 11 a.m.