HOUSE OF ASSEMBLY

Thursday 9 October 1986

ESTIMATES COMMITTEE A

Chairman:
Mr D.M. Ferguson

Members:
The Hon. H. Allison
Mr K.C. Hamilton
Mr G.A. Ingerson
Mr J.K.G. Oswald
Mr M.D. Rann
Mr D.J. Robertson

The Committee met at 11 a.m.

Minister of Health, Miscellaneous, $573 101 000

Witness:
The Hon. J.R. Cornwall, Minister of Health and Minister of Community Welfare.

Departmental Advisers:
Professor G.R. Andrews, Chairman and Chief Executive Officer, South Australian Health Commission.
Dr W.T. McCoy, Deputy Chairman.
Mr D. McCullough, Executive Director, Central Sector.
Mr R. Sayers, Executive Director, Administration and Finance.
Mr D. Coombe, Executive Director, Western Sector.
Mr R. Blight, Executive Director, Southern Sector.
Ms C. Johnson, Executive Director, Management Services.
Dr C.C. Baker, Executive Director, Public Health Services.
Dr D. Filby, Director, Policy and Projects Division.
Dr D. Blaikie, Chief Executive, South Australian Dental Service.
Ms E. Furler, Director, Social Health Office.
Mrs J.M. Hardy, Acting Executive Officer, Mental Health.
Dr A.S. Cameron, Senior Medical Officer, Communicable Diseases Control Unit.
Dr M.T. Collings, Deputy Executive Director, Public Health Service.

The CHAIRMAN: There are a few preliminary matters. The procedures of this Committee will be relatively informal. If the Minister undertakes to supply any information, the last date for its insertion in *Hansard* is Friday 31 October. I propose to allow the Minister and the lead speaker for the Opposition an opening statement of about 10 minutes, if they so desire. There will be approximately three questions per member. Subject to the convenience of the Committee, a member who is outside the Committee and desires to ask a question will be permitted, once the line of questioning on an item has been exhausted, to do so. However, I would appreciate indications in advance of any questions to be asked. All questions are to be based on the lines of expenditure revealed in the Estimates of Payments, and are to be directed to the Minister. Does the Minister have an introductory statement?

The Hon. J.R. Cornwall: It has become my practice over the years when attending these Committees to have prepared statements. If it is agreed by the Committee, perhaps my statement concerning the health budget could be incorporated in *Hansard.*

STATEMENT FOR BUDGET ESTIMATES COMMITTEE: HEALTH

In line with the current domestic economic situation and the budget strategies of the State and Federal Governments, the South Australian health system has moved to achieve all-round savings and economies this financial year.

As we have all been made aware over the past few months, these are very difficult economic times and Governments have been faced with very real budgetary constraints.

Under smaller government, the level of services, many of which the public has come to expect, is unavoidably reduced.

This is something those who preach small government must acknowledge and not balance with contradictory calls for greater services and criticism of the unavoidable consequence of service reductions.

In health, the philosophy which has guided our budget strategy has been to achieve competence in management balanced with compassion for the needs of people.

In implementing the expenditure reductions, we have followed a strategy of ensuring the minimum possible impact on patient services in the public health system.

The interest and welfare of patients has been the highest priority in budget planning and, wherever possible, savings have been achieved in areas not directly concerned with patient care or service delivery to clients.

In the last financial year, the health system came in on budget at just under $762 million. That figure comprised $88 million in operating receipts from health services, just over $120 million in Commonwealth contributions, $550 million in State Government funds and an opening balance in the South Australian Health Commission trust account of about $3.3 million.

This year, the estimate for the entire health system is $794 million.

There has been a net reduction in the reduction in the allocation to all health units based on 1985-86 gross payments of approximately 1.3 per cent.

The goods and services inflation factor has also been set at 4 per cent, an amount which is acknowledged as being less than the projected annual rate of inflation.

Total savings by the South Australian Health Commission and health units will be about $10 million this year, about $4.9 million of which will come from the metropolitan public hospital system.

At the South Australian Health Commission's head office, a strategy has already been devised to reduce the staffing establishment by about 17 per cent, a measure which will achieve a saving of about $1 million.

The strategy was recommended in the first report of the Taeuber committee, which was established earlier this year to review the South Australian Health Commission head office.

From the current establishment of 375.2 full-time equivalent positions, the establishment will be reduced to 309.9 this financial year.

15.4 of the positions to be reduced are temporary and contract positions.

The appropriate advice has been given to the Public Service Association, and all staff will be redeployed either in health units or other Government departments.

The Taeuber committee is due to make a second report by 30 October, and the recommendations should complement a scenario for change and reorganisation already contained in the first Taeuber report, and in the Uhrig Report on administrative arrangements for the metropolitan public hospital system.

The Review of Metropolitan Hospitals, headed by one of the State's most respected private sector industrialists, Mr John Uhrig, recommends the creation of a central board of directors for the nine hospitals in the metropolitan public system (to be known as the Adelaide Hospitals Board), the abolition of individual boards, and a budgetary process of allocation for clinical programs across the hospital system.

The recommendations are aimed at developing an integrated and coordinated hospital system which not only ensures the efficient distribution and use of resources but can guarantee better care to patients.

In response to the report, the commission is in the process of appointing a working party to devise an implementation plan for Cabinet consideration early in 1987.

Despite the tight budgetary situation, we have also found $2.545 million in new money for a range of initiatives throughout the health system in 1986-87, with a full year cost of $2.84 million.

The initiatives have been made possible by good management throughout the rest of the system, and are taking place in areas of the greatest perceived need.

Some of the 17 areas to receive initiatives money are:

- $100 000 for the expansion of adult public dentistry through the South Australian Dental Service. This will be of particular benefit to pensioners and low income earners. Specific attention will be given to services in remote areas and in a number of community health units.
- $150 000 for improvements to obstetric and neo-natal services at the Modbury and Lyell McEwin hospitals. The improvements spring from a review of services at the two hospitals conducted earlier in the year by a team headed by Dr Andrew Child of the Royal Prince Alfred Hospital in New South Wales. The new money will fund additional obstetric registrar positions at both hospitals and increased medical sessions by general practitioners and visiting specialists.
- $400 000 for additional services to assist ageing parents who care for intellectually disabled children. Services to care for these children will be improved in the community and in institutions. The initiative springs from the recognition that caring for these children is becoming progressively more difficult for ageing parents.
- $200 000 will also be spent to improve health services for child victims of sexual assault. The money will fund the position of coordinator of Child Protection Services (to include the services of the Department of Community Welfare) and for increasing staffing at the Adelaide Children's Hospital and the Queen Elizabeth Hospital's Sexual Assault Referral Centre.

In addition to the new initiatives money, funding under the joint Commonwealth and State Home and Community Care agreement, which funds community-based services for older people and the young disabled, will increase significantly this year.

Last year, $1.1 million was allocated for 29 HACC projects and this year over $4.5 million is being made available for new projects or extensions to existing services.

$3.82 million has also been allocated to fund the first year of a two-year strategy to reduce the numbers on booking lists for elective surgery in the public hospital system.

This money has been made available from funds provided to the State under the Medicare agreement when that agreement was initially signed.

Elements of the strategy, which is currently in the process of implementation, include additional sessions in public hospitals, use of the Commonwealth's Repatriation General Hospital, the contracting out of elective surgery to private hospitals, and the computerisation of hospital booking lists.

The strategy aims to reduce the numbers on the list from the estimated January 1986 number of 6 400, to a manageable, and in fact desirable number of 4 500.

This figure represents an average of six weeks elective surgery workload for Adelaide's public hospitals.

The forward capital works program, which will see $240 million spent throughout the health system over the next five years has only been adjusted minimally this year, with some projects being slowed slightly but not cancelled.

Including the re-equipment program for the Central Linen Service, $36.2 million will be spent on capital works in the health area this year.

So, despite the budgetary constraints, some improvements in the health system have been possible this year.

Through good management and sound planning, we have been able to minimise the impact smaller government must have on some services.

This budget may set the pattern for succeeding budgets for as long as the current economic difficulties last.

Hard decisions will have to be taken in all areas for as long as Governments are forced to effectively reduce the level of Government spending.

Efficiency, services, priorities, financial accountability and work practices will all be vigorously examined in the pursuit of excellence throughout the system.

The CHAIRMAN: Has the member for Bragg an introductory statement?

Mr INGERSON: No. We would just like to get on with asking questions.

The CHAIRMAN: I declare the vote open for examination.

Mr INGERSON: My first question relates to the guidelines for vetting applicants for hospital positions. I would like to ask a series of questions about procedures within the Health Commission for checking the *bona fides* of applicants for senior positions in hospitals. At this stage I would like to comment that I am prepared to make available privately to the Minister the details that apply to this question. The Minister will recall that this matter arose in 1983 concerning the appointment of an administrator at the Port Augusta Hospital and the subsequent resignation of that person following investigations by the Crown Solicitor of allegations involving misappropriation of money.

I now refer to a more recent case involving a person employed by a Yorke Peninsula hospital. This person is now employed by a private hospital on Yorke Peninsula as Secretary/Administrator. However, his previous position was as administrator of a hospital administered by the Health Commission. I have been informed that the Yorke Peninsula hospital sought the assistance of the commission in assessing applicants when it advertised the Secretary/Administrator position about 18 months ago. I have also been informed that the Health Commission recommended for appointment the person it had employed previously as administrator. This person has now been charged with misappropriation of hospital and nursing home funds totalling more than $64 000. It is also understood that this person has a previous criminal record for embezzlement and larceny predating his initial appointment within the commission.

Will the Minister investigate this matter to determine the commission's role in the appointment of this person? If the matters I have put before the Committee are established, will the Minister urgently review procedures within the commission for vetting the *bona fides* of applicants for senior positions in hospitals?

The Hon. J.R. Cornwall: Let me make it clear at once that this person was appointed as the Chief Executive Officer of a private hospital. The hospital to which the honourable member refers is not a hospital that comes under the umbrella of the Health Commission in any way, except in the most general terms in that, like every other public hospital in this State, it has to be licensed. There are no Health Commission funds involved whatsoever. It is a gross distortion to suggest that there are. There is no responsibility devolving on the commission for the conduct of this private hospital, other than the general licensing provisions. It is a total distortion of fact to suggest that it is funded by the commission or that it is a recognised hospital that comes under the control or direction of the commission in any way, shape or form.

With regard to the specific allegations of the commission's being involved in the appointment of this person, and with regard to the more general questions as to procedures for interviewing applicants for positions, I would ask the Executive Director, Western Sector, Mr Coombe, to respond.

Mr Coombe: As to the former Secretary of the Moonta Jubilee Hospital, I was made aware last week that there were financial difficulties at that place and that subsequently that person had been charged with embezzlement. Getting to the nub of the question about the selection process, this person was appointed to his former post as secretary of that hospital some two years ago and, at the invitation and request of the Moonta Private Hospital Board of Management, one of my senior officers undertook the role of a personnel officer in respect of advising the board's interviewing panel as to appropriate questions to be asked of candidates and general advice to ensure that the interviews for the position of secretary were appropriately conducted.

My officer did not participate in the final selection process. He recollects vividly advising the interview committee, on which I understand there were eight members, to conduct reference checks, specifically in respect of the nominated candidate's bona fides with his former hospital, which was

Leigh Creek Hospital. In no way did my officer participate in the actual selection process.

The CHAIRMAN: I make it clear that we are discussing proposed expenditure, Minister of Health and Miscellaneous $573 101 000.

The Hon. J.R. Cornwall: Not one cent of that $573 101 000 will be spent this year on the Moonta Jubilee Private Hospital, and not one cent was spent on it in 1985-86.

Mr INGERSON: It is important that I clarify the Minister's statement. There was no suggestion in my question that the Health Commission was responsible for any sum. I made it clear that it was a private hospital, and there is no suggestion that it was a Health Commission responsibility. There is no implication of that. What was clearly part of it was the question whether the Health Commission had made references to the bona fides of the individual, and that has been answered by one of the advisers, and I accept and understand that. We were concerned that this gentleman's record was obvious before his appointment at Moonta and obvious when he would have been appointed to Leigh Creek Hospital, because it was a record before that time. I ask whether those sorts of bona fides are checked and, if they are not, we ask the Minister to make sure that that occurs in the future.

The Hon. J.R. Cornwall: I make the point that the person in question has been charged, but he has not been convicted, and we must be very careful about getting into trial by Parliament.

The CHAIRMAN: We are treading on very thin ice.

Mr INGERSON: There was no reference to his current arrest. His previous convictions are on the record, and there is no question about that. I want to make it clear that I made no attempt whatsoever to have a trial by Parliament. The convictions are on the record and were on the record before his appointment at the Leigh Creek Hospital.

The CHAIRMAN: What the honourable member has said so far is all right, but we must be very careful that Parliament does not prejudice any case that is currently before the courts.

Mr INGERSON: I refer to a recent report in the *Sunday Mail* that the Government is considering changes to the radiation protection legislation. Will the Minister confirm that he has already submitted one Cabinet submission proposing these changes, which will require amendments to the Roxby Downs indenture Act?

Clause 10 of the indenture relates to compliance with various health and safety codes. If the Minister is proposing changes to the indenture, is he in conflict with the Premier who said on 21 August that the Government would not seek to amend the indenture? Has the Government had discussions with the Roxby Downs joint venturers about the changes proposed by the Government? Will the Minister give a guarantee that the Government will not seek to enforce any changes to the indenture which do not have the agreement of the joint venturers?

The Hon. J.R. Cornwall: The member has it wrong. There are no proposed amendments to the Roxby Downs Indenture Act. I state that unequivocally. It is perfectly true that I took a submission to Cabinet some time ago proposing amendments to the Radiation Protection and Control Act. If the previous Liberal Government had not got it wrong, that would not have been necessary. The difficulty was that the then Minister of Mines and Energy and his officers negotiated the Roxby Downs Indenture and the Roxby Downs Indenture legislation without reference to the Public Health Division or to the then Minister of Health.

The then Minister of Health was not privy to the discussions or the negotiations, nor were her officers in the Public Health Division of the South Australian Health Commission. Consequently, the two pieces of legislation do not sit together terribly comfortably. I have taken advice from the former Solicitor-General and from a former Deputy Crown Solicitor (who was recently elevated to the Judiciary) that in order to enforce the as low as reasonably achievable principle with regard to radiation protection an amendment to the Radiation Protection and Control Act is the most desirable way to go. That would not in any way seek to enforce, or result in the enforcement, of any requirements which would be more stringent than the codes of practice referred to in both the indenture and the indenture legislation.

I seek to ensure that the as low as reasonably achievable principle, as enunciated in the codes of practice, can be enforced and considered in any future planning. I stress that the as low as reasonably achievable principle refers to social and economic factors having been taken into account. So, at the moment the situation basically is that the maximum exposure permissible within the codes of practice (and from memory I think it is four working level months annually) can be enforced. However, the as low as reasonably achievable principle, which may see that reduced to as low as two (or even one) working level months, cannot be enforced under the existing Radiation Protection and Control Act. Clearly, it is highly desirable that that should be enforceable. With regard to exposure and the development of lung cancers, it is now generally accepted that there is a linear progression.

In other words, there is no threshold below which exposure is safe. Given all those facts, in order to protect the miners at Roxby Downs and any other workers associated with that very big and worthwhile project, we are currently considering amendments to the Radiation Protection and Control Act. There have been discussions with the joint venturers; there continue to be discussions with the joint venturers; and, as a result of some very long negotiations, the recommendations will be going to Cabinet very soon. I hope that I can introduce appropriate amendments to the Radiation Protection and Control Act before the end of the budget session. Let me say that nothing has been done and nothing will be done that would in any way jeopardise the Indenture or the Indenture Act. Nothing will be sought to be done which would be outside the spirit and intent of the current codes of practice which apply to uranium mining, milling and processing.

Mr INGERSON: Have the joint venturers agreed to the proposals that the Minister has put before the Committee?

The Hon. J.R. Cornwall: Those discussions are current.

Mr INGERSON: In fact, they may not as yet agree?

The Hon. J.R. Cornwall: The discussions are current.

The CHAIRMAN: This the fifth question from the member for Bragg, and I might say I am being very generous to him because he is leading the Opposition questioning.

Mr INGERSON: Thank you, Mr Chairman. I appreciate your good nature. Has the Adelaide Children's Hospital been instructed to close 20 beds as part of its budget cuts? Will the Minister allow the ACH to offer beds to Mutual Community so that children can get the same standard of care at a specialist children's hospital? Will the ACH be fully reimbursed for costs arising from the new careers structure for nurses and for any salary or wage increases arising from the decision of either the Arbitration Commission or the State Industrial Court?

The Hon. J.R. Cornwall: The last question shows a total ignorance of the way that the budget process operates. Any additional costs which arise from changes in awards with regard to salaries and wages are met from the round sum

allowance. This matter seems to come up in budget estimates every year and I have great difficulty in getting some members to understand it. We never telegraph in the budget estimates precisely—

Members interjecting:

The Hon. J.R. Cornwall: It is a pity that these Committees are not used for the purpose for which they were originally intended. If people want to play politics, then they will get politics back. I do have a lot of highly paid and highly qualified officers here who would be only too happy to provide a great deal of information.

The Hon. H. Allison interjecting:

The Hon. J.R. Cornwall: Are you not well, Mr Allison? I have numerous, very senior physicians present, all registered and in good standing with the South Australian Medical Board. If you have any problems, we will be only too happy to help you.

Reverting to the question, any increases in wages and salaries are met from the round sum allowances. They are not a charge against the hospital's budget; they are not a charge against the commission's global budget: they are met by Treasury. That is the way the system has always worked. As I said, they do not appear in the budget estimates because it would be foolish to telegraph in advance to the employee organisations that we have set money aside to meet an increase in salaries and wages of a specific amount.

The simple answer is that, of course, any increase in wage and salary costs is automatically met for each of the hospitals and health units. Regarding the question about closing 20 beds, there has been no instruction to do anything. There have been negotiations between the Health Commission and every one of the hospitals with regard to their 1986-87 budgets, and that is the normal procedure. Each budget is negotiated by the sectors with each of the hospitals, and ultimately agreement is reached as to what is the optimum amount of money that can be provided in that budget.

As part of that process, agreement is reached on how that budget can be met. In the case of the Adelaide Children's Hospital, as part of the negotiations a decision was taken to close Joanna Ward for the normal Christmas shutdown. It is normal practice in each of the major hospitals for wards to be closed during the Christmas-New Year period. Staff want to take their leave at that time and it suits everyone that the elective procedures in the hospital do not take place during that period. Subsequently, when the hospital returns to full activity, those wards and beds are again fully staffed.

In this case, as part of the cost saving proposals, Joanna Ward will not reopen until the end of the financial year unless there are early epidemics. It is normal in all hospitals that there is greater stress on hospital beds throughout the period of the winter epidemics—the upper respiratory infections, pneumonia, croup, and associated conditions. I want to make absolutely clear, however, that if there is a departure from that normal pattern and if that pressure occurs earlier, say, in the Autumn, of course Joanna Ward will immediately be restaffed and recommissioned. I would also like to make clear that we now have primary and secondary level paediatric services in all the Adelaide metropolitan public hospitals with the exception of the Queen Victoria Hospital and, of course, the Royal Adelaide Hospital; so at this moment there is no reason to think that anyone would be disadvantaged by what is proposed at the Adelaide Children's Hospital. I repeat that if the pressures emerge earlier, Joanna Ward will be recommissioned. I am at a complete loss to understand what the honourable member means when he suggests that we should offer beds to Mutual Community.

Mr HAMILTON: The blue book provides detailed information on activity in the public hospital system but there is no information on activity levels in the private hospital system. What is the general pattern of activity in both the public and private hospital sectors, particularly in relation to the impact of Medicare?

The Hon. J.R. Cornwall: I will ask the Chairman of the Health Commission to respond to that specifically and to expand to some extent on activity statistics generally. If we look at things such as bed occupancy, average length of stay, patient turnover, the increase in day surgery, and a number of other indicators in the metropolitan public hospitals system, then one has to reach the conclusion that overall it is being managed very efficiently indeed. The trends continue. The average length of stay is reducing because of better patient management. Bed occupancy is high, which means that we are utilising those very significant resources to the maximum extent possible.

It is also very interesting to look at the bed occupancy of the public hospitals and the private hospitals in the metropolitan area to test the thesis concerning the flight to the public hospitals that has allegedly occurred under Medicare. There is no evidence for that at all in all of the statistics that have been available to this time. I will ask Professor Andrews to respond to the specifics of that question.

Professor Andrews: Hospital activity levels are a complex issue and there are a lot of figures. I apologise for having to load you with a lot of detailed numbers, but they are informative. During 1985-86 in the public hospitals sector admissions in this State grew by 1.2 per cent to a total of 244 000. Occupied bed days in that time decreased by 1.6 per cent to 1.55 million. The result of that in terms of average length of stay is that the average length of stay in our public hospitals dropped from 6.5 days to 6.3 days. In terms of average length of stay I think we enjoy a very efficient hospital system in this State. Occupancy averaged 72.5 per cent.

At the same time in the private hospital sector during 1985-86 admissions increased by 4.9 per cent to 98 000 and occupied bed days increased by 1.5 per cent to 487 000. The average length of stay in the private hospitals sector dropped from 5.1 days to five days, reflecting in the private sector the lower length of stay, since it is dealing with the higher turnover kind of activity that applies in the public hospitals system as a whole.

Within the teaching hospitals admissions have been up by 1.25 per cent and occupied bed days down by 0.9 per cent. Again, the average length of stay has dropped, going from 5.8 days to 5.7 days—a very good performance in our teaching hospital system. Occupancy levels have been high, 84.6 per cent overall, and over 90 per cent at Flinders Medical Centre, reflecting some community pressures in that hospital that we are very aware of. Outpatient and casualty services have increased by a factor of 5 per cent.

The Committee may be interested in the comparison with country hospitals where admissions went up to 1.2 per cent and occupied bed days down 1.6 per cent. The average length of stay also decreased from 7.7 days to 7.5 days, with occupancy at 72.5 per cent.

If we look at the private hospitals, which are mainly in the metropolitan area, category 1 hospitals (the hospitals with the most acute and sophisticated level of services) occupied bed days increased by 1 per cent and occupancy is now at a level of 70.5 per cent. In relation to category 2 hospitals, occupied bed days increased by 1.9 per cent and their occupancy is somewhat less at 57.5 per cent. In relation to category 3 hospitals, occupied bed days increased by 2.8 per cent, with occupancy of 73.5 per cent.

What then has been the impact of Medicare? The financial year 1985-86 saw quite a significant increase in activity, as I have outlined, measured in both occupied bed days and admissions in the private hospitals sector with the level of bed days almost returning to the level of pre-Medicare 1983-84 figures. At the same time the occupied bed days in the public hospitals system fell, with the result that the private sector increased its share of total occupied bed days from 23.4 per cent to 23.9 per cent, and total admissions from 27.9 per cent to 28.6 per cent.

These figures clearly do not appear to indicate that the private hospitals system is in any way being adversely affected by Medicare or that there is a massive drift of any sort into the public sector. At the same time the public system is able to deal with a small increase in admissions by reducing its average length of stay, and the figures have borne this out, and maintaining high efficient occupancies.

During the second six months of the financial year 1985-86 it has also been possible to reduce waiting lists at the major metropolitan hospitals. Any suggestion that there are measurable major impacts or pressures on the public hospitals system as a consequence in any direct or indirect way by Medicare is just simply not substantiated by the figures.

Mr HAMILTON: I have a supplementary question. It seems from the information provided to the Committee that a tremendous amount of monitoring has gone on in the hospitals. How does that gel with the statement on page 347 of the yellow book where one of the specific targets is to develop an information system to monitor booking lists in major hospitals?

The Hon. J.R. Cornwall: We have to go back a little bit to 1984, when the question of booking lists and waiting times first became an issue of public concern. At that time I asked what were the actual numbers on waiting lists or booking lists throughout the metropolitan public hospitals system. I anticipated that in this day and age of computers that that would be a matter of pressing a few buttons and producing comprehensive lists. I must say that I was amazed to find that booking lists generally tended to be kept by individual surgeons and departments in all sorts of rather antediluvian manual systems; and that in fact there was no computerisation of booking lists.

We undertook a review and asked the hospitals to manually go through the various lists within individual hospitals and produce consolidated lists for each hospital with breakdowns of the various areas, such as neurology, ear, nose and throat, and so forth. For the first time we were able to produce figures which showed how many people were on booking lists for elective—that is, non urgent—surgery throughout the metropolitan public hospitals system. Victoria was going through that exercise at about the same time.

There was no waiting list problem until people started to count the number of people on lists for elective surgery. We have come a very long way since that time. We now have systems in each of the hospitals where we can, at regular intervals, update the lists and see how many people are waiting, and compare that with the number of procedures in elective surgery that are done each week so that we know at any given time the overall number of weeks or months for particular procedures.

It is interesting to note that the number of patients on booking lists generally has come down from about 6 400 in January this year to about 6 100 in July, when the last comprehensive check was done. That was in advance of the specific strategy that has been developed to reduce waiting times and waiting lists so that already, because of better management, we have come down from 6 400 to 6 100.

There is now a two-year program actively going into place through this month and into next month which will see strategies devised to particularly tackle the booking lists and waiting times in each hospital. We are probably in a position to give some reasonable detail on that. I ask the Deputy Chairman, Dr McCoy, to provide those figures.

Dr McCoy: The commission, as part of the funds for the booking list strategy, has allocated $129 000 for the preparation of software so that the central computer system to which the Minister has referred can be established. I am advised that the staff member who will be developing that software will be commencing next week and it is hoped that the fully computerised system, as opposed to the manual surveys that have been done until now, will be in place in three to four months. The $3.82 million has been allocated over the five major hospitals. I will briefly refer to the amounts allocated to each and the purposes they will be put to.

The $1.225 million allocated to the Royal Adelaide Hospital will be utilised to recommission an operating theatre and to increase surgical sessions. It is anticipated that that strategy will commence in mid November. The surgical areas to be covered are orthopaedics, plastic surgery, ophthalmology, ENT surgery and general surgery. The aim is to achieve 30 additional operations a week.

At Queen Elizabeth Hospital $458 000 has been allocated for use to recommission a seven-bed ward and to increase the operating sessions at the hospital by two. Also, some funds will be used in the private system: in this case, at Western Community Hospital for the treatment of public patients, those who are health entitlement card holders at that hospital. It is anticipated that orthopaedics, ENT and eye patients will use the extra sessions while urology and vascular patients will be treated at the private hospital and a seven-bed ward will be opened next week, on 14 October.

At Flinders Medical Centre $1.2 million has been allocated. There has been much discussion at that hospital about the best method to use. The current view is that a number of beds in a ward will be converted to a five day a week ward and be reserved exclusively for elective surgery. However, the option is still being kept open to use some of the funds at the Repatriation General Hospital and Ashford Private Hospital.

The sum of $292 000 has been allocated to the Lyell McEwin Health Service. These funds are employed to increase sessions in general surgery, orthopaedics, urology, anaethetics and ENT. The increased throughput is expected to be 12 additional procedures per week in general surgery, three additional in ENT and four in each of urology and orthopaedics. The service has commenced its booking list strategy and has to date completed 150 additional procedures.

An amount of $225 000 has been allocated to Modbury Hospital to increase sessions in orthopaedics, urology and ENT and to utilise the private system for about 50 procedures in urology and orthopaedics, and in that case the hospital selected is Calvary Hospital. Orthopaedics procedures will commence this week and advertisements have been placed for specialist ENT surgeons and these procedures are expected to commence by the end of the year.

Mr HAMILTON: I want to turn now to another matter, the Home and Community Care program (HACC). I have been most impressed by what has taken place thus far. Can the Minister say what progress has been made in that area? What is the impact throughout South Australia of the program? How is it affecting those people who, in the past, have been forced to enter institutions but who are now being placed through this program?

I must say that I was somewhat disappointed to read in the local Messenger Press of the attitude of a group of Seaton residents to the placement of some of these people in a home not far from my electorate office. I believe that such people have a right to be placed and be involved in community activities. Therefore, I ask the Minister what is the impact of the HACC program thus far, particularly in the western suburbs and, as a rider to that, what is the future of Estcourt House-Ru Rua in the short and long term?

The Hon. J.R. Cornwall: I will answer some of those questions briefly and generally. With regard to HACC, the policy and philosophy underlining that program is something with which no sensible person could argue. It is about extending existing services and creating new services to keep the frail aged and younger disabled in their homes in the community for as long as it is reasonably possible and desirable to do so. As such, it is a very humane policy; it is a very sensible policy and, in the longer term, from the point of view of economics, it is substantially better and cheaper to keep someone in their own home with, say, up to two hours a day attendant care than it is to have that person in an expensive nursing home or some other institution.

So, the timing has been excellent. As the population continues to age and the number of old aged—the number of people over 75—continues to burgeon, it is very timely. I would have to say that because of the very great consultation that has gone on, because of the nature of the consultative process, both in the metropolitan area and in South Australian country areas, the implementation of the HACC program has been rather slow and at times almost frustratingly cumbersome.

We have all learned from that process: all of the States have learned; the Federal Minister has learned; the Federal Department for Community Services has learned from that experience as well. It needs some fine tuning but, in general terms the policy, philosophy, the level of funding and the partnership between the State and Federal Government and, in turn, the very extensive involvement of the non-government sector all augur well for the HACC program in the long run. With regard to the specifics of the program to which the honourable member referred, I ask the Chairman of the commission, Professor Andrews, to respond.

Professor Andrews: As the Minister has pointed out, there have been some difficulties in the early days in the implementation of this program, but South Australia was very fortunate, especially in comparison with the other States, in having in place already an extensive domiciliary care program throughout the State, both in metropolitan and country areas. It was possible through those mechanisms to greatly facilitate the implementation, administration and development of HACC funded programs in this State.

Funding is available for a whole range of services, including home help, personal care, housework, respite care, (which has been given particular emphasis in the first year of the program), transport, information, coordination and integration of the community services, home maintenance and modification, food services, community para-medical services, community nursing and education and training for service providers and users. All those programs both directly and in some cases by way of the support, move the system as the Minister has pointed out, towards a notion of supporting people in their homes rather than having them placed in institutions.

We are well down the path towards designing the program and the allocation of resources in consultation with the Commonwealth in such a way that there is an equitable distribution, and this is based on an assessment of the numbers of aged and disabled population in the various metropolitan sectors and subsequently in the country. For instance, the northern metropolitan area gets some 16 per cent of the allocation, the southern metropolitan area 22 per cent, the eastern metropolitan area 15 per cent, the western metropolitan area 22 per cent, with the rest of the State getting 25 per cent.

Services funded under the HACC program will provide specifically for the frail or at risk aged person with a moderate or severe disability and younger disabled persons with moderate or severe disabilities and carers for those persons. The most essential aspect of this program is to provide support, relief and respite to those members of the community, usually women and most commonly daughters, who are responsible for caring for elderly people and other members of a family caring for a younger disabled person in particular.

It is a very extensive program, and I will not take up time detailing with the many projects that are approved, and a large number of which are under way or which are gearing up. An additional number has been approved by the Minister and are being considered by the responsible Commonwealth Minister. They range across the provision of a variety of transport arrangements to provide better access to community services, a number of respite programs to provide the relief that I mentioned for carers, and a number of programs directed at community care directly in the individual's home. These programs are being offered through voluntary organisations, local government, and the domiciliary care programs. One is already aware of the substantial impact that the introduction of the HACC program has made in terms of what would otherwise be a substantial growth in demand for institutional care, particularly long-term nursing home accommodation.

The Hon. J.R. Cornwall: The honourable member also asked a question about Ru Rua which is conducted at Estcourt House. That is not far from where I live, and I am well represented because I live in the electorate of Albert Park. There has been an intention for quite a long time to place the 96 residents at Ru Rua who are multiply disabled, into community house, or more appropriate accommodation than the large institutional setting in which they are presently accommodated. Estcourt House is a fine old mansion and is extremely well located on a very valuable piece of property. It would be our intention that Estcourt House would be part of the property rationalisation program and that ultimately, when it has been vacated, it would be sold and that substantial capital would go into the purchase of other, much smaller, properties, located throughout suburban Adelaide.

The more appropriate relocation of the 96 residents of Ru Rua has not proceeded at the pace that I would have liked. The funding of Ru Rua is under the nursing home arrangements and we must be at pains to ensure that we do not lose the funding when we deinstitutionalise. Those negotiations for retaining funding but putting it into a different basket have been proceeding for a long time. I want to see them brought to a head and finalised in the near future. It is one of the items on the agenda which I wish to discuss when I go to Canberra in the next few weeks: I want to talk to the Minister for Community Services, Senator Grimes.

The CHAIRMAN: Before I call on the honourable member for Albert Park to ask his third and last question, I point out that we have with us the Public Accounts Committee from New South Wales. I have invited them down to the floor of the House of Assembly. We welcome them

and their interest and perhaps there will be an exchange of information that will be of benefit to both Parliaments.

Mr HAMILTON: I have a great interest in the future of Estcourt House and what happens with it.

An honourable member interjecting:

Mr HAMILTON: No, it is not my intention to buy it, but I hope that the Government and a number of Government departments would look favourably on that site in terms of a facility for recreation and sport. I make no apology for rowing my own boat for those organisation with in which I am involved in the western suburbs.

A project dear to the Ministers heart, which I have watched with great interest as an ex-resident of Port Pirie is the decontamination of houses there. I applaud the Minister's lead in that area. There was a bit of huffing and puffing originally, but the Minister was spot-on in his assessment of the need for decontamination, despite the fact that a number of friends up there thought that the Labor Party was out of its tree. I do not share that view. We hit the nail on the head. What progress has been made and what is the future program for decontamination?

The Hon. J.R. Cornwall: The person who has been most directly involved in the Port Pirie decontamination and rehabilitation program from the outset is Dr Malcolm Collings from the Public Health Service. He will not be with us until 2 o'clock and I seek the indulgence of the Committee to defer the answer to that question until Dr Collings is here. I can respond in general terms, but I would prefer, because of the importance of the project, that he should respond specifically.

Mr OSWALD: Is the Minister prepared to give a guarantee that he will not introduce radiation protection legislation which does not have the agreement of the joint venturers?

The Hon. J.R. Cornwall: No legislation will be introduced which in any way exceeds or would require standards that are greater than the current Australian codes of practice with regard to the mining, milling and processing of radioactive ores.

I cannot be clearer than that. No legislation will be introduced which would be more stringent or require more stringent procedures than the provisions clearly set out in the Australian code of practice. Negotiations are proceeding with the joint venturers. In these sorts of negotiations it is natural that the commercial interests are very anxious to protect their own interests. That is only to be expected. However, as Minister of Health I am most anxious to protect the working conditions and the occupational health and safety of the work force—the miners and other people involved in the milling and processing of radioactive ores. I am not about to agree that I would completely close my options in those negotiations to act in the long-term interests particularly of the workers at Roxby Downs.

On the one hand, I am certainly not going to have it on my conscience that I did not do everything reasonable within the spirit and intent of the indenture legislation, the indenture arrangement and the Radiation Protection and Control Act to protect the interests of the miners and, on the other hand, I would not do anything to jeopardise the indenture. That is the current state of play. I will certainly not have it on my conscience that I did not take whatever steps were reasonable to make the as low as reasonably achievable principle enshrined in the codes of practice applicable to the major project at Roxby Downs.

Mr OSWALD: The Minister's simple answer to the question would have been 'No'; because the Minister is not prepared to give a guarantee. I think it is a bit rough of the Minister to imply that the company itself would not have the interests of its workers at heart.

I now move to the Flinders Medical Centre. I have a series of questions relating to the provision of beds, staff and services at that hospital. We have been advised that the Flinders Medical Centre budget has been cut by $1.8 million, and the Minister may wish to confirm that in a moment. How will this cut be achieved without reducing services? Is it proposed to make a reduction of 40 beds at Flinders? How many beds are to be converted to five day beds? Has the number of emergency beds available been frozen at set limits? If so, how many beds have been allocated for emergencies? What will happen to overflow casualties, and who will accept responsibility for any problems that arise as a result of casualties being passed on to the Royal Adelaide Hospital or the Queen Elizabeth Hospital?

The Hon. J.R. Cornwall: First, I think it should be made very clear that there is a cost in human terms of small government. We have heard a great deal about how Governments must cut spending. We have heard from the New Right, from the H.R. Nicholls Society and from their running mates, the Liberal Party.

An honourable member: Read the polls.

The Hon. J.R. Cornwall: I have been reading the polls for South Australia with great equanimity. We have heard a lot from these disciples of both the New Right and the Old Right that the answer to our present problems is small government and less tax. One can argue the merits or otherwise of that all day. However, one thing is unarguable: less tax means less money, which means less human services. It is a very simple equation. Let us not have the cant and hypocrisy of 'Shock, horror—there is to be some reduction in some areas within the public hospital system.' That is an inevitable consequence of less Government spending.

Fortunately, throughout the hospital system we have been able to minimise the impact of cuts on patient services. We have examined every other possible area where savings can or will be made. That is important because there is every reason to think that this is not a one-off difficult budget; there is every reason to believe that the difficult times in which we currently live may well persist to a significant extent beyond the 1986-87 financial year.

In all these negotiations we have looked at ways to achieve savings through better management with minimum impact on patient services. Specifically with respect to the Flinders Medical Centre, of course it has a higher occupancy than any other hospital in the State. The original proposal was that it be a 700 bed hospital, but it was never completed and it is a 500 bed hospital. It will continue to be under pressure until we ultimately have integration, coordination and rationalisation with the Repatriation General Hospital. Those discussions are on going.

The Federal Government has already made some major decisions with regard to the long-term future of repatriation hospitals around this country. Those decisions have been taken within the framework of the Federal Government's being scrupulously careful to protect the interests of veterans. In the longer term it is logical that Flinders and the Repatriation General Hospital will be basically one hospital on two campuses. So, that has to be considered in our forward planning. Of course, we also intend to build a 100 bed public hospital as part of the twin public/private hospital complex at Noarlunga, which again will take some of the pressure away from Flinders. However, we must remember that Flinders operates as a 500 bed hospital and consequently greater pressure is placed on it than any other public hospital in the State. With respect to the budget negotiations and the specifics of the strategy proposed for

Flinders, Mr Ray Blight on my (dare I say it) far right will respond. Mr Blight is the Executive Director of the Southern Sector of the Health Commission.

Mr Blight: There was a budget overrun of about $990 000 at the Flinders Medical Centre last year, as reported in the documentation provided to members. The basic reason for this overrun was an increase in activity level at the hospital. A calculation carried out within the sector office, taking account of not just in-patient activity but day patient and outpatient activity, showed that increase to be of the order of 5 per cent. It should be noted that additional beds were commissioned at the centre during the course of the last financial year. Of course, those beds would have contributed to that activity increase. Taking account of that factor, there was a real net increase in activity of about 3 per cent.

It is the affirmed policy of the Health Commission that where a budget overrun occurs in a health care unit it is to be picked up by that unit in the following year. So, an overrun of just under $1 million at Flinders meant that under our policy it had to take a penalty of that amount this financial year. However, taking account of that policy action, the commission, in striking this year's budget for Flinders, did not apply any further cuts to that hospital.

The 1 per cent funding cover that was applied to other units in the southern sector was not applied to the Flinders Medical Centre. To accommodate that, funds were transferred from within the southern sector and from the western and central sectors to make that a reality. So, the budget cut at Flinders is in effect the penalty figure related to last year's overrun and a further implied penalty that is associated with a 4 per cent inflation factor being allowed on the goods and services component of their budget. A great deal of work has been undertaken at the centre in consultation with the Health Commission to develop a strategy to respond to the allocated budget. The elements of that strategy are based on the premise that any reduction in expenditure, or increase in earnings as you will appreciate, should have an absolute minimum impact on patient care. So, the maintenance of patient care is the first priority in that strategy.

Another element is to reduce the stress on those services which have responded to increases in activity in the past without increases in resources, so particular high activity areas will be singled out and appropriate measures taken to ease the workload in those areas. Overall patient numbers will be reduced. Members should be aware that the emergency load on the Flinders Medical Centre currently runs somewhere around 63 per cent of admissions. I think by any standards that is too high to operate a hospital effectively. So, there will be a deliberate strategy to try to bring down patient numbers, particularly the emergency admissions. Parallel with that, there will also be an increase in overall elective surgical admissions with a view to claiming the cost of treatment of some of those elective surgical admissions against booking list moneys. So, there is quite a comprehensive strategy in place now at the Flinders Medical Centre, and medical staff are cooperating with the administration in putting the finishing touches on that.

With respect to bed closures, in the budget letters that accompanied the budget allocations the commission made it very clear that there would be no closures of beds without the prior approval of the commission being given. There was some suggestion from Flinders management that some 40 beds would need to be closed to accommodate the budget reductions, but since that initial knee-jerk reaction, if I can use that term, more appropriate strategies have been devised and there will be no closure of 40 beds as indicated. The key elements of strategies relating to the use of beds revolve around ward 3E. This ward was originally commissioned as a 12 bed short stay observation ward. It is annexed to the Accident and Emergency Department and over the years, with the pressure on the hospital, those beds have really been brought into general use. One strategy will be to revert those beds to their original purpose.

There will be a reorganisation of beds between levels 4, 5 and 6, with level 6 being maintained solely for surgical beds and level 5 for medical beds. Within those areas, a number of beds will be converted back to five-day elective beds. In all, we are looking to convert some 28 beds in surgery back to five-day; four beds within medicine, and 12 each for paediatrics and O and G. With those five-day beds devoted exclusively to elective work, there will be a much reduced workload in terms of the staff, and we expect we will be able to close those beds over the weekend and make the appropriate savings.

With respect to the booking list proposal, at this stage a joint medical/surgical ward comprising 28 beds is proposed to be converted wholly to surgical work. That will, in effect, give an increase in capacity of 12 beds. It is proposed that those 12 beds be used solely for the processing of patients from the booking lists. With respect to the emergency referrals, there will be a need to refer on emergency patients. However, they will be triaged at Flinders, and emergency patients who cannot be transferred will, of course, receive priority over elective admissions. Current mechanisms and plans to put those processes into place are still under discussion at Flinders Medical Centre. I understand that proposals will be put before the board shortly. No ambulance patients are expected to be transferred. However, when it becomes neccessary to transfer patients, it will, of course, be handled sensitively.

The Hon. J.R. Cornwall: In case there is any misinterpretation of the statement that accident and emergency patients will be referred on after triage, this will apply overall to about 5 per cent of those patients: there will not be a massive referral on. We reached a point with Flinders where, had we continued with that level of admissions—that is, 63 per cent and even higher on weekends—then all of my advice was that we could have ultimately arrived at a situation where we could not always guarantee the safety of all of the patients. That is one of the significant reasons why this strategy has been developed. As I said, when arrangements are formalised with the Repatriation General Hospital and when the 100 public beds become available at Noarlunga, there will be some reduction of that pressure. Until such time as they are available, we have to rationally use the resources that we have. It is not a case of our being short of public or private beds over all the metropolitan area, but there is no question that there is a significant misallocation of those beds. We are certainly short of beds in the southern metropolitan area.

Mr OSWALD: My question relates to the acquisition of the International Linen Service by the Central Linen Service. The Central Linen Service acquired the hospital portfolio of International Linen Service run by a Mr Nemer. I am told that there is a significant component in the price for goodwill, but I cannot identify that amount. I am told that the $1.5 million on the surface when the sale took place was for stock, but it actually covered up the goodwill figure. I am also told that the stock was acquired at current Actil prices but most of the stock is five to six years old and some is cheap and poor quality stock acquired some five years ago from India. The curious aspect of the deal is that International Linen Service was paid current replacement price for the linen which was five or six years old.

Having acquired International Linen Service stock, the Central Linen Service continued to pay International Linen Service to do work for it. What was the price paid by the Central Linen Service for International Linen Service health portfolio? How was the price arrived at? Was there any amount for goodwill and, if so, what was that amount? Was the stock inspected before purchase? Was it old stock? Was the price of the stock fixed at current replacement price calculated by reference to current Actil prices? Was the Central Linen Service continuing to pay International Linen Service for processing linen and other stock acquired by the Central Linen Service after the date of acquisition and, if so, why; and to what extent?

The Hon. J.R. Cornwall: They are never happy about the Central Linen Service. When it competes in the open marketplace on similar terms and conditions and wins contracts from the private sector, it is criticised: when it is approached by the private sector and asked to consider making a fair offer to take over one of the enterprises and when it deals commercially in the marketplace, it is criticised. I really do not know how we can win.

Mr Nemer approached me directly quite soon after the election, so it would have been relatively early in 1986. He informed me that 80 per cent (from memory) of his laundry operation at International Linen Service involved hospital and nursing home contracts. That is the area in which the Central Linen Service has a specific charter to provide services. It is restricted, of course, from going into the hospitality area: it does not service hotels, restaurants and so on. However, the Central Linen Service was performing at a level and was able to charge prices competitively which made it impossible for Mr Nemer to continue with the hospital and nursing home part of his operation on a profitable basis. He offered to sell it to us on commercial terms and conditions.

The basis of that sale was that his linen stock would be checked over a period of weeks as it was cycled through the International Linen Service laundry facilities. It was also determined that there would be a component for goodwill, to be agreed between the parties. The alternative, of course, would have been to say to Mr Nemer, 'This is a commercial decision. Out there in the big bad capitalist world it is dog eat dog. We are driving you to the wall. Get ye to the wall and when you go broke we will pick up the pieces.' Is that what the honourable member would have urged upon us? Is that the way he would have wished us to proceed? In the event, that is not the way I elected to proceed.

I sought Cabinet authorisation to have a senior officer of the Health Commission negotiate with Mr Nemer on a commercial basis. To my recollection, he was paid about $250 000 for the goodwill of the operation and he was paid an agreed amount for the linen after it had been very carefully checked as to quality and quantity. It is also my recollection that the operation was turning over about 26 tonnes a week. While that was a substantial addition to the operation of the Central Linen Service, it had to be seen in the context of a laundry that already had a throughput of about 200 tonnes a week. Certainly, the stock was inspected before purchase. We paid about $250 000 for goodwill for a going concern, and the contracts that were outstanding with some of the major private hospitals with which Mr Nemer dealt are still in place at this time. Therefore, in the taking over of those contracts there was a very substantial element of goodwill. I think we did a pretty good deal. I will ask Mr David Coombe to say how prices were arrived at, who did the valuation, and what the actual purchase and goodwill prices were.

Mr Coombe: I make quite clear that the total price paid to International Linen Service was $1 150 000. The South Australian Health Commission recommended to the Government that inclusive in that amount there could be a maximum payment of up to $200 000 for goodwill. The stock was inspected, and it was not old stock. The basis upon which the price was paid for the stock was that the purchase price for the linen stock involved in the transaction would be calculated in the following manner: all stock would be counted jointly by representatives of the Central Linen Service and International Linen Service; the price to be paid for the items counted would be at a rate of 70 per cent of the prices shown in schedules agreed on 2 May 1986; and at the conclusion of that stocktake and calculation of the value, 10 per cent of the calculated value would be added to the stock valuation in recognition of stock which was hoarded within hospitals and nursing homes and which might not have been discovered during the stocktake.

The Minister said that he was approached formally on 13 March 1986 by Mr Nemer, the proprietor of International Linen Service. The quantity of Mr Nemer's business in respect to hospital and nursing home linen was about 26 tonnes a week, and there was due regard to that volume in the context of the capacity of the Central Linen Service at that time to handle 200 tonnes a week. I will have to take on notice the question of how much was actually paid for goodwill.

The Hon. J.R. Cornwall: I do not have total recollection on the amount paid for goodwill, but it was considered to be fair and reasonable in all the circumstances.

Mr ROBERTSON: The yellow book at page 349 refers to hospice care services for the aged and physically disabled. What is the current position with the development of hospice services in the central northern and central eastern regions, given the specific targets for 1985-86? What progress has been made in establishing a hospice service in the western sector of Adelaide, and what further developments will take place in the remainder of this financial year? Thirdly, what hospice services are available in the southern sector?

The Hon. J.R. Cornwall: During the past three years particularly, there has been a quite active program within the commission, with the active support of the Government, to further develop hospice services, on the basis of a non-institutional approach throughout the metropolitan area. Obviously, there must still be an institutional base and patients will require respite, stabilisation and some in-patient treatment from time to time in any long-term care.

However, the whole basis is to get away from the institutional approach of former days and to have an active outreach and home support program. The hospice movement has gathered substantial momentum. A number of things have occurred; a number of things are proposed. The best way to approach this would be to ask Professor Andrews to give an overview, and then to ask each of the Executive Directors of the sectors to refer to their areas.

Professor Andrews: Recognising the importance of providing high quality and appropriate care to the terminally ill, and recognising that there have been a number of developments in this area within health units in the State and within the sectors of the Health Commission, the commission developed and released a hospice care policy in June 1985. This policy detailed, among other things, the essential principles on which hospice care should be provided in South Australia, and stressed the need for coordination of existing services in a manner which best suits the requirements of individual patients. Hospice care par excellence is an area where the focus must be on the individual patient,

the family and the needs surrounding that specific case, since they are very individual.

More specifically the policy spelt out that the control of symptoms is to be the basis of care, that the patient should be able to exercise informed choice of the type of care and to participate in their treatment rather than being a passive recipient of medical care. Hospice care was to be provided by a variable multi-disciplinary team coordinated by a team leader, and there may be a hospital based team and a community based team, or there may be a core membership straddling both settings. That variation was to reflect the varying structural and resource arrangements in the different sectors in the health units.

Home care as a part of the policy is to be available 24 hours a day, seven days a week, and be coordinated with hospital resources, if necessary. Home care patients are to have ready access to respite beds since these patients often constitute a very substantial load on family members. Education and support are provided for the carers of as a part of the policy and the quality of care is kept under constant review.

The commission is currently undertaking a review of the implementation of this policy throughout the State and has sought input from both Government and non-government agencies in this exercise. The aim of the review is now to take a step back from that policy and identify differences that may have developed in hospice policy within the individual sectors and health units; to propose possible arrangements for reconciling those differences and achieving a uniform and best approach across the State as a whole; and to focus on areas where additional or redirected resources are required. While that process is going on, as the Minister has mentioned, individual sectors have developed specific services. I look to the Executive Directors of the sectors to identify those details.

Mr McCullough: In November 1985 the central sector established two regional hospice care services: one in the northern region based at the Lyell McEwin involving Modbury Hospital and an existing voluntary community group; and another in the eastern region of metropolitan Adelaide based at the Royal Adelaide Hospital. An amount of $100 000 was allocated in 1985-86 for a coordinator and clerical officer position for each of the hospice care services. The service in the central northern area, basically the Elizabeth and Tea Tree Gully areas, has filled the coordinator and clerical officer positions, is well established and is providing an excellent community service. This service involves volunteers, liaises with the Royal Adelaide Hospital and the Flinders Medical Centre and has access to nurses who are skilled in palliative care. However, at present they lack some full-time medical specialist input into the service and this is an issue we are addressing.

The central eastern service has experienced a little difficulty in establishing the service because it elected first, to appoint a medical specialist in palliative care. Unfortunately, there is a dearth of appropriately qualified practitioners, and the one suitable applicant, who was from Western Australia, eventually, after protracted negotiations, refused the offer.

The sector's Hospice Care Policy and Planning Committee has reviewed the structure and has decided it would be best to make appointments for two part-time specialists to coordinate and develop the service with sessionally paid general practitioners providing backup support. These positions are vital to the service and after approval are to be advertised, and that is to occur shortly. In the meantime, Calvary Hospital contacted the Health Commission requesting that consideration be given to the Health Commission making a capital grant towards the cost of redeveloping the Mary Potter Hospice and Home Nursing Service. This service has always catered for a significant number of financially disadvantaged patients whose fees have been waived or significantly reduced.

Numerous discussions have been held between the Health Commission, Calvary, the Royal Adelaide Hospital, and the central eastern hospice service, and it has been agreed that the Mary Potter Hospice would be linked in with the central eastern hospice service and provide the necessary hospice beds. It was agreed that funds would be sought for this during 1986-87. Calvary Hospital is extremely eager to participate in the provision of these hospice care services with the Government. It has been providing services for some time, as I said, to the financially disadvantaged. The new structure for the two services will have specialist input, which is an important aspect for educating and providing consultation to the local community and service providers.

Funds will be sought for the medical specialist and general practitioner services in the next financial year (1987-88) and funds for the linking of Calvary Hospital's Mary Potter Hospice Centre inpatient service to the teaching hospital, that is, the Royal Adelaide Hospital, will also be sought for 1987-88. This is estimated to be between $150 000 and $200 000.

The Hon. J.R. Cornwall: The Executive Director, Southern Sector, will now outline the hospice program in the southern metropolitan region.

Mr Blight: Hospice services in the southern area have worked very effectively over a number of years now under the leadership of an advocacy group known as the Southern Hospice Association. This association has established a coordinating group, chaired by Dr Liz Hobbin of the Southern Domiciliary Care Service.This coordinating group brings together a range of resources for hospice care in the area. Resources range across volunteers from both the Flinders Medical Centre and Kalyra Hospital. These volunteers provide general in-home services.

The Royal District Nursing Service provides nursing care; Southern Domiciliary Care provides professional home care services, and all of this is supported in medical terms through a half time medical coordinator position located at Flinders Medical Centre.

In this year we hope to increase the medical coordinator resource to one full time equivalent. Referrals have more or less stabilised in the south and the service is now accepted in its role as a tertiary referral service that is widely recognised as having greatly improved the care of the terminally ill. This year we are looking forward to the expansion of the educational role of the service to all professionals and extending out into rural areas. That summarises the southern position.

The Hon. J.R. Cornwall: I will ask the Executive Director, Western Sector, to summarise the position in that area. I know that you, Mr Chairman, have a great interest in that area.

Mr Coombe: The Queen Elizabeth Hospital is developing a community based hospice service to complement the dedicated hospice beds at Philip Kennedy Centre to which the Government, through the western sector of the commission, has allocated $160 000 in a full year, in recognition of the role that the centre provides in the western urban area in the provision of hospice beds.

The Queen Elizabeth Hospital for its own part has recently appointed a full-time medical director together with a registered nurse, social worker and clerk to provide palliative care services within the hospital and to augment existing community services. There is a representative and active

community based hospice committee functioning within the western metropolitan area.

Mr ROBERTSON: I wish to ask another two questions about services for the aged and physically disabled. My second question relates to the Home and Community Care program already mentioned by Professor Andrews in some detail. Which of the various models that have been tried—and the last round of HACC funding reflected the fact that a number of different management models are being tried for home based care—does the commission regard as being the best? Have home based models as opposed to group homes been supported separately, and which of the models that have been tried within the group homes—administrative models—are thought to be most effective?

The Hon. J.R. Cornwall: I will certainly ask Professor Andrews to respond specifically to that question. As so often happens with the member for Bright, he has a vast knowledge of such a range of areas and asks such technical questions that they need expert attention.

Professor Andrews: I am not at all certain that the expert can give as clear an answer as might be desirable, either. As the question implies, there are a number of administrative issues associated with the delivery of home care services, and I did mention earlier that we had been fortunate in being able to use the domiciliary care program and its networks for the development of many of these services. However, many of the other services are provided through local government and the voluntary sector, as the question again implies, using a number of different approaches. I am not aware specifically of group homes that have been associated with the HACC program at this stage.

That is a particular model that requires exploration, and within the policy group in HACC is one of the options that is being looked at. There are some complications with respect to the Commonwealth Department for Community Service's attitudes and policies about levels of attendant care and currently these are set at 14 hours a week for intensive care, which clearly places some limitations on the nature of the services that can be provided to individuals. Those issues are continually under policy discussion between State and Commonwealth officers, and I trust that they will result in appropriate advice being given to the responsible Ministers in the near future.

Mr ROBERTSON: It is possible to administer group homes by having community based committee control or by having patient control or inmate control and there are a number of other management models. I was wondering what HACC had been looking at in relation to those. Having made that comment, I will pass to my next question, which relates again to the specific targets for 1986-87. It would probably be acknowledged that, because of the way in which services to behaviourally disordered people in South Australia have evolved—I understand that they have evolved somewhat differently from similar services in Eastern States—that there appears to be something of a gap in services in South Australia between those people who can be treated at rehabilitation centres and those suffering behavioural disorders that shut them out of sheltered workshop situations.

In other words, if a young person particularly has been involved in a car accident and suffers head injuries and has some sort of behavioural disorder which makes him completely intractable and unmanageable in a workshop situation, yet he is rehabilitated to an extent where he can fit back into some sort of workshop, there does not seem to be very much alternative for those people at this stage. I wonder whether it is envisaged that, with the allocation of increased funds to the Julia Farr Centre and specifically the Rotary Building for the head injury service, that would be a possible location for those people and whether they can be catered for within the existing system.

The Hon. J.R. Cornwall: Again, I ask Professor Andrews to respond directly.

Professor Andrews: Referring to the earlier question about models, I now understand precisely what was being raised. Indeed, a whole range of models are being looked at at this stage but we are not yet at a point in any substantial way where we can implement those programs on the ground. When they are implemented the appropriate thing to do would be to implement them in a number of ways and evaluate the outcomes. There are strong feelings about the most appropriate management approach to the provision of those kinds of services and we need to have concrete information on that.

The question of the behaviourally disturbed—especially post head injury—is a critical one. As implied in the question, the outcome of head injury can be variable. Some individuals are fortunate enough to be virtually fully restored to normal patterns of behaviour and activity; others are at an extreme level and require virtually continuous intensive care and life support to their dying day.

In between those extremes are a number of other categories of severely disturbed persons, to the degree that they are not able to manage in the ordinary workshop environment, are a problem in terms of their management in the ordinary home situation, but are not sufficiently disturbed to justify institutionalisation as a category. Within the plans for Julia Far Centre it is proposed that there be a day centre. Currently we are negotiating with SGIC the possibility of its being involved in the funding of that day centre. Originally it was interested in that, but perhaps it is not as enthusiastic as it was in the beginning and we are vigorously attempting to resurrect its interest, while at the same time discussions are proceeding with the Commonwealth over the future of the Payneham Centre, which has been a Commonwealth operated centre providing, among other things, outpatient services for head injured people, including some in the category about which the member raised his question.

The simple answer is 'Yes'. It is envisaged that in the comprehensive provision of service for head injured people the services to the group of people that the honourable member mentioned will be included, and the focus there will be on outpatient and particularly day care type programs.

Mr INGERSON: My question relates to the statement made today at the Australian Police Federation meeting in Adelaide, which strongly criticised the Government's marijuana legislation. This federation represents all the police offices in Australia. It has also said that the Minister of Health should reconsider his position, as the legislation undermines the national drug offensive. Will the Minister seek discussions with the federation about its concerns? Has the Minister or his officers had discussions with the South Australian Police Commissioner about his attitude to the legislation, and has the Commissioner expressed concern about the legislation?

The Hon. J.R. Cornwall: In the last week I have been criticised very publicly by the country hospitals and now by the combined police unions, and I am trying to think who were the other people who carried a vote of no-confidence in me earlier in the week. Specifically, I have been criticised for wanting to look after the safety of mothers and the wellbeing of their babies, for wanting to stop young people taking up tobacco smoking and, quite trenchantly, by the Secretary of the local police union, and now presum-

ably by the other police unions, for not wanting to make criminals out of teenagers.

My views on the whole question of controlling substance abuse and how that should be tackled are well known. I might also add that the Bill, which has been passed by the Council and will be considered by the House of Assembly when it resumes on 21 October, is a Government Bill. In my recollection, it ran the entire gamut of public debate and discussion. Ultimately, it was developed in my office, as Minister of Health. It went through my Caucus committee and then through the Cabinet and Caucus for formal approval. It is not my private member's Bill but a Government Bill.

We have developed a multi-faceted approach to the whole question of drug abuse, of which legislation is one part. Through legislation, we attempt to control the supply. That is useful, but it is by no means highly effective. If one could control the supply of illicit drugs by the use of legislation and the criminal law, there would not be 180 000 narcotics addicts in the city of New York. No other country in the Western world has pursued those who traffic and trade in illicit drugs and who use and abuse illicit drugs more than has the United States. It is probably fair to say that no other country in the Western world has failed to the extent that the United States has.

In terms of restricting supply to the extent that that is possible, we use the law. I can understand the natural and strong desire of the community to have illicit drugs stamped out by the use of the criminal law and the pursuit of those scum, those criminals, who trade and traffic in illegal drugs. We take account of that. The penalties that have been applied under the Controlled Substances Act since 1984 were the most draconian in Australia. Under the legislation that will come to the House of Assembly, the penalties for trafficking and trading in hard drugs are even further increased. For trafficking in hard drugs, there will be life imprisonment, a fine of $500 000 and confiscation of any assets that might be, directly or indirectly, involved in the commissioning of that trafficking. They are the highest penalties in mainstream Australia. Only Queensland has a higher penalty. The penalties for trading in hard drugs will again be increased even further, to 25 years and $500 000. The penalties for trafficking in marijuana will be increased to 25 years or $500 000 for commercial quantities of marijuana.

So, it is quite wrong to suggest that we have been other than very tough in our approach to the use of the law, but the law is only one facet. Young people experiment with mind altering substances, whether it be glue sniffing or a whole range of other substances. We have put in place, and are further developing, protective and preventive education right through from reception to year 12 in our schools. We are developing early intervention programs and educating health professionals. Indeed, we have specifically set up a unit for that purpose at the Royal Adelaide Hospital. We are involved in early intervention, treatment and rehabilitation, and through 1987 we will finally have in place all the initiatives that have been developed over the past three years.

At that point, right across the spectrum from protective and preventive education (which is important in overcoming the current cycle, and drug abuse historically has been cyclical), we will have in place the best programs in the country. Where we have the criminal black market element trading and trafficking, whether in marijuana or in hard drugs, we have the toughest penalties in mainstream Australia.

It has never been my view, and it is not the view of the Government, that anybody in their late teens who is busted for simple possession of marijuana should have a criminal conviction for the rest of their lives. If anybody with teenage children can seriously suggest that, if their son or daughter were busted on Saturday night, when tens of thousands of South Australians smoke marijuana on a casual basis, they should carry a criminal conviction for the rest of their lives, with all that that implies, it is a point of view. However, I simply do not believe that that is sensible. I certainly do know that it is counter productive.

The greatest way to open a credibility gap is to proceed down the line that Queensland has pursued. In Queensland, for personal possession of similar amounts of cannibis to that which we are talking about in the legislation before this Parliament, young people can attract a maximum penalty of 15 years imprisonment, and the property associated with the commission of that offence, be it a parent's car or home, can be confiscated. If that is what the Opposition wants, it should say so.

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

Membership:

The Hon. P.B. Arnold substituted for the Hon. H. Allison.

The CHAIRMAN: The member for Bragg has one question left.

Mr INGERSON: I have a supplementary question to ask on the question that I asked before lunch about marijuana. I thank the Minister for his reply. It seems to me that we have made a first step towards the decriminalisation of marijuana use. While the Minister may not share that opinion, it seems to me that that is the way we are going. On a previous occasion the Minister conducted a poll and withdrew similar legislation on the grounds that about 80 per cent of respondents were opposed to it. Did the Minister conduct a poll this time to enable him to get some sort of public feeling before introducing the legislation and, if not, why not?

The Hon. J.R. Cornwall: I did not. I was treated so unkindly by the Opposition when I commissioned a poll in 1983 that I thought that it would be unwise.

Mr INGERSON: I refer to drug usage at the Royal Adelaide Hospital. Is it correct that in March this year the Drug Committee at the Royal Adelaide Hospital warned the board that there was impending over-expenditure of $800 000, which is a rise of 25 per cent on the previous year? Was this the final expenditure on drugs? Will the Minister supply the Committee with all the minutes and attachments of the Royal Adelaide Hospital Drug Committee, particularly any correspondence to the Administrator and the board for 1984-85 and 1985-86 and the instructions to the committee from the board, the Administrator or the Health Commission? Finally, have any decisions been made on the types of drugs to be used at the Royal Adelaide Hospital which would predicate against the best possible drugs being used, particularly in the area of chemotherapy?

The Hon. J.R. Cornwall: That is quite a specific series of questions. Obviously I will ask Mr Des McCullough, the Executive Director of the Central Sector, to respond in a moment. However, I point out that the Royal Adelaide Hospital came in very close to being spot on budget. That is an excellent achievement, of course, in all the circumstances because it now has a budget very substantially in excess of $100 million. It speaks volumes for the management of the hospital. In regard to the specific question, I ask Mr McCullough to respond.

Mr McCullough: The Royal Adelaide has a budget well in excess of $100 million, and expenditure on drugs last financial year was $5 690 000. The Royal Adelaide spends quite a large proportion of its goods and services allocation on drugs. The hospital did balance its overall allocation for the year, and it did not raise with the Health Commission an issue of any undue cost pressures in relation to drugs. I believe that drug expenditure has been kept within the normal confines of indexation over the past several years. The Deputy Chairman has some details on the use of a contrast medium, which is a form of drug, and he may wish to add something about that. I can only stress that the issue of additional funds for drugs was not raised with the commission by the hospital last year and that the RAH balanced its overall funding allocation.

The Hon. J.R. Cornwall: Before I ask the Deputy Chairman of the Health Commission to provide further details, I make it clear that there was never a situation where cytotoxic drugs were threatened because of any budgetary situation. I think that a grapevine rumour of some description has been generated by a person or persons unknown, suggesting that there was some difficulty during the 1985-86 financial year which may have been prejudicial to cancer patients at the Royal Adelaide Hospital. That ought to be put to rest immediately. It is not the case and was never the case. I ask Dr McCoy to respond specifically in relation to the commission's response to a request that was made for the purchase of a very expensive contrast medium.

Dr McCoy: It has been brought to my attention that significantly increased funds were provided by Treasury to the Health Commission last year to account for devaluation. Part of that involved drug expenditure. The part provided by Treasury was $3.75 million. So, additional funds were made available to the hospital for those drugs that had to be purchased mainly from America.

Turning to the question of contrast media, it is a constant problem in health administration to control expenditure caused by increasing technology. One technological advance has occurred in contrast mediums that are used in radiology for internal examinations of the kidney and other organs. There is now available a new contrast medium called non-ionic: it is highly purified, and the reactions that it sometimes (but rarely) causes in patients are very significantly reduced. The problem is that the cost of the contrast medium is about four times the cost of the contrast medium that was previously used. For example, the Royal Adelaide Hospital is currently spending about $125 000 a year on contrast media but, if it was to move exclusively to this new non-ionic medium, it would cost of the order of $600 000. That is the type of cost pressure that is constantly before the commission.

The Royal Australian College of Radiologists has issued guidelines for the use of this contrast medium. For example, at the moment it is used in about 30 per cent of cases at the RAH. The cases are selected on the basis of those that have had past reactions to the old medium, those who have an allergic history and some frail elderly people. In time it may be that the use of this medium will become more widely spread. However, a significant cost will be attached to it. The commission is in the process of developing a policy on its use and to see how that can be funded.

Mr INGERSON: I have a supplementary question which is really part of my original question. Will the Minister make available to the Committee the minutes of the drug committee, as already requested? I requested the minutes for the years 1984-85 and 1985-86 of the RAH Drug Committee. Is it possible for the minutes to be made available to the Committee?

The Hon. J.R. Cornwall: It is not a public document.

Mr INGERSON: Has a priority list for the purchase of capital equipment been drawn up for the RAH? If so, can the Committee be provided with that list with an indication of the price of each piece of equipment and also an indication of which items will be allowed to be purchased this year?

The Hon. J.R. Cornwall: The answers are 'Yes' and 'Yes'. Whether we have the detail with us, I am not sure: I will ask Mr McCullough.

Mr McCullough: I would appreciate a minute or two in order to prepare a response to that question.

Mr RANN: In view of the public concern about the spread of the AIDS virus and disease, can the Minister or his officers inform the Committee of the current situation in South Australia? I am aware that South Australia has not fared as badly in this area compared to other States, but AIDS is still a subject that causes a great deal of concern in the community. Therefore, it is perhaps an appropriate time and place for a progress report on AIDS, particularly on the possible spread of the disease among the heterosexual community in South Australia.

The Hon. J.R. Cornwall: I am sure members would be aware that I have been scrupulously careful, as Minister of Health, with reference to all aspects of AIDS to have the statements regarding control, epidemiology and all other aspects of the programs that we have developed to control the various diseases in this State handled by our public health authority. However, I think on this occasion it is appropriate that I should make a public statement using the forum of the South Australian Parliament.

A co-ordinated South Australian public health response to the AIDS issue began with State Cabinet approval for a control and management strategy early in 1985. The strategy addresses all levels of care from counselling to the management of terminal cases in our hospitals. At the time the strategy was aproved there were no cases of AIDS in the State. Since that time, cases diagnosed interstate have been nursed here, and four South Australian cases have been diagnosed. Two of these have died, one at the Flinders Medical Centre and the other in Queensland. This has occurred in a national context of 306 known cases of the disease being diagnosed. Of these, 146 have died.

Clearly, then, this State has experienced a low number of cases so far, but a recent increase in the number of people who are antibody positive is an indication that a rise is now likely to occur. Antibody testing through the AIDS program and the Sexually Transmitted Disease Clinic at North Terrace began in February 1985. The most recent figures show that there are now 135 people recorded as being antibody positive in South Australia; 84 of these have been diagnosed at the STD Clinic. The full analysis of those figures has not been completed, and we do not yet have the proportional breakdown of the risk categories which comprise that figure.

However, we do have a breakdown on the figures immediately prior to that, and these figures were available on 30 June this year. At that time there were 117 people who were confirmed as antibody positive. Of this number, 20.5 per cent were intravenous drug users; 68 per cent were bisexual or homosexual men; 7 per cent were transfusion and blood product recipients; 5 per cent were both homosexual and intravenous drug users; 2.5 per cent had no known or notified risk factor; and 1 per cent became infected through heterosexual contact. The AIDS program addresses four major areas of concern. They are:

Services to the individual either concerned, at risk, or infected, offering counselling, education, medical follow-up and specialist referrals.

Education of the public and of health professionals through lectures, discussion groups and the distribution of written material.

Liason with other agencies such as the Department of Correctional Services, Drug and Alcohol Services Council, the gay community, prostitutes, and the South Australian Police to distribute information, improve access to diagnostic services and develop appropriate support services and foster research.

Research both epidemiological and fundamental, particularly in the area of behavioural change.

The program, which is also located at the North Terrace premises with the STD clinic, employs five full-time staff and a part-time research assistant. The program works in close co-operation with the STD clinic, the Royal Adelaide Hospital, the Institute of Medical and Veterinary Science and major teaching hospitals. The proportional statistics for the number of people who are confirmed antibody positives give the program some guidance for its short and medium term efforts to control the spread of the disease. Up to now some males have been infected predominantly through homosexual intercourse, but it is clear from the statistics that both sexes are being infected through intravenous drug use. It is a fact that there are perhaps 2 000 or so people who are intravenous drug abusers in South Australia.

An inherent characteristic of the community which administers illicit drugs intravenously is the sharing and re-use of syringes and needles. This also results in the sharing of pathogenic organisms, especially the hepatitis virus and the Human Immunodeficiency Virus, which causes AIDS. Overseas studies sound some very clear warnings to South Australia about developing trends in this area.

In 1984 a survey in New York City found that 8 per cent of the intravenous drug users surveyed were antibody positive. In Edinburgh, Scotland, a study was carried out which showed that 160 intravenous drug users attending a general practice were antibody negative. Within two years of that survey, 51 per cent of these people had become antibody positive. The central issue to this aspect of the debate is the ready availability or otherwise of clean needles and syringes to intravenous drug users.

Health authorities throughout Australia have received information from Professor David Pennington, the head of the National AIDS Task Force, that intravenous drug use is the single most likely avenue for the disease to spread into the heterosexual community. In South Australia, the head of the Communicable Disease Control Unit and the Chairman of the South Australian AIDS Advisory Committee, Dr Scott Cameron, has raised the issue of syringe and needle availability. It is his opinion, and this is shared by other public health officials in this State, that the free and ready availability of syringes to drug users could limit that spread. While community attitudes could obviously be against such measures, there is a public health issue which has to be addressed. This is an issue on which I do not express an opinion and which, I believe, is not a matter that should be addressed in the political context. Much more importantly, the considered view of the AIDS task force and the Public Health Sevice is that ready availability will not encourage further drug use and will go some way to limiting the spread of dangerous pathogens.

This view is supported by recent experience in the Netherlands, where a system of exchanging needles and syringes has been introduced without appearing to increase the prevalence of drug abuse. Under the Dutch system, 95 per cent of used needles are exchanged, and of 120 clinical cases of AIDS in Amsterdam only two are intravenous drug users. Already at the North Terrace clinic, clients of the AIDS program who are intravenous drug users are provided with new needles and syringes on a replacement only basis. It is noteworthy that the South Australian percentage of intravenous drug users of the total number of antibody positives is 20 per cent, the highest figure in Australia and higher than the American figure of 17 per cent.

Although our overall number of positives, and most certainly the overall number of full-blown AIDS cases which have developed, is very low in the national context, the percentage of those positives, nevertheless, is the highest in this country and high by any standards.

There is a problem of the significant potential spread of AIDS in the heterosexual community by the use of contaminated needles and syringes. In New South Wales the Health Department has negotiated an arrangement with the Pharmacy Guild whereby packs of five syringes with prominent 'Do not share' labels on the syringes, including a warning note about the risk of AIDS and hepatitis B, are dispensed by chemists upon request with no questions being asked. The guild has agreed to carry out this service for a standard dispensing fee of $2.40, and negotiations are currently under way with the Commonwealth for the provision of funds for wholesale purchase of syringes and needles.

In South Australia the supply of syringes has recently been eased by the decision of the Pharmaceutical Society of Australia to rescind the professional regulation that pharmacists should sell syringes only to people who are known to them. In the past the practice has been to sell syringes to diabetics who are personally known to the community pharmacist. I might add that, due to the removal of the professional regulation, it is not an offence for pharacists to sell syringes to strangers. It remains an offence, of course, under the Controlled Substances Act to possess instruments for the administration of illicit drugs. There has been no change to the law in that respect, nor is any change contemplated.

The amendment of the professional regulations means that, if a pharmacist supplies syringes and needles to an intravenous drug user, they will not be charged with unprofessional conduct under the pharmacy legislation. I repeat that the possession of instruments to inject an illicit drug remains an offence. The action of the Pharmaceutical Society is a direct response to information received from Professor Pennington.

In South Australia it may be that to fully address the very serious public health questions raised by this issue we should examine the system that is already operating in New South Wales. Quite obviously, people involved in the control of AIDS and those of us who wish to do everything possible to control illicit drug abuse are facing a serious dilemma. On balance, I believe that that one program, that is, the provision of sterile syringes and needles through community pharmacies to drug addicts, according to the advice we have received and the experience overseas, should not lead to an increase in the incidence of drug abuse. On the other hand, quite clearly it has a very great potential to control what is easily the most serious threat of the spread of AIDS in the heterosexual community. This is something about which the community must make up their mind, but I repeat that it is a dilemma. However, on balance I do not believe that we can stand by and allow this very serious threat of AIDS spreading through the heterosexual community to continue.

Mr RANN: Will the Minister advise the Committee on the establishment of a social health office in the central office of the Health Commission incorporating the Office of the Women's Adviser, and in particular will the Minister explain how this fits in with the Government's policies on social justice and social health generally?

The Hon. J.R. Cornwall: Cabinet approved the appointment of a Director of Social Health earlier this year. A firm undertaking was given in the run-up to the 1985 election in that regard, and we moved very quickly to honour it. The whole question of social health is being considered by progressive Governments around the world and, of course, by the World Health Organisation. It moves the whole philosophy and policy of health and the positive promotion of health away from the narrow model of treatment of sickness after the event. It takes into account all the factors and the denominators that contribute directly and indirectly to health as a condition of physical, spiritual and mental well-being. Those factors obviously go right across all Government departments. This is called the inter-sectoral approach, or the trans-department approach. It includes adequate housing, reasonable income, local environment, access to timely and relevant education, decent public transport, and all the other things that go towards making communities function and towards supporting families.

Those policies are being developed actively, and we hope that a general strategy for the promotion of social health will be available for Cabinet consideration within the next few months. Once that major paper on social health is available, it will be distributed widely throughout the State for discussion. Of necessity, if a social health program is to work, there will be a significant element of community development. We want local communitiies and local regions to have a major say in the development of health services which are relevant and pertinent to the needs of the people as the consumers see those needs rather than, as has tended to happen in the past, as the health professionals perceive what the people ought to have.

The Social Health Office will incorporate the Office of the Women's Health Adviser. That should not be seen in any way as a diminution of the priority that we give to women and health, that is, women's roles as both consumers and providers of health care. Quite the reverse: it should be seen as the next logical and major step in taking women's health issues into the very important arena of social health. We will be at great pains to ensure that the very good work that has been done in terms of establishing both women's health centres and a women's health network around the State is preserved and enhanced.

In fact, we are actively considering the development of a Women's Health Council, the role of which will obviously be to monitor continuing progress in meeting the special needs of women in the health area that have been delineated in the past four years. The Social Health Office, as part of its overall strategy, inevitably fits in with developing a long-term social justice program. We are well down that track. In March, Cabinet adopted a strategy that involves 11 major points, such as financial counselling and advocacy (to mention just some). Some of these initiatives can be carried out fairly rapidly by administration, but others take longer and may require legislation. Of course, some iniatives will require money, and they will be the more difficult to put in place. The general idea is that we hope to develop a social justice secretariat, South Australian social justice council, to monitor the progress of social justice programs over five to 10 years.

One of the roles of a social justice secretariat will be to act as a monitor and adviser on the decisions of Government generally so that all departments, and all Ministers ultimately, who are taking major recommendations to Government and Cabinet will be asked to assess the positive or adverse impacts of those decisions on social justice, in just the same way, as a responsible Government as we always look at the economic impact of any decisions. Certainly, the social justice strategy should not be seen as having any negative impact in that context. Quite the reverse: one would hope that the economic and social justice impacts, provided they are handled sensitively and sensibly, would complement each other, particularly in the longer term.

Mr RANN: The Second Story was opened in September last year as part of a major initiative by the Government in adolescent health. Will the Minister report on its progress during the first year of its operation? Does the Government intend to develop or extend its services in any way?

The Hon. J.R. Cornwall: The Second Story is a youth health centre with a brief to provide a range of health promotion programs, a general practice clinic, counselling, advocacy and support for individual young people. I guess it was the first major move in my portfolio areas towards an inter-sectoral approach. It involves a number of agencies providing direct counselling services at The Second Story and involves referral, where appropriate. We have inputs such as health, education, welfare, drug and alcohol services, and a whole range of other agencies which are appropriate to the needs of the young people who attend.

I will say something about the activity statistics in a moment, because they are quite impressive and I think the work of the Director of The Second Story and her staff should be acknowledged. A couple of matters should be clarified before I do that. First, we really should look at what The Second Story is not; and two things it is not. First, it is not specifically a facility for adolescents at high risk—that is, for street kids—exclusively. It is important that the Department for Community Welfare and the voluntary agencies continue to put significant resources into those areas. In fact, presently we are having a very good look at ourselves in Community Welfare to ensure that those services we deliver are relevant.

We are developing a five year strategy on child protection and looking after adolescents at risk. As part of that we are looking at the relevance of our services. The Second Story is far more broadly based than that. It is available as an adolescent health centre in the broadest sense. Secondly, it is not some sort of all embracing drop-in centre. It is not a Health Commission version of the YMCA. Certainly, a number of activities are conducted, ranging from rap dancing, yoga, to arts and crafts, as part of the broad approach that is taken. We do not label young people—kids—at The Second Story as being 'problems'. They approach the place and we try to make it as user-friendly as possible.

That philosophy is starting to pay some real dividends. It has only been open now for a little more than 12 months. The statistics show that when we did open in September 1985 we were providing drop-in services only—in other words, a friendly shoulder—and we were operating 10 hours a week. Through the subsequent 12 months we have developed services to a point where we are now providing 35 hours service per week, apart from the use of the centre by other groups.

We continue to have the drop-in services which include clinic, radio, counselling, weights and aerobics for 15 hours a week; a magazine group for three hours a week; nutrition, two hours a week; drama and dance, three hours a week; city living skills, courses 1 and 2, nine hours a week; parenting, three hours a week; and a doctor is available on a sessional basis for three sessions a week and that will be expanded to meet the demand as it occurs.

Mr OSWALD interjecting:

The Hon. J.R. Cornwall: Certainly, and drug and alcohol counselling as well.

Mr OSWALD: In 1985-86 the allocation for the pensioner spectacle scheme was $1.897 million and the 1986-

87 budget is $1.825 million. How will the Government reduce the number of spectacles needed in view of the growing number of elderly people in the community? In 1986-86 the allocation for the pensioner dental scheme was $2.165 million and the 1986-87 budget is $2 million. Why has this been reduced in view of the fact that the number of elderly people in the community is increasing?

The Hon. J.R. Cornwall: I will ask Mr Sayers, Director of Administration and Finance, to respond specifically to those questions in a moment. These two programs are extremely successful, to some extent almost victims of their own success. During the last financial year we provided something in excess of 9 000 dentures, either upper, lower or full set, under this dental scheme at an average cost of significantly less than $40 patient contribution. On average we were providing them for about 10 per cent of actual cost, if those pensioners had had to approach a private dentist and pay the full cost. I pay a tribute at this stage to the input from the private dentists who participate in the scheme.

The spectacles scheme also has been a very great success. During the past financial year we have provided approximately 65 000 pairs of spectacles and a small number of contact lenses, where that was clinically appropriate, under the scheme. The cost to the patient again was of the order of $20 as against the full cost of the spectacles. Since the spectacle scheme started in late 1982—it has been running now for a period of almost four years—it has supplied a quarter of a million spectacles. The pensioner denture scheme and the South Australian spectacles scheme have been two of the unsung success stories of the programs in place.

Concerning the apparent reduction—marginal though it might be—in funding for those two schemes during 1986-87, I again make the point and will continue to make it throughout the next 12 months and beyond, if necessary, that those who preach and teach small government must be aware of the consequences in the human services area.

Fewer taxes mean fewer services; less money means less funding for programs. As a community we certainly have to accept in the present economic climate that some reductions in Government spending are not only inevitable and may be necessary, but I also believe that we have to balance that by being aware of the consequences of reduced Government spending. It is all very well to think of Government spending as involving paying some anonymous public servant who sits in the back room of an unidentified building. No doubt we would all like to see the lot of the unidentified public servant who, folklore has it, is non-productive tightened up. However, the reality in the health and welfare areas is that we start to cut services it has an impact on the people who can least stand that reduced service.

The only practical way in which the State can redistribute wealth is through increasing equity of access to services, whether they be health, welfare or education services. There is very substantial and well documented evidence that, if there is to be a redistribution, if we are to move people out of poverty traps and move families to situations where they have a reasonable lifestyle, clearly the most effective way to do that, and probably the only effective way given the current climate, is to give them equitable access to human services. I repeat that those who preach small government must be aware of the relatively high cost in human terms of small government. I ask Mr Sayers to respond specifically.

Mr Sayers: The two schemes—the Pensioner Denture Scheme and the South Australian Spectacles Scheme—are somewhat different in their administration. In the denture scheme an authority is issued prior to the incurring of the expense, so that is controllable by the commission. The spectacles scheme is reactive to the marketplace and accounts are paid as they are received, so the commission does not intervene in the approval process.

The reason the spectacle scheme has been funded less than in the 1985-86 year is because additional funds were put into the scheme in 1985-86 to meet a small backlog of accounts from the 1984-85 year, so there is an abnormal year in 1985-86. It is our estimate, because we are reactive to the marketplace, that funds provided for the spectacles scheme in 1986-87 are adequate to meet the requirements.

If that should not be the case the commission must then look at whether it needs to change the rules surrounding the scheme. At this stage we still hope that the claims against that fund will not exceed the amount allocated. The Pensioner Denture Scheme is different, and I would like to handover to Dr David Blaikie to comment on it.

The Hon. J.R. Cornwall: I ask Dr Blaikie, Director, South Australian Dental Service, to respond specifically on the Pensioner Denture Scheme.

Dr Blaikie: The Pensioner Denture Scheme has been without doubt a successful scheme since its 1981 introduction. It is fair to say that the allocation to that scheme this year is reduced marginally, as the Minister explained. Other areas of activity in the health services system have also been reduced marginally. However, as I said, the scheme has been very successful and has certainly met the needs of the population of South Australia. Since its beginning in 1981 the number of patients treated under the scheme has increased by 723 per cent, that is, from a figure of 1 191 patients in 1981-82 to 9 797 last year. Indeed, in the last two financial years the scheme, with allocations of about $2 million, has been able to treat 10 000 patients or more.

The waiting lists for dentures in days gone by involved two years or more. Waiting lists are well under six months in all public dental clinics in South Australia and under the Pensioner Denture Scheme they are of the order of about two to three months now. It might be worth saying, when looking at the Pensioner Denture Scheme, which is the scheme using private dental practitioners, that we should also be aware that a new scheme is also commencing in some country areas for the treatment of general dental care through private general practitioners and this year the South Australian Dental Service will allocate $100 000 for that scheme. The combined allocation to the Pensioner Denture Scheme and the new General Dental Scheme will restore the budget allocation to last year's figures.

Mr OSWALD: I refer to psychiatric hostels (page 351 of the yellow book). There are 18 licensed psychiatric rehabiliation centres which house at the present time somewhere over 500 residents. The State Government pays a subsidy of $3.10 per patient per day, and $2.35 was paid prior to 1 January 1986. It was an understanding that, as from 1 May 1986, the subsidy would be upgraded in accordance with the CPI. However, the letters from the association representing the centres have remained unanswered by the Minister's office. The centres receive a total of $235.40 per fortnight, derived from 75 per cent of the residences' pensions plus the subsidy of $3.10 per day. It is quite impossible for the centres to continue on this basis and several of them are up for sale. What is the intention of the Government in regard to subsidy for psychiatric centres in the 1986-87 financial year and, if the centres close, how will the Health Commission handle the more than 500 residents who will be deprived of a home?

The Hon. J.R. Cornwall: I will ask Judy Hardy, Acting Director, Mental Health Services, to respond specifically in a moment. Let me make the general comment that the

psychiatric hostels have played a very useful part in South Australia over almost two decades. I am sure that most members would know that the number of patients in our two psychiatric hospitals—Hillcrest and Glenside—is now subtantially less than half the number in the late '60s.

That was quite a revolution. There were many chronic patients who, because of medication and for a number of other reasons, were able to live outside the hospital environment. The psychiatric hostels at that time played a very useful role. Nothing stands still and, in the ongoing evolution of services for the chronically mentally ill, in some respects the hostels now do not play a role that is as useful as they played in the context of the 1960s and 1970s. For that reason we are actively developing alternative programs, both residential and non-residential. I ask Judy Hardy to give some of the more specific details of that program. There has been a significant amount of new money made available in 1986-87, despite the difficult times in which we live, to foster and further develop the program.

Mrs Hardy: The mental health hostel system is unique to South Australia and started here approximately 20 years ago. We reviewed that system about 18 months ago and at that time became fully aware of the limitations of the system. Since then we have been actively working towards the establishment of a whole range of accommodation options. The system comprises 18 hostels, and provides accommodation, and virtually nothing else, to 522 people, who are predominantly middle-aged to elderly people with a diagnosis of chronic schizophrenia. The service is limited, in that the hostel owners have had very little training and are unable to cope with difficult behaviour, so we have a new group of patients who require accommodation but who cannot be accommodated in the system.

So, we have had to put all our resources into developing alternative options to enable groups that are currently not catered for to be catered for, and we have a new initiative fund of $250 000 for 1986-87 to do that. Those funds will be allocated to a range of different options which will cover a specific hostel program for young schizophrenic people. The process that has been in operation for over 10 years of deinstitutionalisation, whereby beds available in this State have reduced significantly, has meant that we have a new problem in mental health—young people who develop schizophrenia in their late teens and early 20s and who years ago would have stayed in hospitals for years. Now they have repeated admissions to hospital, but for short periods. They require accommodation that needs ongoing supervision and support. A significant amount of the new money for this year will be devoted to that group.

An ongoing problem for the women's shelters has been the number of women coming along who are not only victims of domestic violence but who also have concurrent mental health problems and they are a specific problem to the shelters, so some of the new allocation of funds will be going to that area. I mentioned previously the review of hostels and the development of alternative programs. We have assessed all the people in hostels and realise that not all need to be there. They do not require that level of care. So, we are developing a network of community houses.

The Housing Trust has been extremely cooperative in this venture, and a number of their organisations that have formed housing cooperatives are allowing us to use some of their houses. Currently, we have access to three houses from the Housing Trust, and 12 more will be available this year. The Manchester Unity Housing Co-operative has provided us with five units, the GROW organisation with another five, and the St Vincent de Paul Society has a boarding house. We are slowly decanting people from the current inadequate hostel system to the alternative options which are more acceptable in today's climate. Unfortunately, the existing hostels are virtually long-stay mental hospital wards that happen to be located in the community, and it is very hard to support and justify their ongoing maintenance.

In respect of the subsidy, we have been negotiating for some time with the South Australian Employers Federation, which represents the hostel managers, and we had an agreement with it that the subsidy would be increased on an annual basis. It then acted unilaterally in raising the fees. The commission is considering a response to that, but we anticipate that in November there will be the normal annual increase in the subsidy.

Mr OSWALD: What was the recommendation of the inquiry into psychiatric hostels regarding the subsidy per day per person?

Mrs Hardy: The sensitive nature of the financial data that was provided resulted in the commission employing a group of private consultants to analyse that data. The data that we obtained from the hostel managers was incomplete, and there was no consistent way to analyse it. Ultimately, we had to ask them to cost a mythical 30-bed hostel providing the sorts of services that we listed. That was done, but they costed it using staff numbers that none of the hostels provided. They are primarily owned and staffed by a manager and his spouse, and frequently they employ family members. The recommended level was $6 per person per day (at this time it is $3.10), and we are moving incrementally towards a higher level.

Mr OSWALD: The Minister may wish to take this question on notice, and provide a reply later. How many and what inquiries, committees and working parties did the Minister set up in 1985-86? How many of them have reported, and what has been the cost of these committees?

The Hon. J.R. Cornwall: I would have to take that on notice. There was a question regarding the capital equipment funding at the Royal Adelaide Hospital, to which we now have the answer. The member for Albert Park asked this morning about the lead decontamination and rehabilitation program at Port Pirie. I am pleased to say that Dr Malcolm Collings has joined us and, with your concurrence, Mr Chairman, and that of the Committee, after Mr McCullough gives the RAH answers, I shall invite Dr Collings to address the Port Pirie question.

Mr McCullough: There has been expenditure on many items of equipment in the RAH and I will list them. They fall into different categories. I am dealing only with major equipment. The first item that should be noted is that arrangements have been made with the RAH for the refitting of the angiographic unit, which is comprised mainly of equipment, and that will cost $2.4 million and is budgeted for 1986-87. There are also general equipment items such as the East Wing air-conditioning unit, which cost about $500 000, and there is a final payment for this year of $162 000. There is also final payment for the linear accelerator, which cost $1.659 million. Also, the State is negotiating with the Commonwealth Government for the installation of medical resonance imaging equipment at an estimated cost of close to $3 million.

A series of computer equipment is to be purchased for the Royal Adelaide Hospital this year, including the networking and work stations for the ATS/PMI system, which will cost $455 000. There will be some software purchases of commercial (that is, business) systems of $41 000; and for clincial systems (hardware and software) the cost is $112 000. In addition, there is an amount of $100 000 for the thoracic computer. In addition, there are several specific

medical equipment items: an image array processor at a cost of $85 000, an image intensifier at a cost of $77 000, a mammography unit at a cost of $122 000, a cardiac control monitoring unit at a cost of $228 000, compensating filter equipment at a cost of $110 000, a haemophorosis machine at a cost of $48 000 and coronary care centralised monitoring equipment at a cost of $416 000.

This equipment does not include the equipment that the Royal Adelaide Hospital purchases from within its operating budget which in 1986-87 will cost at least $500 000. In addition, the hospital is the benefactor of a number of purchases from the Commissioner for Charitable Funds amounting to hundreds of thousands of dollars. However, I do not have details on that. It must be realised also by the Committee that this equipment does not include equipment purchased for the IMVS, which is the laboratory for the Royal Adelaide Hospital. That equipment is quite separate. Equipment purchases from the capital account for the IMVS amount to some $600 000 and in addition there is some several hundred thousand dollars from within the IMVS operating account.

The Hon. J.R. Cornwall: While Dr Collings is joining us, I will say two things: first, I think it is appropriate that I should acknowledge the $4.2 million a year funding over three years that we are receiving from the Federal Government to upgrade capital equipment in the teaching hospital system (that amounts to almost $13 million over a three-year period); and, secondly, I should declare my vested interest in any equipment to do with angiograms, because I have had an angiogram at the Royal Adelaide Hospital. That did not influence the commission's decision to give priority to the $2.4 million for the new equipment. Dr Collings from the Public Health Division has now joined us. As I said this morning, I think Dr Collings has been more closely associated with the Port Pirie program than anyone else in the service. I now ask him to respond to the questions asked by the member for Albert Park this morning.

Dr Collings: I understand that the question was couched in terms of the progress made and the capacity of the program to continue to achieve the stated goals. It is useful to point out that the original hopes and aspirations for the Port Pirie lead program included a view that the seven to 10-year time frame mentioned by the Minister was always achievable provided that we could manage to decontaminate a number of homes each year (of the order of 250). We were funded at an appropriate level last year, and it was quite disappointing to us that major staff difficulties caused a slowing of the project and underspending. However, in this financial year that underspending has been reinstated in the Port Pirie budget, so we have an allocation this year of $2.795 million. That is consistent with continuing to work at the rate proposed and with achieving the final goals of the program in the original seven to 10-year time frame.

The Minister reported earlier that within the last financial year we completed the decontamination of 120 residences. He may also have mentioned that from the beginning of the program to the end of last financial year we were actively involved in a total of 287 homes in Port Pirie. I can point out now that in the first quarter of this financial year a further 70 jobs have been completed and an additional 93 are either in hand or ready for tender. I think the evidence is clear that we are progressing at the rate that is required to meet the stated objective.

It is also important to say that merely measuring progress in terms of the numbers of homes decontaminated is misleading. The real test of whether or not the project is working effectively is the blood lead levels of the children at risk at Port Pirie. All the indicators that we have suggest that those blood lead levels are already beginning to show the sorts of downward turns that we would hope for. In each of the six-monthly testing cycles conducted so far (and we are now into the fourth) the percentage of children who are above the level of concern has dropped from over 9 per cent in the first cycle to a little over 6 per cent in the third. We have monitored closely the effect on the blood lead levels of individual children whose homes have been decontaminated. In the vast majority of cases those individual blood lead levels are also declining at a very encouraging rate. I believe that is a far more important indicator of success than merely counting the number of houses that have been decontaminated.

Other parts of the project which I believe are continuing to achieve results include the CEP funded greening project in Port Pirie, which has had an enormous boost in the past 12 months and is due to be completed in about a week or so on 18 October. I find it quite astonishing that under that project 91 000 trees and shrubs will have been planted in Port Pirie in the past 12 months. The contribution that makes to stabilising a very dusty environment is obviously substantial. From the point of view of our program, prevention of movement of lead through the city in the form of dust is clearly very important because it minimises the extent of recontamination of the homes in which we have been working.

The final point that I should make is that Port Pirie is a unique project in many ways. There is no experience on which we can rest, even in other parts of the world. So we continue to learn about the effectiveness of what we are doing. Mr Geoff Inglis from the Department of Environment and Planning has spoken to an earlier Estimates Committee hearing from his own departmental perspective about the work that his department has been doing to monitor the environment in Port Pirie. He has given an indication that the work of his department is drawing to a close. We are hopeful that in this financial year we will have accumulated sufficient data about the sources, quantities and movements of lead in the Port Pirie environment to enable us to complete the fine tuning of the direction in which the project should continue to go. Provided that the sort of investment that we are receiving at the moment in the program can be maintained, we have no doubt that our original goals can be achieved in the time frame originally stated.

Membership:

Mr Duigan substituted for Mr Hamilton.

Mr DUIGAN: I follow on from the question asked by the member for Briggs and the answer given by the Minister in respect of The Second Story. I came into the Chamber to listen to the Minister's answer in terms of the changing nature of the programs made available through The Second Story. I am not quite sure whether I heard the Minister indicate the nature of the usage of the services being provided by The Second Story and whether he could supply any information on usage as distinct from the types of programs available.

The Hon. J.R. Cornwall: I will ask Mr McCullough from the central sector to give us some specific figures on the daily, weekly or monthly utilisation rate. The place has almost been a victim of its own success. There are literally hundreds of adolescents and young people going through every week. I might say that there has been some unfortunate criticism about The Second Story from people who have been sadly ill-informed about the roles and functions that

it is set up to perform: that it is not meeting the needs, for example, of street kids who are a very important group and whose needs we must meet. We meet them in other ways besides The Second Story.

The Department for Community Welfare and voluntary agencies have specific charters to look after the adolescents at risk, and in fact that department is about to launch a major five-year program specifically targeting adolescents at risk. They would comprise probably 200 or 300. The Second Story is there to meet the health needs across the full spectrum and in the best inter-sectoral way of all of the young people of metropolitan Adelaide. It is the flagship, as it were, and will act as a model in developing adolescent health services, not only in the suburbs but also in Whyalla, Mount Gambier and other parts of the State.

It is interesting that there has been a fair bit of experimentation with the various groups. Initially, when it was new, everybody wanted to have a look, to try it out, and it was invaded by various groups successively. At one stage the Aboriginal street kids almost took it over for a brief period and then tended to go back to the Hindley Street project. At another stage, the eastern suburbs private school kids took it over. It became a safe haven for them to smoke—tobacco, that is—without the prefects being able to nab them in Rundle Mall. It was not set up for that purpose and we had to adapt and very quickly change the rules.

We have had a very busy first 12 months. It was always intended that it would be adapted according to the needs of the adolescent population of Adelaide. In that sense, it had to be unique: it could not be The Door in New York, or any other adolescent health centre. We have come a very long way in 12 months. We have a lot of runs on the board. Specifically with regard to numbers, I ask Des McCullough to respond.

Mr McCullough: As the Minister said, The Second Story has so far had a relatively short life. When it was originally conceived, it was thought that it would probably only have groups of about 30 at a time. However, it has been an overwhelming success and, as the Minister says, a victim of its own success, and there have been numbers there consistently in excess of 150 and up to 250. In fact, one night it was recorded that over 300 attended. I have been there on a number of occasions and have seen a variety of youth. It is quite a mix of Aboriginal children, white street kids and college kids who rub shoulder to shoulder. To some extent, it is a haven for some. For others, it is a place to go.

The Second Story pretends to be something that it is not. It is a non-threatening environment for children, and when they are there they feel fairly relaxed and are exposed to a number of health facilities of which they can take advantage. Of course, high on that list are the clinical services that are available. We have identified a variety of needs at The Second Story, and these needs change with the type of children. For instance, college students often have needs that are quite different from those of the Aboriginal children or other white street kids.

The Second Story runs a variety of programs which include fitness (using weights), aerobics, nutrition classes, drama, sexuality and information in addition to the medical clinic. There are young women's groups, young men's groups and, at the moment, as the Minister pointed out, the centre is operating for about 35 hours per week. This would appear to be the maximum that it can be stretched to presently, given the existing resources. It would seem that The Second Story has identified for youth a need in the community, and it goes only part of the way towards fulfilling that need. However, it is an overwhelming success and has identified a model that can be applied as resources become available.

Mr DUIGAN: Supplementary to that, in his reply, the Minister referred to the Hindley Street youth project. I notice in the book containing additional information to support the 1986-87 estimates that there is in fact a payment of $16 200 to the Hindley Street youth project under the general heading 'Grants to health agencies'. Could the Minister indicate the health component of that project? Presumably that $16 000 is a direct health related payment as distinct from payments that may be made to the Hindley Street youth project which I acknowledge is working with different groups of children than The Second Story. Could he indicate the particular health focus of that grant?

The Hon. J.R. Cornwall: The Hindley Street project complements the work of The Second Story. It was established first. It was filling a need before The Second Story was ever established. It still fulfils a need. There are some kids who obviously feel more comfortable in the Hindley Street project. There are some kids who find the Hindley Street environment less threatening than having to move up into different territory in Rundle Mall. The Hindley Street project is a joint project sponsored by the Adelaide City Council, the Department for Community Welfare and the South Australian Health Commission. Among other things, the centre has a street worker, so they do not sit at 104 waiting for clients to come to them: they go out and talk to the kids and work with the kids on the street. Again, they have a more limited and different clientele. On a percentage basis, they tend to deal with significantly more street kids.

There is certainly a health aspect. There is no doubt that many of the clients with whom they deal are adolescents at risk. When I say 'at risk', I mean at risk of a number of things including potential drug abuse, alcohol abuse and sexually transmitted disease, to name but three, so there is certainly a significant health component. The Hindley Street project, I believe, works well, supplements and complements the work at The Second Story, which has a much broader spectrum of clients, and we are very happy to continue to participate in its funding. Wearing my other hat, we in the DCW are also happy to continue to participate.

Mr DUIGAN: I note that it is intended in 1986-87, as part of the provisional ambulance facilities, to plan for an air ambulance facility at the Adelaide Airport and that a regional St John service will be established at Berri. The blue book indicates that the preliminary budget allocation for the St John Council is $12.3 million, as against $11.6 million last year, and that receipts for this financial year are estimated at $7.3 million. How has the process of separating the ambulance service from the St John Council been operating in the period since the board was established? Further, is the $7.3 million in receipts derived from ambulance subscriptions, and does the small increase indicate that the number of subscribers we can expect to the ambulance service has reached saturation level?

The Hon. J.R. Cornwall: The subscription scheme has been maintained for a very long time. There are a number of problems. The promotion, collection and administration costs of the ambulance subscription scheme absorb about 30 per cent of the money raised, so in that sense it is inefficient. There is also a straight two-tier system: people pay either the full subscription or 50 per cent subscription if they are pensioners. In that sense, the system is not progressive: there is a flat rate, and some people regard that as not particularly equitable. On the grounds of efficiency and its being equitable, one of the many recommendations of the select committee of the Legislative Council was that

the State Ambulance Board review the subscription scheme, but that is a task it has yet to perform.

The board has had plenty to do in the period since its establishment (less than 12 months from memory). It has certainly had teething problems working out the relationship with the St John Council in particular and the St John organisation in general (that is, the brigade and the association). That is a task it has approached very positively. I am optimistic that a great deal of goodwill will ultimately prevail between the various arms of the St John organisation and the State Ambulance Board. That is hardly surprising, because a significant number of the members of the board come from the St John Council, the St John Association or the St John Brigade; in fact, four of the nine members come from the St John organisation.

Basically, there are three ways in which money is raised for the good conduct of the St John Ambulance Service, and I must say in passing that, despite some industrial problems, it is indeed the good conduct of a first class ambulance service involving both paid officers and volunteers. Money is raised from the subscription scheme, from patient transfer (particularly inter-hospital transfers) and, thirdly, from the additional funding made available by the Health Commission. Mr Blight will comment on the specifics of the recurrent revenue budget of the ambulance service.

Mr Blight: The breakdown of the revenue figure for the metropolitan area is: 59 per cent from transport fees; 40 per cent from subscriptions; and a little under 1 per cent from other sources. The honourable member may be interested to know that the transport fees component can be distributed across four principal sources: hospitals, about 47 per cent; the Department of Veterans' Affairs, 10.5 per cent; the State Government Insurance Commission, 10.5 per cent; and individual fees, about 32 per cent.

Mr BLACKER: I refer to community concern in country areas about the future of maternity and neo-natal services throughout areas of the State. I appreciate that much of the concern arose from a report that was instigated within the Lyell McEwin Hospital and Modbury Hospital in about April and the subsequent publicity. At that time I contacted the Minister's office and the Health Commission, and various assurances were given not only to me but also to the Eyre Peninsula Hospitals Association. Since then, the CWA State Conference has been held, and that aroused a lot of concern among country women, who in turn have aroused concern within the general community. A report of the CWA State Conference in the *Eyre Peninsula Tribune* of 2 October 1986 states:

> Dr McCoy, Deputy Commissioner of Health, was the last speaker for the conference. He spoke on the Health Commission's plans for providing better obstetric and neo-natal services by having these services centralised and not allowing hospitals with less than 50 births per year to provide beds for obstetrics. The association [the CWA] realises that if obstetric beds are taken from small hospitals the result will be the loss of doctors in the area and loss of hospital staff because they are not going to be able to practise their skills. Babies will be born on roadsides because centres will be too far away. This could foresee closure of country hospitals as an offshoot.
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> If it becomes necessary for all births to be in Adelaide as the central hospital, problems will occur when mums have to leave home up to two months before the birth. More home births could be mothers' choice and these will not have any medical back-up support. 'Mothers can decide on a home birth but do not have a choice of which hospital other than a central hospital,' Dr McCoy said. State Council considered this situation also includes anaesthetists as the plan is to reduce theatre work in some hospitals.

I believe that the Minister would appreciate that such a report has resulted in widespread community concern. My electorate office informs me that 23 letters arrived at my office this morning objecting to this action. I have been in fairly constant contact with the Minister's office and the Health Commission, and I have been given assurances along the line but, despite all that, these reports are still emanating. If hospitals where there are fewer than 50 births a year have that section closed down (and many believe that the whole hospital would eventually close down) about 49 hospitals would be affected. If the figure was reduced to 20 births a year, still 14 country hospitals would be affected. The concern is great, and any assurance that the Minister can give, particularly in relation to the sparsely settled areas where there are long distances between hospitals, would be very much appreciated.

The Hon. J.R. Cornwall: The Deputy Chairman has been ostensibly maligned, and particularly the Minister, who has been an innocent bystander. Yesterday I said—and I will repeat—that I believe that there has been a lot of scandalous scaremongering going on in country areas concerning the review of obstetric and neonatal services. It is important that we briefly trace the history of this whole business. There have been a number of assessments and reviews of obstetric and neonatal services in South Australia over a period of a decade or more. Most recently we had Professor Child come to South Australia from Sydney to review obstetric and neonatal care at the Lyell McEwin and Modbury Hospitals. He came specifically to do that and made a number of specific recommendations. Already we have acted in the 1986-87 budget to implement some of the major recommendations he made concerning obstetric and neonatal services in those two hospitals.

In his report he made the observation, in passing, that despite a number of recommendations of a number of individuals and committees over a period of more than a decade, no action had been taken with regard to obstetric and neonatal services in non-metropolitan areas. It was determined that we should act to review obstetric and neonatal services in South Australia. That includes the Queen Victoria Hospital, the Queen Elizabeth Hospital, the Flinders Medical Centre, as well as Kimba, Loxton, Naracoorte, or any hospital within Mr Blacker's electorate.

To begin that review we put together a committee comprising representatives from the learned colleges of obstetricians and gynaecologists, paediatricians, and the College of General Practitioners, among others. They issued a discussion paper which canvassed a wide range of issues. It was no more and no less than a discussion paper. They are currently going about their work. It is part of a process which obviously will culminate in a blueprint for obstetric and neonatal services in South Australia.

The point I would make, have consistently made and will continue to make, is that in any decisions that might be taken subsequently the safety of the mother and the well-being of the baby will be paramount. As far as I am concerned, as Minister of Health—and I give this quite unequivocal guarantee—and as far as the Government is concerned—and I give this guarantee on behalf of the Government—that will not only be the paramount consideration, but it will be the sole consideration *vis-a-vis* any economic consideration.

I make it very clear that not one obstetric service in any hospital in South Australia will be closed on the grounds of economy. I cannot responsibly give the same assurance with regard to the safety of the mother and the well-being of her baby. In fact, if overwhelming evidence is produced that the mother would be safer and that the baby would be delivered with a lesser chance of morbidity, then clearly I would have to closely examine any recommendations that

were made to the commission by the committee and subsequently by the committee to me.

I would obviously be involved, as would the commission, in a consultative process which would devolve around the recommendations of the committee before any decisions were made. I repeat: any decisions that were even canvassed, as far as I am concerned as Minister of Health, would be based on the paramountcy of the safety of the mother and the protection of the baby. We do not just measure the well-being of the baby on raw mortality statistics. We would have to look at morbidity indicators as well: do babies in certain circumstances in certain hospitals run a higher risk of brain damage or other problems at or around the time of birth? We have given these assurances to the South Australian Hospitals Association. I am prepared to give them to anyone who wishes to approach my office. I give them now formally to the Parliament. There will be absolutely no rush to decisions and I would repeat that if any decision is taken it will be taken on clinical grounds, absolutely not on the basis of economy. That is well accepted throughout the commission; if anyone doubts it they now have my word in *Hansard*.

In the circumstances, it is most regrettable in my view that 50 country hospitals and the South Australian Hospitals Association, without any consultation with my office or me at all, staged this very strange meeting. They said that members of the media were allowed in but that they must not be identified for fear of reprisals. I found that most extraordinary. This is not South Africa, Chile or the Soviet Union. I would have thought that freedom of assembly is still something that is available even to country hospitals. I found it most regrettable. They have done themselves, in goodwill terms, an enormous amount of harm; they have passed a vote of no confidence in me, as Minister, without talking to me, without knowing what my position was or without bothering to try to find out. I cannot deal with them, of course, until they rescind that motion, and they should be aware of that. Clearly, they cannot deal with a Minister in whom they have publicly expressed no confidence.

Mr INGERSON interjecting:

The Hon. J.R. Cornwall: I will not deal with an organisation that has directly expressed no confidence in me. At the same time one of their senior spokesmen went on air and said, 'It is really the commission's fault. If only we could get to talk to the Minister I am sure the whole thing would be resolved.' How can the leaders of this 'old right' orchestrate a meeting in which they pass a vote of no confidence in the Minister, declare war on the Health Commission, and then say they want to negotiate. That is a very strange way indeed to negotiate. I have enough faith in the good sense of the rural communities of South Australia to be able to say that when they know the truth of the matter, instead of this scandalous scaremongering that has been going on—with a little help, I might say, from some key players in the Liberal Party—they will be happy to come and talk to me, and I will give them exactly—

Mr INGERSON interjecting:

The CHAIRMAN: Order!

The Hon. J.R. Cornwall: You know very well that the Leader of the Opposition and the Leader of the Opposition in another place have been out and about creating mischief. I have considerably more confidence in the member for Flinders, and that is why I am responding to his question very seriously and at some length. I would like him to convey to his electorate the same undertakings and guarantees that I have conveyed through you, Mr Chairman, to him and to this Parliament.

Obviously—and I conclude as I started, before asking the Deputy Chairman, who is painted as something of a villain in this newspaper piece and the Chairman of the Health Commission to respond—my position is quite clear. I repeat: the well-being of the baby and the safety of the mother are the paramount considerations. No decision will be taken until all of the recommendations have been made by the committee, until there has been a full process of rational consultation. I might also say with respect specifically to the West Coast that it would be a nonsense to suggest that we could close down obstetric services at rural hospitals which were remote from other hospitals—a complete nonsense. That most certainly will not happen while ever I am Minister of Health.

Conversely, where there are small hospitals 10, 15 or 20 minutes drive from larger country centres, and if there were a recommendation that clinical services could be better consolidated in those larger hospitals while still giving general practitioners admitting privileges to the larger country hospitals 10 or 20 minutes drive away, that may be a different proposition. It would be a complete nonsense and quite counterproductive to withdraw obstetric services from remote hospitals in the State. I ask the Deputy Chairman, in the first instance, since he appears to have been maligned or misquoted, to respond.

Dr McCoy: I addressed the annual general meeting of the Country Women's Association. I was happy to do so. I was very careful in the words that I used. I have a copy of the speech which I gave to the conference and which I would be happy to table here if it was thought necessary. I would like briefly to refer to the things that I said that may have been misquoted. In my speech I was going over the history of this very difficult clinical problem and I said:

> Then more recently, in April of this year, a Review of Obstetric and Neo-natal Services at Lyell McEwin Health Service and Modbury Hospital reported that peri-natal mortality and morbidity rates at the hospitals were higher than expected for low birthweight babies. This review went on to state that preliminary examination of Statewide data revealed a need to review perinatal services provided in metropolitan health care units with fewer than 2 000 deliveries a year and in country units with fewer than 50 deliveries a year.

So, the recommendation was to review those services. I subsequently stated:

> To this end, suggestions have [previously] been made at times that babies should be born only in centres with more than 500 births a year. Some have even put the figure at 1 000 births a year. [If that was done] this would virtually mean that all babies in South Australia would have to be born in the metropolitan area.

I then underlined the next sentence, and I am sure I gave it due weight, when I stated:

> However, such a socially disruptive and destructive policy is definitely not supported by the South Australian Health Commission.

I was at some pains to paint the picture of a proper and careful examination of the facts, and certainly gave no mention of any potential closures and mentioned none during the course of that talk. I would like to briefly further comment.

It is probably the most difficult policy area that has faced the health system, certainly in my time in the commission. I would like to briefly run over the facts that have been made known. In 1976 the Nicholson report was presented to the Government and recommended that there be rationalisation of obstetric services in country areas, with gradual concentration of deliveries in regional centres. In 1979 the Obstetric and Gynaecology Advisory Committee, then chaired by Professor Lloyd Cox, recommended that long-term planning goals should be for obstetric services in the metropolitan area to be concentrated into units managing

at least 2 000 confinements a year; that small obstetric units be encouraged to discontinue their obstetric services; that there should be a provision of regional obstetric care; and that no new metropolitan units be established without proper planning.

In 1980 the Task Force on the Queen Victoria Hospital Project released its report, and its recommendations were not in conflict with the above. In 1983 the Sax inquiry reported and suggested that some restriction of small hospital obstetrics was necessary and that various factors should be taken into consideration in determining whether a hospital should stop handling deliveries. It also suggested that regional obstetric services development groups should be established. As the Minister has already said, in 1986 the Child Report on the Lyell McEwin and Modbury Hospitals made recommnendations to which I have previously referred.

I would like to make two other comments. The commission has prepared a discussion paper and has printed 3 500 copies for circulation to interested individuals, groups and organisations and a consultative committee has been formed with representation from the Royal Colleges of Obstetrics and Gynaecology, the Royal College of Nursing, Australia, the Royal College of Paediatrics and the Royal Australian College of General Practitioners and the Faculty of Anaesthetists. It also has representation of the Maternal, Peri-natal and Infant Mortality Committee, the Country Women's Association—Mrs Gamlen, the President of the association, is a member of the consultative committee—and Health Commission officers are also involved. The committee has undertaken many consultative group meetings, a number of public meetings have been addressed—one of which I did myself—and responses from that discussion paper have been requested by 10 October, which is tomorrow.

After that has been completed the committee will collate the information and prepare a draft policy. Again, copies of the policy will be circulated after Cabinet approves the draft policy and there will be a further round of discussions.

Finally, I would like to say that, in the heat of this debate, there has been on the side of the commission and certainly on the side of the AMA inappropriate use of statistics in making a point. These have now been recognised as mistakes. Last night we had a meeting between commission officers and members of the AMA at which I believe substantial agreement on the statistics and their true meaning has been reached. I hope that the debate will now proceed in a calm and rational manner.

Professor Andrews: The obstetrics services issue is terribly important and therefore worth spending a little more time on, even though a great deal has already been said. Neonatal, peri-natal and maternal mortality and morbidity is one of the most fundamental ways of assessing the health status and quality of health services of any State or nation. In South Australia, we enjoy a high quality of health care, and that is reflected in the overall peri-natal mortality rates. In 1983, by way of example, the peri-natal mortality rate for South Australia was 6.9 deaths per thousand total births, and that compared with Finland and Sweden, who are leaders in this field, with 8.1 and 8.4 respectively. When one analyses such figures more closely, one sees that it is possible to show differences in different locations and in different types of hospitals, and so on. The difficulty in interpreting those figures is related to the fact that one may then be dealing with rather small numbers in any given year in a particular area or group of hospitals. Therefore, they must be interpreted carefully.

On the other hand, although we enjoy a good performance in this area, we can do better. We should be able to improve even further the reduction in mortality and morbidity associated with birth. That is what the current exercise is all about. It has been undertaken in a proper, professional and scientific fashion. It is tinged with the appropriate level of compassion and sensitivity that such an area of human intent and concern must be. It is absolutely essential that the health authority of the State be allowed to undertake such exercises. If we were unable to do so, and if we were effectively challenged by any group that had an interest one way or another, we would be unable to assure the Government that the health of people of South Australia was being protected.

Much of the present reaction to what is basically a discussion document aimed at achieving even greater improvement in the health of the community is inappropriate. The document does not focus on numbers of births per hospital, but looks at the quality of care and the need to establish levels of care. In defining levels of care, it is proposed that there should be three, from the basic and straightforward levels of care required for simple uncomplicated births to the more sophisticated and highly complex areas where there are potentially serious complications.

It looks at those levels of care in terms of qualifications of professionals to carry out midwifery practices at different levels, facilities and support services necessary in hospitals to carry out safe obstetric and neonatal care, and the expertise and training necessary for professionals to maintain skills, quality assurance matters and the overall number of beds and neonatal cots needed in South Australia as a whole. There are all sorts of issues apart from the simple one of the number of births in any hospital or group of hospitals.

There are a number of ways of tackling the problems to ensure that there are adequate levels of training and expertise among the staff that work in hospitals throughout the State. I believe that those people who are worried about this activity can be absolutely reassured that no end point has been decided. It is a process that has been associated with the widest consultation. I believe that the concerns expressed are quite unfounded and, indeed, that the process is extremely necessary.

Mr BLACKER: I have read the discussion paper. I hope to have my own response in by the due date. More particularly, in assessing the level 1, level 2 and level 3 categories, would I be correct in assuming that basically the services offered by country hospitals such as those on Eyre Peninsula (and I refer quite specifically to my own area) come within the level 1 category?

Professor Andrews: It is likely that that is so, although there is clearly scope in non-metropolitan areas for hospitals to be in other than the category 1 level. Again, some sort of support arrangement and regional arrangements would be required to ensure primarily that women and babies in country areas had appropriate access to the level of care necessary to meet their needs. In some instances that would clearly mean that they would need to come to metropolitan centres. Of course, that happens at present. It is just a matter of ensuring that that happens whenever it is necessary. In that sense, a number of the non-metropolitan hospitals, as a result of this process, may well be upgraded in terms of the quality and extent of services provided at present.

Mr BLACKER: Following on from that, the document mentions level 1, level 2 and level 3, so I would assume that many country hospitals would operate in similar stages now. I refer again to Eyre Peninsula, where I assume that most hospitals would be level 1. level 2 would be those hospitals where it was diagnosed that there might be a complication and would therefore be taken out; and level 3 would be the evacuation cases (the top 3 per cent) that

would go straight to Flinders or the Queen Victoria Hospital.

The Hon. J.R. Cornwall: One of the real difficulties might be with the relatively small number of cases where it is hard to categorise what level of care is required in advance. I ask Professor Andrews to respond.

Professor Andrews: Just to go back a little, I have been reminded that all hospitals on the West Coast (and the member mentioned that area specifically) would be in the level 1 category. Of course, only larger non-metropolitan services would reach the category 2 stage. The point made by the member about hospitals presently operating at that level is quite valid. However, the value of this exercise is to lay down quite precise standards that are necessary to ensure that that level 1 service is provided at an appropriate standard and with an appropriate quality of care. Quite innovative approaches may be necessary to ensure that, for instance, the nursing staff working in these situations are indeed appropriately qualified and have the necessary level of experience. This problem relates not only to obstetrics in rural areas but also to rural health in other areas.

The commission is conscious of the need to monitor and progressively upgrade and support rural health services and to ensure that there is adequate and appropriate access to the whole range of services required outside the metropolitan area. A number of strategies have been developed to ensure continuation or the supply of medical services, for instance, and, I am pleased to say, many have been developed in cooperation with the AMA.

Mr OSWALD: My question also relates to country hospitals, but not necessarily in regard to obstetric services; it is framed more in terms of the general allocation to country hospitals. What is the reason for the high funding cuts in some country hospitals, particularly on Eyre Peninsula? I refer to page 10 of the blue book, which states that the gross payment (actual) for Booleroo Centre in 1985-86 was $846 000. The allocation for this coming year has been reduced down to $837 000. For the Cowell Hospital it was $708 000, reduced to $707 000; Cummins it was $723 000, reduced to $720 000. Incidentally, the last two that I mentioned are receipts for the year, so their expected receipts are also down. Last year the Elliston Hospital was $519 000, and now it is down to $488 000 (and its estimated receipts for the year are also down); Kimba has gone from $757 000 down to $726 000; Streaky Bay was $676 000, and it is holding at that figure, yet its receipts are down.

Is there to be any review of the funding cuts to these hospitals or are they final? If they are final, how does the Minister expect them to be able to provide the same level of service? Is it correct that country hospitals have been warned that next year's budget will also contain funding cuts? My explanation for my last statement comes from a document put out by Ray Blight, Executive Director, Southern Sector, who states under 'budget limits':

> Commitment levels for the coming year will again be based on the intentions reflected in this budget and you should note that any over expenditures by the health unit will be excluded from the funding base for the following year and a penalty imposed.

The Hon. J.R. Cornwall: If the hospitals have not been warned that next year's budget may also contain cuts, then they certainly should have been. The savings that all the health units have been asked to make across the board amount to 1 per cent of last year's budget (a reduction of 1 per cent in real terms) and a 4 per cent allowance for inflation on goods and services. Obviously we acknowledge that that will be below the real inflation rate. So, overall, the gross effect of that in real terms means reductions of the order of 2 per cent on the gross budgets of all health units. That is no different from every other Government department, whether it be Environment and Planning, Mines and Energy or E&WS.

All Ministers in all their portfolio areas were asked to find or offer up as a minimum position 1 per cent reductions in real terms on last year's budget and to accept a 4 per cent inflation rate in the clear knowledge that the real inflation rate in 1986-87 is expected to be in excess of 4 per cent. As I said earlier in the day, when that starts to impact we must consider the high cost of small government in human terms.

I cannot say that too often. If the present situation persists, then the current indicators are that we may have to look for further savings in 1987-88. I do not make a virtue out of that. Unlike my predecessor, I am very sad that we have to make any cutbacks in public spending in the human services area. I have always believed that one thing State Governments can do, and can do well, is offer services in health, education and welfare. One way that we can improve the lot of the less fortunate in our communities is to offer equal access to health, education and welfare services. So, it does not cause me any joy at all. I am saddened by it, but in the times in which we live it is a reality. Therefore, the country hospitals have been asked to carry their 1 per cent reduction and their 4 per cent allowance for inflation in the same way that metropolitan hospitals have (as has every other division in every other State Government department).

Concerning the specific hospitals referred to, obviously that is not within my direct knowledge. I ask Des McCullough, Executive Director of the Central Sector, and David Coombe, Executive Director of the Western Sector, to refer to the specifics. Also, the Executive Director of the Southern Sector would like to have a brief word.

Mr McCullough: A feature of funding country hospitals is that significant amounts for equipment or minor works are often in their operating allocations. This equipment is not normally required every year, so one hospital may get a new item of radiography equipment which causes a significant increase in its repairs and maintenance. The next year it does not require it, whereas some other hospital may require that type of equipment. Booleroo Centre was just such a case when it received approximately $45 000 additional funds for drainage works of a major nature and equipment for the day-care centre. This figure can be identified in the blue book on page 1 of section 7 where, alongside Booleroo under the heading 'Minor works and services' it identifies $38 932 and under 'Equipment' an amount of $7 424.

Mr Coombe: With respect to the five hospitals in the western sector that were mentioned—Cowell, Cummins, Elliston, Kimba and Streaky Bay—the percentage reduction in the allocation to date of the current funds for all of those hospitals is as follows: Cowell, .93 per cent; Cummins, .88 per cent; Elliston, .83 per cent; Kimba, .91 per cent; and Streaky Bay, .86 per cent. In terms of Cowell's budget of over $700 000, a reduction of .93 per cent represents $6 600. Cummins has a reduction of $6 400 in a budget of $731 000; Elliston has a reduction of $4 400 in a budget of $531 000; Kimba has a reduction of $6 800 in a budget of $750 000; and Streaky Bay has a reduction of $5 800 in a budget of $677 000. They are recurrent allocations to date. As was mentioned earlier in today's proceedings, those allocations will be varied upwards during the year due to things such as award increments, if they come to pass.

Detailed discussions and negotiations are held with each of the hospital's chief executive officers and their senior staff and boards before these budget allocations are determined. In determining them, due regard has to be paid to

the previous year's financial performance. My colleague, Des McCullough, mentioned that, in addition to that financial performance, on many occasions they are one off expenditures which we take out of the current budget base. Specifically, with respect to Elliston Hospital, last year it overran its budget by $15 921. In our discussions during the lead-up to this current year's allocation, in negotiation with that hospital we were able to accept that there were valid reasons why that overrun amount should be reinstated into its budget base for this year. Similarly with Kimba, the over expenditure of $20 000 in 1985-86 was reinstated because we were able to satisfy ourselves, in association with the board of management and the Chief Executive Officer, that that over expenditure resulted mainly from a payment of backlog of annual leave.

On the other hand, Streaky Bay was in a more favourable situation because it was able to come in virtually on budget; similarly with Cummins. So, we need to understand that the recurrent budgets are set in very detailed discussion and negotiation with the Chief Executive Officers and boards of management of those places. At the moment, the reductions compared to last year's recurrent allocations represent marginally less than 1 per cent, and when we talk about an average recurrent budget at this stage for those hospitals in the order of $700 000, a reduction of marginally less than 1 per cent in dollar terms comes out to something in the order of $6 000. I have every confidence in the management abilities of the Chief Executive Officers and the responsibilities that the boards of management in my sector will accept and display in 1986-87, and I expect they will accept the challenge of slightly reduced funding which has been passed across the board to everyone and they will maintain the excellent services which they have provided in the past.

Mr Blight: With respect to the southern sector units, the budget allocation given to each hospital was accompanied with a detailed explanation of the structure of the budget, including details of one-off adjustments for special items and details of control line allocations, all in addition to the salaries and wages and goods and service allocations. The budget letter also spelled out a number of ground rules which would apply to the budgeting period. One of those relates to the application of penalties where a health care unit overruns the budget.

There is a firm Health Commission policy that must be adhered to if we are to remain responsible financial managers, and that is that overruns will not be tolerated. They will actually be applied as a first call on the funds for the following budget period. As I said in response to an earlier question, such a penalty has been applied to the Flinders Medical Centre, and it will be seriously adhered to in relation to the small country hospitals. One of the other points made in the southern sector budget letters was that the policy of global allocations would continue, meaning that there is flexibility for transferring funds between salaries and wages and goods and services where possible, thereby allowing health care units to adapt to changing needs and priorities.

A further point made in the southern sector budget letters related to planning for future years. We made clear that Treasury had indicated that the difficult financial circumstances in which the current budget had been framed could well continue into the future and that further adjustments to expenditure patterns may indeed be necessary. The purpose of that message was to encourage unit managers to continue to actively pursue cost containment strategies that would offer scope to release resources in the future and not to just go for the quick, one-off saving measures.

As there are national wage increases, there will be automatic flow-ons to the hospital budgets, and to the extent that that occurs there is a further inflation provision that is not reflected specifically in those figures. If there are any emergency breakdowns that seriously affect the operation of the hospital, of course they will be funded.

The Hon. J.R. Cornwall: I refer to a previous question asked by the honourable member concerning the Central Linen Service and the goodwill segment of the purchase of International Linen Service.

Mr OSWALD: I take a point of order, Mr Chairman. I am happy to accept that reply shortly, but I would prefer to finish this line of questioning first.

The CHAIRMAN: I understand that the honourable member wants to ask a supplementary question.

Mr OSWALD: My question is dictated by confirmation by one of the officers of the department or commission that the deductions from the budgets of those hospitals I listed amounted to about 1 per cent. In actual fact, with inflation, on my reckoning these hospitals are operating under about a 9 per cent reduction in available funding to the end of the 12-month period. Is it correct that promotions, reclassifications, reorganisations, and so on, will not be possible unless the hospital can afford them from within its own budget? Does the Minister realise that this will virtually rule out any promotional opportunities for staff regardless of how deserving they are? Are nursing staff affected if it is decided to implement the new structure in country hospitals? Will all hospitals be reimbursed the full cost of the new career structure?

The Hon. J.R. Cornwall: That is irresponsible. I explained the position this morning, but I ask Mr Sayers to go through it again.

Mr Sayers: The career structure for nurses is certainly being specially funded. Once the career structure is implemented into hospitals, funds will be allocated at the same time to meet the associated costs. A number of areas, such as a career structure, will certainly receive additional funding. It is not as though the hospitals will be left entirely to their own discretion. As Mr Blight has said, increases in salaries and wages due to national wage increases will be passed on, and in this case career structures will be passed on. That does not mean that reorganisations undertaken by the hospitals themselves will be funded. The commission receives applications from hospitals in relation to the costs associated with reorganisations, and in the main at this point in time they are not funded. Some are funded, and I think that each case must be taken on its merits. Certainly, career structure will be funded.

The Hon. J.R. Cornwall: It is most erroneous to suggest that any hospital in the country or anywhere else is facing cutbacks of 8 to 9 per cent. That is quite erroneous and quite misleading and I hope not mischievous.

Regarding the Central Linen Service, I have been given the exact figures. In April 1986 Cabinet approved up to $300 000 as the goodwill component of the negotiated purchase of the hospital and nursing home segment of International Linen Service. Subsequently, we negotiated and settled for $200 000 for the goodwill of that service.

Mr INGERSON: Will the Minister—

The CHAIRMAN: Order! Opposition members have now asked five questions. I was prepared to accept two questions from the member for Flinders and one from either of the other members, but we have gone beyond that. I think it is time for members on the other side to come in, and I call on the member for Bright.

Mr ROBERTSON: My three children have gained considerably by their proximity to the various locations of the

School Dental Service at Somerton Park and Minda. All three have the benefit of those services, so I have some first-hand experience of the ability of the School Dental Service and the quality of work carried out. Hugh Kinnear, who was largely responsible for establishing the service, is one of my constituents—and his brother is the local priest. How far advanced is the School Dental Service in meeting the Government's policy of extending treatment to secondary school students? Can secondary school students in South Australia look forward to being covered by the School Dental Service in the near future?

The Hon. J.R. Cornwall: I am happy to say that the School Dental Service is well on the way to meeting the Government's policy, which was enunciated in 1982, of extending school dental care progressively to all secondary students up to and including the year in which they turn 16 years of age. In the calendar year 1986, treatment will be offered to all students in years 8 and 9 and about half of the State's year 10 students, plus all secondary students on the free book list (Government assisted scholars).

We expect to be able to extend care to the remaining students in years 10 and 11 by the end of 1988, and that will complete the school dental scheme, and it will be a significant achievement for the bicentennial year. The only difficulties that we can foresee at this stage in achieving this target are associated with the apparent unwillingness of young dentists to work in country areas and the temporary shortage of dental therapists. I am sure that members will recall that the dental therapist training scheme was suspended in 1979 following a decision of the Tonkin Government to restrict the School Dental Service to primary school children. That meant that there was no intake of therapists from 1980 to 1982, and that has caused some difficulty.

It is worthy of note that South Australia is the only mainland State to have offered treatment to high school students in accordance with the original aims laid down for the Australian school dental scheme in 1973. South Australia is also the only mainland State to come anywhere near meeting the initial target of treating all preschool and primary school children by 1980. We met that target during the first term of 1981. During the calendar year 1985, the School Dental Service treated about 165 000 children, an increase of nearly 20 000, or 14 per cent, since 1982, the year in which the scheme was formed.

Of those 165 000 children, nearly 30 000 were attending high schools. We estimate that the total number of children treated by the service in 1986 will approach 175 000. Although the majority of those children will be treated by dental therapists and dentists operating from over 100 fixed or mobile school dental clinics throughout the State, some 1 500 or so children will be treated by private dentists on a capitation basis. Under the capitation programs—which I might say is another first for South Australia—local private dentists are paid a fixed annual fee per child to provide comprehensive school dental care.

The first capitation contract was signed in 1981 for the treatment of children at Coober Pedy. Similar contracts now operate at Cleve, Streaky Bay, Woomera, Ceduna, Cowell and Yorketown. The current fee is $64.20 per head per year. A contract has recently been signed with a private dentist in Broken Hill to provide care for children attending the Cobar Area School.

In conclusion, I point out that the dental health of South Australian children is now amongst the best in the world and the average 12 year old child now requires less than one filling per year. The School Dental Service placed 80.9 fillings per 100 patients in 1985 compared with 92.5 fillings per 100 patients in 1984. Therefore, it is not only excellent but continually getting better.

Mr ROBERTSON: I note on page 350 of the yellow book under 'Services for the Intellectually Disabled' a reference to a reduction in community services funding from Canberra and the continued provision of the open employment scheme in Mount Gambier by the commission. I also note on the same page reference to demonstration projects, including open employment and advocacy under the handicapped persons project. I applaud the initiative of the State Government in picking up the ball from the Federal Government, which apparently has stepped out of that area to some extent.

Have the various alternatives of open employment been publicised as well as they might have been? Are all employers in the community aware of the schemes currently available to enable disabled people to make a transition from sheltered workshops into open employment? Are families and disabled people aware of those schemes? What can be done to promote them? I suggest that the recently established Disability Information Resource Centre might take up that as one of its briefs to highlight the schemes available to publicise them to employers and disabled people in South Australia.

The Hon. J.R. Cornwall: Those questions are quite specific and I would not attempt to answer them without notice. I will ask Mr McCullough to respond to the extent possible. Mr Richard Bruggermann is the Director of the Intellectually Disabled Services Council, and he is not with us, but the line of accountability is through Mr McCullough, who has a working knowledge of the disabled area generally. If further details are required I will take that on notice.

Mr McCullough: By way of background, the IDSC has had increases of 10 per cent to 11 per cent over the past four years. Significant development funds have been passed on to IDSC since it was incorporated. Members will be interested to learn that IDSC, when it was incorporated, took under its umbrella the Strathmont Centre, the Ru Rua Nursing Home, the Intellectually Retarded Services (at the time known as IRS) and Minda Incorporated. It has a budget all up in the vicinity of $40 million at present.

In relation to the funds made available, in 1982-83, $1.15 million extra was provided for 31 staff for the establishment of the IDSC, including its rental accommodation. Of that $150 000 was to support non-government organisations. In 1983-84 carry over funding for the staff employed was added to the base, and that was $500 000. In addition another $500 000 was added to provide additional staff (professional and nursing) and to set up a computer data base, which has now been established, so IDSC has an excellent data base on its total client population.

In 1984-85 additional funds were provided for carryover costs for staff and for support for non-government bodies and community housing initiatives. The community housing initiatives were to deinstitutionalise residents from institutions, and that amount was $400 000. The total in 1984-85 was $575 000. In the current financial year funding has been provided to assist ageing parents as carers of the disabled and to establish group homes. Funds provided will amount to $350 000.

In addition to the funds that have been provided the IDSC has found from within its total funding budget funds in excess of $1 million which it has provided directly to voluntary agencies. The IDSC has a thrust in its development of providing funds to these voluntary agencies. It is a cheaper model for the provision of services to intellectually disabled persons. That is about all the information I can presently give.

Mr ROBERTSON: I have a supplementary question. Explaining the last part of my question, which was basically whether DIRC might take on the responsibility of publicising the various schemes available, by my reckoning there are seven schemes currently available by which disabled people might make the transition from sheltered workshops into open employment. Clearly someone needs to direct the traffic. That was the reason for my question.

The Hon. J.R. Cornwall: There is a real problem in coordination of disabled services generally around this country among the Federal Government, the State Governments and the voluntary sector. I am sure the member for Adelaide would probably know more about this than any of us because, during the time he was the distinguished ministerial assistant to the Attorney-General, the Attorney-General formally had the responsibility for disabled services. That was so because there were still legislative matters that needed attention in the equal opportunity field. I have always had as part of my portfolio the Intellectually Disabled Services Council. Of course, the Disability Adviser to the Premier was appointed quite early in our first term of Government, and that was an Australian first.

That does not overcome the question of coordination or the lack of it. It is a matter which has concerned me for some time, particularly since I took on the community welfare portfolio as well. I convened a meeting, something like four months ago, of all the stakeholders from the public sector—education, health, welfare, the Disability Adviser and others—who had an interest in the area. I have asked them for a response. Ian Cox, the Special Adviser to the Premier, was also involved.

The response I found a little slow and a little disappointing in forthcoming, so I recently convened a much smaller meeting which was action oriented. Clearly, we will have to do a post-implementation review on the Intellectually Disabled Services Council, because it has been operating for just over four years and the time is now opportune. I have also asked that they come back to me with the recommendation for a review of disabled services generally.

We do not want the two at this stage to become the one exercise. That would create too much concern with all of the players in the disabled area generally, but we will be doing a post-implementation review of the IDSC, and as part of that we will look at the non-government agencies which they fund and which they assist in coordinating, such as Minda. We will seek the cooperation of the Department for Community Services and we will do a similar exercise with services to the rest of the disabled community, principally the physically disabled.

The IDSC has reached a point where it has the very real potential to function extremely well. It needs some fine tuning. We need mechanisms for coordination between the Federal Government, the State Government and the voluntary sector. We still have rather a long way to go in regard to disabled services generally. One of the catalysts in this has been a small but significant program called Community Living for the Disabled in which a group of young people with some abilities, some of whom at least in the past would have been dumped in Julia Farr but who really have no need for that level of support, are living in a community housing situation. One of the difficulties highlighted there is that the Federal Department for Community Services funds initially at 100 per cent, then 80 per cent and then 50 per cent.

The voluntary organisations getting into those things are expected to plan their affairs in such a way that fairly rapidly they are fund-raising to a point where they can meet substantially up to half of their recurrent budget. That can be very difficult indeed. So, there are a number of difficulties. I have asked for specific responses, first, in the intellectually disabled area and, secondly, in the disabled area generally.

Mr DUIGAN: I thank the member for Bright for his indulgence in allowing me to ask the third question. I noted in the document that the Minister tabled at the beginning of this hearing that he referred to the Uhrig report and that he was in the process of establishing a working party to devise an implementation plan to be considered early next year. My questions relate to that report: first, can the Minister give the Committee some idea of the categories of membership that might be included on the working party to which he has referred; secondly, can the Minister give the Committee an idea of the process of consultation that might be followed by that working party and, in particular, the process of discussing the major recommendations with the two universities and their medical schools?

The Hon. J.R. Cornwall: I thank the member for that question. I could almost have written it myself, but I certainly did not. I did not know it was coming, but it is a good and timely question. There were three members of the Uhrig Committee: John Uhrig chaired the committee, supported by Dr Bill McCoy, as Deputy Chairman of the commission and Mr Ray Sayers, Director, Administration and Finance. I discussed with both of those players, as recently as yesterday, the next step in developing an implementation strategy, so I ask Dr McCoy to respond specifically to the question.

Dr McCoy: The Uhrig review report has been circulated widely, but it is in fact a report to the Taeuber Committee of inquiry that is reporting on the structure of the South Australian Health Commission. No formal action will be taken on the Uhrig report until the Taeuber report is received, which I believe will be before the end of this month. After discussions with the Minister yesterday, it is our preliminary view that an informal discussion will now commence with the chairmen and the administrators of the nine metropolitan hospitals that are the subject of the report.

Following that, recommendations will be made to the Minister on the actual method to be used to implement the report. There will have to be a period of consultation: that will be importantly with members of the boards of the nine hospitals, with the members of staff of those hospitals, with the unions representing the staffs of those hospitals, and that will be a long process which will take much time and which will probably go well into next year. The other point I make is that the Taeuber review, which will be reporting before the end of this month, will itself have reviewed the Uhrig review. I do not believe it will make any dramatic changes but it may suggest some refinements in the method of implementation of the Uhrig findings.

The Hon. J.R. Cornwall: The way in which I have gone about this as Minister has been quite deliberately to release the report without adopting a specific position or without taking it to Cabinet so that options would be closed off by Cabinet's taking decisions that would be based on premature information.

We have released the report and we are now in the process of consultation. We will await Ken Taeuber's reaction to the Uhrig recommendations when he makes his recommendations in turn as to the future arrangements and organisation of the Health Commission and how we might organise on a State-wide basis. All of those things now are into a very broad process of consultation. When that has got itself reasonably along the track I will be asking the professional officers of the commission to make a recommendation to

the Commissioners and, when the commission has adopted a formal position, they will make a recommendation to me.

There will still be some flexibility—some ministerial discretion—but arising out of that I will then go to Cabinet with the recommendation. It will be a very open process and we will be seeking at all stages to try to achieve the greatest degree of agreement possible. Given the radical nature of the Uhrig committee's recommendations, I would have to say that the response to date has been very positive. It would have been very easy for everyone to throw up their hands in horror at the very idea of organising clinical disciplines across seven hospitals, for example. It would have been quite understandable if both university medical schools had reacted like some of the country hospitals—but they have not. I am very pleased—

Mr DUIGAN interjecting:

The Hon. J.R. Cornwall: At this stage there is no working party in the formal sense. Bill McCoy has virtually been given a shuttle diplomacy role, if you like: he has been asked to consult with the parties jointly, severally and individually, to get the measure of agreement that is possible, and then to work back through the commission and ultimately through me to government. But the universities of course must be involved—they have already been involved.

Obviously, they have expressed some reservations, particularly Flinders, but it is still early days. I am not hard and fast, but I initiated the Uhrig review because I realised that we had to meet the challenges coming in the late 1980s and into the 1990s within the hospital system by ensuring a mechanism that would give us rationalisation, coordination and integration of services. We could not have a system in metropolitan Adelaide where the major teaching hospitals were actively competing against each other in a winner's or loser's position for very expensive resources.

Membership:

Mr Hamilton substituted for Mr Duigan.

Mr INGERSON: My question relates to what appears to be a conflict between a statement made this morning and one made in mid June. I understand that the statement made this morning as it relates to the practice of adjusting budgets when they overflow into next year is that they are taken off the next year's budget. How is that reconciled with a statement made on 11 June 1986 when Professor Andrews, Chairman of the Health Commission, said that the Flinders Medical Centre would probably finish the year with a $1.1 million overrun? However, the commission did not regard this as serious, given the increased workload, and the money would not be deducted from next year's budget?

The Hon. J.R. Cornwall: There is always flexibility within the system for us to accept an unavoidable cost. The pressure on Flinders, because of the continued development in the southern suburbs and because it is only a 500 bed hospital, has been very great. If those pressures are shown to the satisfaction of the Commission and Treasury to be unavoidable and to be irresistible, individual hospitals can receive supplementation. That is very different from a situation in which they do not work in close cooperation, when they first become aware of genuine difficulties. For example, if Flinders is flagging from the mid point of the year, and using genuine figures and not the worst case figures that are produced by many hospitals as part of the game, it is given serious consideration. That was the position with Flinders. As Professor Andrews was far more directly involved in the negotiations than I was, I ask him to answer specifically.

Professor Andrews: I assume that the quote is from an article that appeared in the *Advertiser* under the name of Mr Barry Hailstone. It might be of interest to the Committee to know that, although that quote appeared in the paper with quotation marks around it, Mr Hailstone never spoke directly with me. He spoke to an officer in the Minister's office, and I believe that the conversation went along the lines of, 'Does that mean that the Commission does not believe this is a terribly serious matter?' He got the reply that the commission was negotiating the position with the hospital and clarifying the position, and was not leaping about at that stage.

Mr Hailstone then, for reasons that could be known only to him, decided to put that quote in the newspaper as if I had said something directly along those lines. I had said nothing of the sort, and the fact that Flinders Medical Centre was at that point reporting a potential overrun of that order was, of course, a matter of great concern to the commission. Any overrun in any hospital especially of that order is a matter of concern, and negotiations were taking place. At that stage we had not decided on the strategy to deal with the potential overrun. We had not fully understood the reasons for it and a series of discussions that involved myself, the Deputy Chairman and the Director of Administration and Finances took place with the hospital, during which time we examined arguments put to us by the hospital that related to the activities. We obtained much more detailed information on the financial operations of the hospital both to examine the strength of the arguments that they were putting to us and to establish in detail the facts. The end result in no way conflicts with the position that we were in in January of this year. I regret very much what I believe was a somewhat inadequate piece of reporting.

The Hon. J.R. Cornwall: I have a commendation for the commission, and I take this opportunity to congratulate it publicly. In a total budget last year of $763 million, and when there was a good deal of pressure in a number of hospitals and health units, the budget came in within $291 000. It involved 81 recognised hospitals, ranging from the Royal Adelaide Hospital to Kimba and various other small hospitals around the State, and literally dozens of other health units, including units such as the IDSC, with a budget of almost $40 million.

When one considers the disparate nature of the health system and the relative independence of over 150 units that perform in it and the very big budget, I am glad to take this opportunity of publicly congratulating the commission on its performance in the 1985-86 financial year. That is entirely in order, because the commission has been made something of a whipping boy in the past 12 months, mostly for political purposes, and by a number of opportunists in the system. It does a splendid job. Nobody is perfect, but we are working on it.

Mr INGERSON: Page 4 of the Auditor-General's Report shows that the central office staff increased by 25 from 298 to 323 and that the cost of operating it rose from $13.248 million to $14.81 million. What are the new positions and the names and salaries of the additional 25 staff? How many people are to be removed from the central office this year? Is it 64, and, if so, what are the names, positions and salaries of those people? How were they notified? Were they notified by a pink slip or were they written to? Are the people who are being taken out of central office to be put elsewhere in the health system and, if so, are those areas expected to absorb those people without being allocated extra funds to do so?

The ACTING CHAIRMAN (Mr Hamilton): I take it that the Minister does not remember all the names and positions and that he will provide that information in written form.

The Hon. J.R. Cornwall: No, he most certainly will not. I wish to make it very clear that I have no intention of providing the names, positions and salaries of officers who have been redeployed. That is over and above what would be considered reasonable. A great deal of information is made available through the *Government Gazette* and a number of other publications, and we run a very open policy at the commission. Naming specific officers, down to and including clerical officers grade 1, who might have been redeployed, who might have opted for early retirement or who might have gone for any other reason would be grossly unfair, and I have no intention of doing it.

With regard to the additional numbers, one reason why the central office had grown during the period that I was Minister was that we undertook a number of significant initiatives: for example, the Migrant Health Unit. Previously there was no such unit but now there is a Migrant Health Unit, which is working very well indeed. There was no Women's Health Adviser and there was no women's health policy. In the past financial year, there were eight people in the office of the Women's Health Adviser, including contract positions and, incidentally, from memory, four of them were contract positions and have been or will be terminated as part of the contraction of the central office. From memory, 7.5 temporary employees were involved in working on the clinical career structures for nurses. That is just an outline of some of the initiatives which resulted in additions to central office staff.

Of course, we were aware of the recommendations of the Auditor-General in 1984-85. It was as a result of those recommendations that we established the Taeuber review in the first place. In fact, Mr Taeuber reported to me and the commission with an interim report immediately prior to 30 June 1986. So we had a specific response to the Auditor-General's comments of 1984-85. It is partly as a result of the Auditor-General's Report, partly as a result of Mr Taeuber's interim report and partly because of the budgetary stringencies with which we have had to cope in 1986-87, and more particularly because of further upgrading of management, that we have taken some quite drastic action with regard to staffing of the central office. At this stage I think it would be appropriate if I asked Colleen Johnson, the Executive Director of Management Services of the South Australian Health Commission, to comment specifically on the strategy that has been adopted in the central office from the beginning of this financial year.

Ms Johnson: In the months leading up to late September this year there was recognition that there should be an adjustment to the staffing levels of the central office of the Health Commission. Some work was done within the commission to look at areas where certain functions could be possibly scaled down. There was a view within the commission that no positions were dispensable—that there were no surplus positions. However, in view of the tight budgetary position there would certainly be some areas where certain activities would have to be reduced or stopped. Investigations were carried out within the commission to look at various areas, and it was agreed that staffing levels for each area of the central office of the commission would be adjusted.

Negotiations were carried out with the Public Service Association to inform it of the reductions that would be necessary and the procedure that would be followed, and agreement was reached about principles for redeployment of individuals in positions that were affected. On 24 September a general letter signed by the Chairman of the Health Commission was issued to all staff. The letter talked about the budgetary constraints, the difficulties that the constraints presented and the fact that some positions needed to be vacated and that the individuals concerned would be redeployed to other areas in the health sector or within the public sector at large.

The letter also mentioned that the individuals concerned would be notified within the next couple of days. On the same day, 24 September, directors of sections within the Health Commission who had staff affected by the redeployment were given a letter that talked about the redeployment processes and issues, together with some principles of redeployment, and so on. These letters were to be handed to staff, who were to be personally advised if it was their position that needed to be vacated.

On 26 September this action was followed up by an individual letter to the redeployees concerned. The letters were contained in sealed envelopes and were distributed through Executive Directors and branch heads to advise the individuals concerned that there would be an opportunity for follow-up discussions about any concerns that they might have about redeployment and about exploring potential areas for their placement.

Following discussions with the Public Service Association this week, an additional letter was distributed to all staff yesterday (8 October). The letter, signed by the Chairman of the Health Commission, was issued to all staff to advise them that, if they wished to volunteer for redeployment, they could do so by notifying the Director of Personnel Services.

The Hon. J.R. Cornwall: Professor Andrews has indicated that he would like to add to that.

Professor Andrews: I will make a couple of points. First, I reinforce the statement made by Colleen Johnson that the commission does not accept that it has had an overstaffed central office. The 1.9 per cent approximately of the total health services budget in this State that is applied to operating the central office of the commission represents a very lean form of administration. However, the commission did accept that within the Government's overall budget strategy, and indeed in these tough economic times, it was necessary to operate with some financial constraint.

It is not unreasonable, if we are asking health units, and major hospitals in particular, to take cuts in their budgets, that we should apply the same treatment to ourselves. It was in that spirit that we accepted the Taeuber recommendation that we should attempt to reduce the central office wages bill, including the Public Health Service, by a factor of 10 per cent over a two-year period. That means a reduction in this current financial year of $1.03 million in the money spent on salaries and wages in the central office of the commission. The fact that the commission has been able to respond to that target and develop a strategy I think again underlines the degree of effectiveness and efficiency which characterises the central administration of health services in this State.

The second point I make is that in no way can one undertake an exercise such as this, which includes quite substantial redeployment of staff, and do it with absolute finesse. Of course, we have tried, as has been pointed out, to follow a program which minimises the impact on individual staff members and ensures that no-one is in any way discriminated against. The strategy that we have followed was fully discussed with the unions concerned, particularly the PSA, before it was put into operation.

The last point I will make, in case people took note of an article that was in the newspaper this morning, I think,

is that there was no piece of pink paper left face down on individuals' desks. There were indeed some central office scallywags who copied a white circular, for the record, which was the letter of information that Colleen Johnson referred to earlier, advising individuals that they were currently occupying a position which was scheduled for deletion and they would themselves be subject to redeployment. I think it is very important that the Committee understands that the commission has gone about this exercise in what I believe is a most responsible and appropriate way. It is not, however, an exercise easily undertaken by any organisation given the scale of reductions and the numbers of redeployments involved. We accept the necessity for it.

Mr INGERSON: There have been consistent rumours about the future of the Chairman of the Health Commission. Will he be leaving his position before Christmas? If not, when?

The Hon. J.R. Cornwall: There have been discussions about the future of a number of senior officers in the Health Commission. I have made a public statement in which I said that speculation was counterproductive and mischievous. I am not in a position to make any statement at this stage about the future of any of the senior people in the commission. The position is obviously under active consideration. I have not made any recommendations to Cabinet and it would be quite wrong of me at this stage to canvass publicly any options until such time as decisions have been taken.

Mr RANN: I am aware of the Minister's concern and also the concern of the member for Stuart (Gavin Keneally) to ensure that Port Augusta has the benefit of specialist medical services. Can the Minister inform the Committee of the progress made in the development of residential services at Port Augusta; and, further, what action has been taken to develop shared and cooperative services between the Whyalla and Port Augusta hospitals?

The Hon. J.R. Cornwall: I could respond to that but, to save the time of the Committee, it is far better to ask Mr David Coombe to respond, because he is directly in touch with the most recent events in Port Augusta and Whyalla.

Mr Coombe: Late in 1985 a working party was convened to advise on the provision of salaried medical specialists at Port Augusta. At the same time, a consultative group was also established to assess and comment on the proposals of that working party. Both of these groups had far ranging membership, including the Health Commission (interestingly, from both Port Augusta and Whyalla Hospitals), the South Australian Salaried and Medical Officers Association, and the general practitioners from Whyalla and Port Augusta. The working party reported unanimously to the Minister in late 1985 that a core of resident specialist medical officers should be established at Port Augusta. The core of specialties identified included the areas of anaesthetics, general surgery, obstetrics and gynaecology, general physician, pediatrics and orthopaedics.

The proposals of the working party, endorsed by the joint consultative committee, provided for the initial payment of specialist responsibility allowances to each of the specialists. That allowance was to be in the form of an establishment payment for the administration function of head of the clinical unit in the particular specialty. A range of other incentives to attract resident specialists to that part of the State were also agreed on. One of the most important components of the unanimous decision was that general practitioners accredited to the Port Augusta Hospital would also continue to provide clinical services on a modified fee for service base.

Having reached that agreement the Port Augusta Hospital Board of Directors undertook extensive advertising in that range of core specialties, and I was absolutely delighted that we are now in a situation whereby an orthopaedic surgeon will commence at Port Augusta on a resident basis on 5 November, and an anaesthetist has accepted an offer of appointment. His registration has been granted, and it is expected that he will take up residency in Port Augusta in early 1987. On Tuesday, a pediatrician spent all day at Port Augusta and Whyalla, and it is expected that he will seek to negotiate a salaried appointment to one of those two hospitals. The Port Augusta Hospital also has a resident obstetrician and gynaecologist. Extensive advertising continues for the remaining specialties in that identified core, being physician and general surgeon. The Government, through the western sector, has provided initiative funding of $150 000 this financial year for this provision.

Port Augusta and Whyalla collectively have a population of approximately 55 000 to 60 000. Other than the lower South-East and Mount Gambier area, it is the most densely populated area in rural South Australia. Port Augusta and Whyalla Hospitals jointly have approximately 350 beds. So, with a population of 60 000 and 350 available beds, there may be substantial benefits gained through twinning, coalescence or togetherness. Therefore, in mid 1986, representatives from each of those hospitals—the chairmen of the boards of management, representatives of the medical practices, administration and general practitioners—met with the Minister and representatives of the Health Commission, myself included, with a view to addressing how those two hospitals may become closer together for the benefit of the population that they serve. Since mid 1986, there have been three joint meetings, as a result of which the inevitable working party was formed. It decided it would document some issues for further investigation, including cooperation and a sharing of current resources employed by both hospitals and the provision of medical services.

It must be remembered that there are now reciprocal privileges between both hospitals, but we would encourage more than that, where appropriate, and the possible establishment in the future of a single board of management. There is goodwill between the representatives at that working party, and they have planned another meeting in about four weeks to further examine the specific progress of those three issues. Of course, formal documentation is not required to commence and continue a lot of joint sharing arrangements, and that can occur in the areas of clinical services, administration, computing, the most vital area of supply and purchasing, or laboratory services. It is in those areas where productive discussions are taking place.

Mr RANN: What action has been taken to raise the standard of radiography in South Australia, particularly through the training of general practitioners and dentists who use X-rays?

The Hon. J.R. Cornwall: There has been a quiet revolution taking place in some ways in raising the standards of radiography from the point of view of patient protection over a number of years but more particularly since April last year. I had not realised, until I read some briefing notes very recently, how many people had upgraded their skills and how much work had been done by the Occupational Health and Radiation Protection Branch. Dr Baker will give further details.

Dr Baker: The Radiation Protection and Control Act provides for the control of activities related to radioactive substances and irradiating apparatus and for protection against the harmful effects of radiation. The legislation was introduced following the report of a working party on human

diagnostic radiography which was set up in 1979 by the then Minister of Health. The report indicated an urgent need to raise the standard of radiography in South Australia.

The Act, which was proclaimed in 1982, allows for the following licences and registrations: licence to operate X-ray equipment; licence to use or handle a radioactive substance; registration of X-ray equipment; registration of sealed radioactive sources; and registration of premises in which unsealed radioactive substances are handled or kept. Requirements to hold licences and registrations came into effect between 1 September 1985 and 1 September 1986.

To date 2 850 licence applications and 1 820 registration applications have been received. The criteria for granting a licence are as follows. The commission must be satisfied that:

(i) the applicant has the qualifications prescribed in relation to the operations proposed to be carried on by the applicant in pursuance of the licence; or

(ii) the applicant has appropriate knowledge of the principles and practices of radiation protection to carry on such operations.

For those applicants who do not hold prescribed qualifications, the commission has had to conduct some 800 examinations and run basic radiography courses. To date, 249 general practitioners and 123 nurses have undertaken these courses. The intent of these courses was to raise the awareness of individuals to radiation protection and to minimise the number of repeat examinations that were felt to be necessary. Certainly, the greatest exposure to the general population is through medical and diagnostic radiography, and we must ensure that the patient gets the best treatment.

We have limited the number of licences issued to general practitioners, so that general practitioners in country areas need undertake only basic radiography training. The patients who require more specific investigation are referred to radiological practices or hospitals that have radiological suites. This minimises the exposure of the community to radiation and ensures a high standard. In regard to registering X-ray equipment, we have noted deficiencies of maintenance and servicing of equipment. Servicing has been upgraded and minor modifications that reduce radiation exposure at each press of the button have been carried out.

The Hon. J.R. Cornwall: This has been a relatively long haul, but we are just about there. As a result of work carried out in the past several years, standards have been significantly upgraded. The protection that is afforded the public generally in south Australia is significantly better than it was even three years ago.

Mr RANN: Finally, and perhaps most importantly, will the Minister report on the progress and intended development of the Lyell McEwin Hospital, and will he say whether it is intended to further develop obstetrics and prenatal services at Lyell McEwin? I would like to pay tribute particularly to Dr Reynolds and the staff of the Lyell McEwin Hospital: they do a darn good job, despite the most scurrilous attacks by members opposite who are simply more interested in headlines than facts.

The Hon. J.R. Cornwall: I am aware that the member for Briggs and his spouse have had first-hand experience of the paediatric services at the Lyell McEwin quite recently, and I am very pleased that the outcome was first class. The Lyell McEwin was given a high priority from the outset of our return to Government in November 1982. It is fair to say that that had been neglected by successive Governments over a long period. Certainly, the fabric of the hospital was very poor by any standards. My predecessor started to sort out the medical staffing at the hospital, and we have continued to give the Lyell McEwin a very high priority.

Management expertise, financial information, and medical, nursing and general staffing have all been given high priority, and while at this stage the Lyell McEwin has not yet reached the peak of perfection and is still being hindered to a significant extent by the physical limitations of the building, it now has a level of care and a measure of quality assurance that puts it up with the other metropolitan public hospitals. As part of our priority to ensure that Lyell McEwin becomes and remains a major health facility (and not just a hospital facility, because we are developing and expanding the Lyell McEwin Health Service), we are currently constructing a health village that incorporates a new hospital. That is being done in four stages at considerable expense. Mr McCullough will outline the current state of play.

Mr McCullough: It is a pleasure to be asked to comment on the progress at the Lyell McEwin. Stage 1 of the redevelopment is due to be completed in November 1986 and will comprise mainly operating theatres, CSSD, delivery suites, and emergency services. It is pertinent to note that the emergency services personnel and staff have been significantly upgraded over the past few years and, whereas that was a cause of constant problems, it is no longer a problem. There will be vastly upgraded outpatient facilities, community health facilities, a base for domiciliary care, an admission centre and a front entrance.

Funds have been provided to commission stage 1 and this year the Lyell McEwin has had additional funds of $493 000 from which there will be a first call for some equipment in the operating theatres because of the different style of operating the CSSD from the way it was done in the past. It is due to officially open about February 1987. Stage 2 will follow shortly afterwards. This will be mainly involved in ward areas, and the number of beds at the hospital will be increased from its existing 184 to 211. Work is expected to commence on stage 2 in 1987-88. Presently, a brief is being prepared. After that there will be stages 3 and 4.

The obstetrics and neonatal services at the Lyell McEwin hospital were the subject of a joint review by Dr Child of the Lyell McEwin and Modbury hospitals. It was a series of recommendations, most of which have been carried out, including the appointment of an obstetrics registrar.

Funds were provided for this position. Another point to note of recent events at the Lyell McEwin is that the commission has funded the purchase of a computer, which is a joint project. The service has used its own capital funds for this with the commission contributing 50 per cent ($130 000). As well as that the PABX has been upgraded at an additional cost of $90 000 per annum on a lease basis. The booking list strategy was mentioned earlier. This year $292 000 has been provided for additional services in orthopaedics, ENT, urology, and some general surgery.

It is with some pride that we can draw attention to the blue book (page 1 of 2) where it shows that the average cost of treating a patient at the Lyell McEwin is now the same as at Modbury, and this figure is some $274 per patient day. No longer can Lyell McEwin be quoted as the poor cousin of South Australian hospitals; in fact, it now ranks equally with Modbury Hospital from a resource point of view based on the population served.

Mr OSWALD: How much has been allocated this year in the Health Commission budget to promote and encourage the use of condoms to prevent sexually transmitted diseases? If it is only $15 000 is budgeted, as I am told, why is there such a small amount in view of the huge cost of sexually transmitted diseases and assorted social problems? Has there been an increase in funds made available to the Sexually Transmitted Disease Services? If not, will the Min-

ister reconsider the allocation? Is the Minister aware that that service is now indicating to groups in the community, such as nurses, doctors, schools, etc., that it does not have the resources to provide personnel to lecture on these problems.

The Hon. J.R. Cornwall: With regard to the condom campaign, I will ask Dr Simon Chapman, Director of the Health Promotion Branch, to respond. The questions in relation to the Sexually Transmitted Disease Service and its funding would be best handled by Dr Chris Baker, Director of the Public Health Services. First, Dr Chapman could respond to the question re the condom campaign.

Additional Departmental Adviser:
Dr S. Chapman, Director, Health Promotion Branch.

Dr Chapman: It is true that $15 000 has been allocated in the current budget for the Health Promotion Branch. If this seems a small amount in view of the seriousness of the problems that condoms are in the forefront of preventing—AIDS, sexually transmitted diseases and unwanted pregnancy—this reflects our concern that the private sector, notably manufacturers of condoms, have increasingly entered into the health education arena themselves. We have never seen it as our task to replace the advertising and promotional activities of the private sector but rather to facilitate its activities in that area as best we can.

Consequently, the $15 000 allocated in the budget this year is largely to be spent on research into attitudinal barriers to the use of condoms by high risk individuals, notably teenagers and young people, especially homosexuals. In fact, it is very timely, because this evening I will be working on a proposal that will be put to a condom manufacturer to see whether it believes that our proposal is consistent with the sort of promotional activity it may wish to be engaged in.

The other money that that will be spent on is financial support for the AIDS hot line and in activity designed to increase the distribution in the community of condom vending machines. In fact, a letter to that effect has gone out in the branch's mailing list to some 700 people—mostly health workers throughout the State. We have been encouraged to find that one group of health workers in the Noarlunga region has identified in excess of 35 sites where they believe condom vending machines could be installed but are not installed at present.

In summary, it has never been our intention to spend a large amount of money trying to replace the commercial advertising activities of condom manufacturers. We believe that they will increasingly be doing that themselves. Indeed, we have had some very productive discussions with the Ansell company in that regard.

The Hon. J.R. Cornwall: The condom campaign would be a splendid example of the mixed economy in a pluralistic society. It will combine the best elements of the public and private sector. Perhaps Dr Baker will now respond to the question about the STD clinic.

Dr Baker: The member is quite right in saying that condoms are an important measure in public health. Not only do they stop unwanted pregnancies but they stop the transmission of sexually transmitted diseases, one of which is AIDS. The Public Health Service has been reallocating funds internally in this time of constraint to ensure that there is adequate provision of sexually transmitted disease services. In the 1986-87 budget the allocation for STD Services is $292 608. The AIDS program has funding of $350 000, which is subject to Commonwealth 50/50 sharing. Through STD Services condoms are provided free to persons who are attending that clinic. Also, the clinic is ensuring the provision of condoms through other agencies and by coordinating the programs with Dr Simon Chapman's service, as he advised. Other agencies in the State providing condoms include the Family Planning Association, which obviously has an interest. I cannot specify on a line-by-line basis about the STD budget and how much is allocated specifically to condoms. If the member wishes, I can provide that in a written answer.

Mr OSWALD: Yes.

The CHAIRMAN: I hope that information will be provided in time to be included in *Hansard.*

Mr OSWALD: I ask this question on behalf of the member for Hanson. How much will be granted to COPE, at Marion Road, Plympton, this financial year? Does such a grant meet its request and, if not, why not? COPE does a wonderful job in assisting people who require follow-up support. About 12 months ago the Minister opened COPE's new premises in Marion Road, Plympton, and he would be well aware of its aims and the assistance to be provided.

The Hon. J.R. Cornwall: The premises that I opened in Marion Road, Plympton, housed GROW, a mental health support group. COPE is in Hutt Street, Adelaide, but both groups receive funding. COPE receives significant funding.

Mr OSWALD: If GROW is in Marion Road, Plympton, perhaps that is what the member is referring to. As there is some confusion I will refer the matter to the member for Hanson and I will ask a further question.

The Hon. J.R. Cornwall: I am happy to take the question on notice as to the funding for both organisations and respond later in writing.

The CHAIRMAN: The answer can be included in *Hansard.*

The Hon. J.R. Cornwall: Yes, we will do that.

Mr OSWALD: I refer now to a person who holds the position of Policy Officer with the Policy and Projects Division of the Health Commission. Is he qualified for the position to which he is appointed and paid, or is he still studying for that qualification? Why was he also immediately seconded back to the Minister's office after his appointment? Does that person's salary now come out of the budget of the office of the Minister? If not, why is he being paid by the Health Commission when he is working for the Minister? Is this an attempt to conceal additional ministerial expenditure? Are people being taken out of central office and put elsewhere in the Health Commission? If so, are those areas expected to absorb these people without being allocated extra funds to do so?

The Hon. J.R. Cornwall: No. The answer is 'No' to all of those questions—there is no attempt to hide anything. Why do you not name the officer? It is John Webb, commonly known as SPAC—Senior Policy Adviser on Coalescence. The position to which he was appointed was advertised and attracted a number of applicants. There was an interviewing panel and John Webb obviously got the job on his merits. He has had very great experience as a journalist over 30 years. He worked in Fleet Street for eight years; he worked in the United States of America in a very senior position for two years; and he came to me early after we were re-elected, in February 1983, I think. He has very substantial talents and I have a high regard for his ability. Currently, he is studying, well outside the 60 to 65 hours a week that he spends in his position as a policy officer, for a BA—and doing very well. If there were not such terrible time constraints he would be getting more distinctions. I might also say that he writes well. I am not sure what else one would like to know about him.

I have replaced him as Press Secretary with Lachlan Colquhoun, who is a young man of very substantial quality for whom I have a very high regard. His productivity is extraordinary—he is a very good speechwriter. I have a ministerial officer, Mrs Sue Gilchrist, who was working as a technical and scientific officer in the Infertility Clinic at QEH before she came to work for me. She has has a BA that she acquired in the early '70s, she is currently doing a health administration course, and I think she is well qualified for her job.

I also have, on a two-thirds basis, in welfare Ms Anne Pengelly, who is a qualified social worker of very considerable experience. She is also the immediate past President of the South Australian branch of the ALP, and a very good President she was, too. So, I have one and two thirds ministerial officers on my personal staff. I have a press secretary, as does every other Minister. I have two very busy portfolios, and I have a budget allocation for the 1986-87 financial year that is around $900 million. In those circumstances, to have two and two thirds staff and John Webb seconded back to my office physically to work in particular on coalescence of the commission and the Department for Community Welfare is a modest and reasonable proposition.

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

Works and Services—South Australian Health Commission, $34 088 000—Examination declared completed.

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

Community Welfare, $90 709 000

Chairman:
Mr D.M. Ferguson

Members:
The Hon. Jennifer Cashmore
Mr K.C. Hamilton
Mr G.A. Ingerson
Mr J.K.G. Oswald
Mr M.D. Rann
Mr D.J. Robertson

Witness:
The Hon. J.R. Cornwall, Minister of Health and Minister of Community Welfare.

Departmental Advisers:
Ms S.S. Vardon, Director-General, Department for Community Welfare.
Ms R.N. Wighton, Deputy Director-General.
Ms L. Mann, Assistant Director-General.
Mr G.L. Boxhall, Director, Administration and Finance.
Mr G.R. Billett, Acting Manager, Financial Services.

The CHAIRMAN: I declare the vote open for examination. Before I ask the member for Coles to lead off the questioning, I give notice to the Committee that before 10 o'clock I will need a resolution of adoption of the report from the Estimates Committee. It is non-controversial, so there should be no problems. We shall distribute the proposition so that members can have a look at it before 10 o'clock.

The Hon. J.R. Cornwall: I would like to have inserted in *Hansard* my submission in relation to community welfare.

STATEMENT FOR BUDGET ESTIMATES COMMITTEE: COMMUNITY WELFARE

The Department for Community Welfare will be targeting its priorities to services for children at risk, adolescents in crisis, young offenders and families in poverty. Although the budgetary reductions applied to all other Government departments have been applied to community welfare, staff increases have also been approved in a number of vital areas.

These include an additional eight staff to be allocated to the Crisis Care Service and another 14 positions for child protection workers to be spread throughout the state.

Child protection services, for children who have been either sexually or physically abused, will also be boosted by 3.5 full-time equivalent positions for clerical support staff.

The extra staffing represents a full year funding commitment of $588 000. The $294 000 funding this financial year is calculated on the basis that the additional staff will not commence duties until January 1987. The staffing increase recognises the effort that is required to deal with the increased reporting of child abuse, and the high priority which the community is placing on action in this area. In addition to the increased staffing, funds have been increased by $100 000 for Aboriginal youth development programs, and by $218 000 in the area of increased rates for foster care.

Other initiatives will occur in the area of concessions, where concessions for water and sewerage rates (6 per cent), local government (6 per cent), electricity (6 per cent) and transport for unemployed people in country areas (7 per cent) have all received more than the 4 per cent increase for inflation allocated across the board.

The joint Commonwealth-State supported Assistance Accommodation Program has received a substantial increase of $713 000 this financial year over and above inflation.

Increases for this program, which funds the State's women's shelters, youth shelters and a range of services for homeless single people and families, will result in improved services across the board and in several new facilities, most notably a new service for young women who have been sexually abused to be located in the north-eastern suburbs.

This year, the Department for Community Welfare is planning the first stage of a campaign to make all children safe in their homes in South Australia within five years.

Staff savings have been achieved partly through the withdrawal of DCW funding to two youth project teams previously based at Kilkenny and Elizabeth West which have worked with school-children in cooperation with the Education Department.

The withdrawal of funds will result in a saving of 7 full-time equivalent positions for the Department.

Positions will also be reduced in management services within the Department (one), and in the State Disaster Plan (one).

Again, I would make the point that the budgetary reductions we have been forced to make due to economic circumstances have unavoidably resulted in some service cutbacks.

In human terms, smaller government has a high price but the equation is simple—less taxes, less services.

Moral support is a fine thing, but it is no substitute for financial assistance.

Even given that context, I believe that in Community Welfare, competent management tempered with compassion has resulted in a minimal impact on client services.

This year, staff will emphasise excellence in intervention, the development of community support networks and community education programs for the prevention of child abuse.

The Department also aims to foster greater cooperative effort and network among agencies, making effective links with police, health, education and the justice system in a coordinated approach to child abuse.

In the area of foster care, a permanency planning policy will be developed and implemented, so that children will not suffer from frequent and destabilising changes of placement.

The report of the Adoption Review Panel will be presented to Cabinet very soon. It will take the form of a public discussion paper and will recommend some legislative change as well as changes in departmental practices.

The high standard of young offender programs will be maintained, and planning will continue for smaller secure centres throughout the metropolitan area to replace the larger institutions.

Specific efforts will also be made in the area of improved access for disabled people to Departmental services, and in multiculturalism with the increased use of interpreters and multilingual signs and leaflets.

The Department will also continue its work on a comprehensive Social Justice Strategy as the Government's long term framework to redress injustice and inequity in South Australian society.

Eleven major points for action have been identified, and the department is currently developing detailed strategies in each of the areas.

The Government will begin the implementation of the strategy in the current financial year.

Overall, the Department will continue its coalescence, or growing together, with health services to better coordinate effort in the human services.

The coalescence will occur simultaneously with the development of a pro-active and interventionist social welfare policy which will result in a modern, accessible and pro-active approach to the activities of the department.

The Hon. JENNIFER CASHMORE: My colleagues and I are indebted to the Hon. Diana Laidlaw, who, as shadow Minister of Community Welfare, has been the principal analyst of the budget for the Opposition. I advise the Minister and the Committee that we see five issues as central in community welfare. The first is coalescence between the South Australian Health Commission and the Department for Community Welfare; the second is protection of children from child abuse in all its forms; the third is child maintenance payments; the fourth is the acute need for widespread assistance and counselling on domestic financial management; and the fifth is concern about what the Opposition sees as discriminatory funding levels for women's shelters. In answer to a question in the other place, the Minister stated:

The sheltered accommodation assistance program is getting an additional $713 000 and the women's shelter part of that program is getting something like a third of that money in addition to their inflation factor. So where they received an average of $160 000 for the 13 of them last year, this year they will receive very close to $200 000.

Contrary to that statement, the information provided to the Opposition by women's shelters indicates that, of the additional $713 000 of Federal funding to the sheltered accommodation assistance program this financial year, not the full amount was available for distribution to general use and women's and children's supported accommodation programs. Some $24 000 of this sum was siphoned off for the salaries of workers at two youth services, leaving $689 000. This sum was divided, with general and youth programs both receiving 37.5 per cent, so the women's and children's sheltered housing had only 25 per cent, which was not a third, as was stated by the Minister.

Subsequently, from this 25 per cent, $100 000 was set aside for the establishment of a new service, Judith House, for sexually abused youth, leaving women's and children's shelters with only $72 250, or 10.13 per cent of the new funds. Further facts could be added, but the summary is contained in a press statement released by the women's shelters on 3 October.

It stated that since women's services were forced to join the supported accommodation assistance program three years ago their share of funding was reduced from 47 per cent to 33⅓ per cent last year and now it is only 10 per cent of new money this financial year. They claim that in total contravention of the well considered decision of the Women's Supported Accommodation Advisory Committee the Minister has chosen to support the decision of one of his other funding advisory committees to provide only 25 per cent of new Commonwealth and State moneys to the women's and children's sector.

Will the Minister confirm or deny whether the position that I have outlined in relation to the distribution of new funds to women's and children's shelters this financial year is correct? Will he explain why the recommendation from the Women's Supported Accommodation Advisory Committee—that women's and children's shelters should receive a third of new Commonwealth and State moneys—was subsequently amended to 25 per cent, and does the Minister believe that this 25 per cent is a fair distribution of new funds?

The Hon. J.R. Cornwall: To answer the member's first question last, yes. The position is that the women's shelters are now relatively well established. I once conceded that they had quite a battle getting established for more than a decade but that now, relative to the general shelters accommodation program, and particularly the youth shelters accommodation assistance program, they are well established. Their wages and salaries are considerably better than they were, and they are certainly in good shape *vis-a-vis* youth shelters.

If I could persuade my colleagues at both Federal and State levels that millions of dollars in additional funding should be made available for the shelters program generally, I would love to be even more generous to everyone. However, the situation is that in a time of very real budgetary stringency, at a time when the conventional wisdom urges upon us that we must make cuts rather than expand funding and when we people in the human services area are constantly reminded of the high cost in human terms of small government, we still have been able to jointly fund with the Commomwealth an extra $713 000 new money for the 1986-87 financial year.

I am advised by the Programs Advisory Committee, on which the various interests are well represented, that, from the $713 000 expansion funds that are available, $261 000 should be made available to the general supported accommodation assistance program; $261 000 should be made available to the youth sheltered accommodation assistance program; and $176 000 should be made available to the women's sheltered accommodation assistance program. It has obviously been decided by a majority that, as I said, women's shelters are considered to be relatively well established and relatively well funded. I certainly do not claim that they could not use more money—obviously they could. However, the priorities have been especially given to the youth sheltered accommodation assistance program.

In addition, it has been recommended that, of the $176 000 that we should make available, $100 000 recurrent annual funding should go to establish a shelter to be known as Judith House for teenage girls who have been sexually abused. The women's shelters argue that, therefore, you add the $100 000 to the $261 000 and you take it away from their $176 000 and come up with a figure of $76 000 over $713 000, which somehow makes 10 per cent. I have supported the recommendations made to me by the Programs Advisory Committee. I wrote to Don Grimes as recently as Monday this week advising him that I accept the recommendations, and I am waiting on him to ratify the recommendations, as he has to do because it is a joint Commonwealth/State program.

I believe that Senator Grimes will ratify the recommendations, although I have not had formal confirmation of that. Frankly, I think that, if Opposition members want to argue the merits of the case, I am perfectly happy to debate it with them. There is not the slightest shadow of a doubt that the number one need relatively in this entire area at this time is for youth shelters for the support of homeless youth. If anyone has been following a number of stories in the media recently, and more particularly in the *Advertiser*, they would know that the situation of our homeless youth—the situation of our adolescents at risk—is such that they most certainly deserve the highest priority to bring them up to the levels of assistance in funding that are currently available to the women's shelters program.

I further point out that the total funding for women's shelters in this financial year, with the additional funding that will be made available, will approach $2.5 million. I think it is just a simple argument. We are giving a priority to adolescents at risk and to youth shelters, while acknowledging that there is still a need for the women's shelters.

The Hon. JENNIFER CASHMORE: While acknowledging the acute need for youth shelters, which is emerging as a genuinely horrifying trend, I hope that the Minister would agree that the need for women's and children's shelters has in no way diminished. Certainly the women's shelters believe that the efforts of the past decade are being continuously eroded by the Minister. That statement comes from the women's shelters in a press release of 3 October. Have all the women's shelters signed a contract agreeing to the conditions of funding and, if not, which shelters have not signed?

The Hon. J.R. Cornwall: Seven of them have signed. I cannot specifically name the ones that have not. They continue to receive their funding, from memory, on a fortnightly basis. Let me make it very clear, before Ms Cashmore tries to paint me as some sort of villain in this matter, that it is a joint Commonwealth/State program and there is a program advisory committee, and there has to be accountability. I completely reject the notion that we should simply hand over whatever amounts of money are asked for and the shelters should then do their own thing. There has to be accountability; there have to be standards.

The shelters are now funded with a very significant amount of taxpayers' funds, public money. I have often made the point that I can choose to be as careless as I like with my own money—and indeed, some of those close to me would say that I have been over a period of more than 30 years—but I am scrupulously careful with other people's funds. There has to be accountability, particularly in a program which is jointly funded. There will be accountability and that is the end to it. Obviously, the Federal Minister insists that there has to be accountability, and he takes what some would consider quite a hard line on the matter. It is a line which I consider to be a perfectly reasonable one.

The Hon. JENNIFER CASHMORE: In asking that question, I was in no way implying that there should not be accountability. I do not think the question implied that—it was simply seeking information. On page 360 of the yellow book under the headings 'Issues' and 'Strategies' is a reference to the work being pursued by the Health Commission and others to develop the framework for what the Minister describes as coalescence and preparing for the implementation phase. The timetable for the merger set a date of 1986, according to the Minister in one of his statements, for the final submission to Cabinet for endorsement of the proposal for coalescence with the implementation strategy to take place from January 1987.

Six weeks ago the Premier was reported in the *Advertiser* as expressing concern about the directions of the merger talks and calling for a rethink. This attitude by the Premier seems to reflect reservations among field workers and certainly among staff of the Health Commission who have spoken to me. Is it the Government's intention to press ahead with the amalgamation of DCW and the Health Commission from January next year, or does the Government now intend to scrap the plan in favour of, as has been suggested, a trial using two or three pilot programs to test efficiency and administrative functions? As both the health and welfare areas have a total budget of $618 million in 1985-86, or 21 per cent of Government expenditure, will the Minister explain what the Government's rationale has been in amalgamating the two areas of responsibility into a commission in favour of a structure which would be more directly accountable to the Minister?

The Hon. J.R. Cornwall: The honourable member has taken on a number of issues, some of which are incorrect and some of which, in general terms I suppose, are correct. Addressing the question of more direct accountability to the Minister, I have made no secret of the fact that since I inherited the health portfolio, I thought the system that I inherited was basically unworkable. The notion of literal autonomy encouraged by my predecessor was clearly a nonsense: it created all sorts of problems in the system. The Lyell McEwin Hospital is a classic example. The previous CEO and one of his offsiders obviously misled the Health Commission when, in 1981-82, they invented phantom nurses to balance their budget. That was during the time of my predecessor. They carried that nonsense into 1982-83. Eventually it was the hospital's auditor, and more particularly the central sector, that found out what was going on. However, that sort of thing does not happen any more because we have drawn the strings and strands a lot closer.

I do not believe that the commission model, if one compares it to the Electricity Trust, for example, can possibly work in either the health or human services areas. It is just not feasible, given that the Minister of the day is accountable to Parliament and, under the Westminster system, is accountable and is certainly held responsible for the actions of people in individual health units or in individual offices of the Department for Community Welfare. It becomes a nonsense to simply say, 'Give us the money and let us get on with it', which is what the Liberals were about.

So, I have been fairly diligent over a period of almost four years in making the lines of accountability and financial reporting far more direct. As a result of that, we now have a system which is relatively very well managed. Anybody who was here today between 11 a.m. and 6 p.m. and had the good fortune to hear the responses from senior officers of the commission, right across the board, whether it was concerning hospitals or any of the other incorporated units, would realise that management by and large is very good. Accountability to the central office has been a core part of that improved management. The management of the Department for Community Welfare, I would submit, is the best in the public sector. It is significant that the Director-General of the Department for Community Welfare, at the request of the Public Accounts Committee, was asked only a few months ago to appear before it, not to give an account of the deficiencies in the department but to tell the committee about how the department is run, because the committee believed that it may well be a model for other Government departments. I most certainly am not about to throw that baby out, with or without the bathwater.

The management record of the Department for Community Welfare is one of which we are very proud. By the end of this month I will be receiving a report from Mr Ken Taeuber, who has conducted a review for us of the organisation and Statewide operations of the Health Commission. The Uhrig Committee, chaired by Mr John Uhrig, has reported to the Taeuber Committee, and has made recommendations regarding the management of the Adelaide public hospital system. The recommendations are that there be one board; that there be a much tighter system of accountability; and that there be significant changes in management structures to achieve coordination, rationalisation and integration. That is the background against which all of these things are currently being considered. It is certainly intended that we continue to coalesce. 'Coalescence' is defined in the *Shorter Oxford Dictionary* as 'growing together'. It is a word

which I quite deliberately chose as I lay on the beach at Batemans Bay in January contemplating the directions in which we ought to proceed in the next four years. I think it is a very good word. We have literally been growing together ever since I was given the two portfolios.

Of course, we had been cooperating for a number of years before that, but it is true to say that there had also been a degree of friction at times between social workers in the Department for Community Welfare and community health workers and others in the health spectrum. We are now talking to each other, we are drawing closer together, and a number of protocols have been developed for connecting health and welfare services. A good deal of preliminary work has been carried out during the first nine months of my joint stewardship in defining areas of overlap, areas in which we have common goals, or areas in which neither of us may be servicing our clients or our patients as adequately as we could. That process is well down the track.

It was never intended that there be a formal merger, and indeed 'merger' is a word that I have been scrupulously careful to avoid using. We have never talked about a merger, because that has connotations of one company taking over another. Let me assure the Committee that we go into this arrangement on an equal footing. There has never been the suggestion of a merger: it has always been considered in terms of coalescence. There has never been any suggestion that we would be formally amalgamated in any way, shape or form by 1 January 1987. That is a complete nonsense. As I said, a lot of preliminary work has been carried out. A formal submission on coalescence will go before the Human Services Committee of Cabinet in November. In due course, that submission will go to Cabinet, and we will ask Cabinet to formalise a strategy so that the coalescence will become formal policy.

It will be carried out in the following way. We will set (and we are in the process of setting) a series of goals and objectives agreed mutually between the health services and the Department for Community Welfare. We will then develop an operational policy and a strategic plan to achieve those goals and objectives. From there, we will develop an implementation strategy which, with the goals and objectives clearly spelt out, will be available to the field. The coalescence will be accelerated (and I repeat that it is already occurring out there where the workers are in the field) in a bottoms up movement. The formal bureaucratic structure and even the formal legal structure can be decided at a later date.

The pace at which coalescence occurs will be the pace which the system can stand. Whether it takes three years or five years, I would have to say, is not a matter of great moment as far as I am concerned as Minister, as long as there is a continuing process. It will certainly not be achieved at a pace that will cause anyone to be deflected from the most important business of delivering services to our clients, our consumers and our patients.

It will proceed against a background of a five-year strategy to enable us to say within that period that the overwhelming majority of children in South Australia will be safe in their own home. It will proceed against a background of a very active reform of the processes of child protection in the broadest sense. It will proceed against a background of major recommendations from Mr Ian Bidmeade, our senior legal consultant, who has just completed a review of the Children's Protection and Young Offenders Act. It will proceed against a background of the implementation of the recommendations of the Child Sexual Abuse Task Force, which is due to report through me to a joint meeting of the justice and consumer affairs and human services Cabinet committees on 27 October, thence to Cabinet and public release.

It will report against a background of the development of a major long-term social justice strategy and the establishment of a social justice secretariat and social justice council. It will develop against the background of the development and implementation of a major social health program and a major five-year social welfare strategy, which will not only ensure that we enhance the existing services and meet our statutory obligations even better than at present but also allow consideration of the broader issues of social welfare.

I suggest that the bureaucratic structure in relation to coalescence is, in practical terms, the least urgent item on our agenda. We will not be short of things to do in the next five years that I am Minister. Certainly, coalescence will occur, but it will occur against a background of all those very other exciting areas of reform, which will be put into place concurrently.

The Hon. JENNIFER CASHMORE: Is the Minister's strategy for this financial year proceeding along the lines he has outlined? Time does not allow me to refute his allegations about Liberal policy. Will that approach involve additional costs and, if so, there appears to be no provision for coalescence costs (whatever they may be) in either the program estimates or the budget estimates. Will there be any cost and, if so, where is it identified?

The Hon. J.R. Cornwall: There will be no additional cost in 1986-87. The actions are taking place in the field.

Mr HAMILTON: I refer to a press release dated 10 February this year in relation to the Crisis Care Service. I must say, however, that the information supplied from the Minister's office on health and community welfare matters is a very enlightening source of information, and I use it quite extensively in my district not only for various targeted groups but also in the newsletters that I put out to constituents fairly regularly. I might add that the response is very good. The Minister's officers must be very busy, given the large number of press releases that emanate from the Minister's office.

On 10 February the Minister issued a press release in which he said that country residents will have access to a 24-hour crisis care telephone counselling service from that date. The Minister also said that a toll free telephone line would be installed (the number was given) and that the Crisis Care unit provides help any time of the day, any day of the year. He said that the Government was concerned about the increasing number of reports of child abuse in this State, and that people who have had problems can telephone the number given. How are country people responding to this access? How are Crisis Care services being utilised in general?

The Hon. J.R. Cornwall: I will pass that question to the Director-General and ask her to respond. In doing so, we could profitably address two matters. The 008 toll free line enables callers from outside the metropolitan area to contact Crisis Care for the cost of a local call 24 hours a day, 365 days a year. We have some statistics on that, of course. In view of the fact that there has also been a very significant addition in this budget to the funding of new additional positions in Crisis Care, it would be relevant for the Director-General to outline some of the statistics, and additional funding and positions that are proposed in 1986-87.

Ms Vardon: In relation to the Crisis Care line, we were aware last year that the country was not getting a good access to Crisis Care Services and in February this year we introduced a 008 line. From the country areas we are getting on that line about 120 calls a month, which we were quite surprised about, and the number is increasing every month.

The total number of calls for Crisis Care last year was 50 500, so the country is beginning to make an impact because the year before there were about 40 000 calls. We are getting about 138 calls per day generally.

In relation to the type of work that Crisis Care is doing—and this includes country calls—about 15 per cent of our costs relate to domestic disturbance (and I will come back to that later); 29 per cent relate to a child in trouble or at risk; 17 per cent relate to sexual violence or some kind of other violence in the family; 6 per cent relate to accommodation; 2 per cent relate to some other traumatic experience; 20 per cent relate to personal problems; and 8 per cent to other matters. We find particularly that country people like the anonymity of the Crisis Care Service.

One of the other interesting things we did this year was to work very closely with Dr Sue Britton and a team of people to try to work out how better to get health and welfare together with crisis services. We have made an agreement that the Crisis Care Service will be the crisis care service after hours for the health facilities and psychiatric services. We will be amalgamating, hopefully, our after hours services for health and welfare.

We will also be working much more closely with the police. The Minister referred to new initiatives this year: eight additional staff will be attached to Crisis Care to increase our relationship with the police in areas of domestic violence and health, particularly in relation to children at risk. Crisis Care had its tenth anniversary this year and it is probably a very outstanding service in Australia, to such an extent that we identified it as our 'Service of Excellence' for our Jubilee 150 project.

We are about to have a major conference and the 350 seats are booked out by people from all over Australia. People are queueing for it, so that they can come and look. We are very proud of our Crisis Care Service and the developments that have occurred this year and the ones we have planned for next year.

Mr HAMILTON: In relation to his press release of 29 May entitled 'More information for separated families', the Minister would be aware that over a period of years I have directed to him correspondence from many of my constituents seeking more information about their natural parents. What response has the Minister's office received in relation to the adopted persons contact register? I believe that it would assist many people in the community to find their natural parent or parents. Are there to be any other changes to the adoption laws in this State? If so, will the Minister provide further information on that?

The Hon. J.R. Cornwall: I will ask the Deputy Director-General to respond to specific parts of the question. The adoption review that was established late last year is due to report to me very soon—I understand within a matter of two weeks. It reviewed the situation in South Australia and elsewhere in the country, particularly Victoria, which has passed and implemented, proclaimed, new adoption laws, and also looked at the situation in other countries. That will be the blueprint, I anticipate, for some very significant amendments to the adoption laws in South Australia. However, it would not be wise for me to speculate on what that report might contain. Suffice to say that I hope there will be some firm recommendations made to Cabinet arising out of that review in time for new legislation to be ready during the autumn session of Parliament.

In saying that I am encouraging my officers to stay on the fast track. Once the review is out—and it is not a question of reinventing the wheel; it is a question of reviewing a great deal of information and experience that is already available—we will have had the inevitable comments, and we can proceed at least to try to develop legislation for the autumn session of Parliament. Certainly, there will be major legislative reforms arising from that review, but as I said, I will not speculate on the nature of those reforms at this time. I would ask Ms Wighton to respond to the specific questions.

Ms Wighton: During the past year 265 adult adopted persons and 188 natural parents who had relinquished children for adoption placed their names on the contact persons register. Those numbers are not significantly different from the numbers of the previous year. Contacts were made this year for 39 adopted people with their original families, sometimes with siblings. That is more than the year before, when 25 contacts were made. This year we opened up the register and changed its name. We called it the Family Information Service so that people who in the past became what used to be called wards of the State or were in any way separated from their families through State intervention in the distant past can seek contact with their parents, if they are still living, with brothers, sisters, or relatives, and can seek to find out the circumstances in which they were made wards of the State.

That service has been publicised and since then 31 people have sought help to find family members. That number does not sound very great, but it seems to be growing all the time. Judging by the experience of other States it is a service that will be used by an increasing number of people.

Mr HAMILTON: My next question, I think, goes back to 18 April. The Minister spoke of a national child support scheme, and I noted his press release of 3 October. Can the Minister provide further information as to the effects such a scheme will have on people who are depending on maintenance in South Australia?

The Hon. J.R. Cornwall: I must congratulate the member for Albert Park on his diligence in filing our press releases. I am delighted to know that at least some intelligent members read them. The question of child support is something that I took unto myself with considerable enthusiasm shortly after I became Minister of Community Welfare. It seemed to me quite anomalous that the non-custodial parent in anything up to 70 per cent of cases was able to eschew his or her responsibilities—most frequently 'his' responsibilities—by the simple expedient of moving interstate.

The payment of child support in this country by and large has been optional, and that is totally unsatisfactory. There is no question that both parents of children should be responsible for the support of those children. We happen to have in this State a maintenance collection system—funded federally, incidentally—which is the best in the country. But even in those circumstances we collect only 70 per cent of the maintenance due. That is more than twice as good as most of the other States, but it still means that 30 per cent become dependent upon the social security system for minimal support, even though the non-custodial parent might be in relatively good financial circumstances.

I pressed the matter at the first Social Welfare Ministers Conference which I attended and which was held in April this year in Adelaide. Minister Howe at that meeting was able to inform us that he and his department were working hard on a number of options, including using the taxation system to collect maintenance. That was considered by the Federal Government in the run-up to the 1986-87 budget, although in the event, it was not able to be developed for implementation in that budget. However, I am sure that members would be aware that the discussion paper was made available in advance to the spring meeting of Social Welfare Ministers, held in Darwin last Friday, when there was further discussion of the proposals.

The discussion paper released in Canberra yesterday proposes in general terms that from 1 July 1987—it is prospective in that sense—non-custodial parents should compulsorily pay for the support of their children according to a predetermined formula through the taxation system. The formula will be available for people to check against their taxable income. Therefore, they will know in advance what their liability will be. It would certainly be one of the considerations in the dissolution of a stable relationship or a marriage. It will have limited retrospectivity, as I understand it (or this is the proposal that has been put out for discussion).

Where there has been an arrangement endorsed by the Family Court and the non-custodial parent has been meeting that obligation, which means in practice that that parent has arranged personal budgeting in such a way as to regularly meet that undertaking, then as I understand it, it is not the intention that that situation should change. However, where a non-custodial parent has been defaulting and not meeting maintenance obligations, in those cases, the scheme of collection through the taxation system would be retrospective.

I must say, on the face of it, that it seems a very fair way of approaching it. It means that both parents will have an obligation. Under the formula the non-custodial parent will be assessed according to ability to pay, according to income, according to the needs of the children, so that basically every child of separated parents will either receive adequate support through the input of the non-custodial parent or, where the non-custodial parent is in poor circumstances, will have the safety net still of the Department for Social Security.

I would think, at a first reading at least, that it is probably one of the best systems devised in the world. I would take the opportunity of congratulating the people in the Department for Social Security, the people in the Minister's office and the Minister for the proposals that have come forward. No doubt there will be a little fine tuning around the edges but, in general terms, I would not have any difficulty in endorsing it quite enthusiastically.

In fact, the meeting of Social Welfare Ministers, comprising Ministers from all Parties—a Liberal from Tasmania; a National Party Minister from Queensland; and Labor Ministers from four States—issued a joint communique in which they expressed 'enthusiastic support' for the proposals.

The Hon. JENNIFER CASHMORE: I am glad that this question was raised, because it is one that I was going to ask. Earlier today the shadow Minister, Hon. Diana Laidlaw, issued a statement calling for community pressure to be directed to the Federal Government to insist that the system does not exempt couples who have separated prior to the introduction of a new scheme. Certainly, it was my reading of the report that confirmed that those who have separated prior to the introduction of a new scheme will be exempt.

In light of the Minister's comments about limited retrospectivity, I would like to ask him whether he agrees that the scheme should not make a distinction between families on the arbitrary grounds as to whether a couple separated before or after the introduction of a new scheme. Certainly, it seems to us that the scheme as proposed, namely, exempting couples who separated prior to its introduction, will perpetuate the financial hardship of an enormous number of single parent families where the non-custodial parent defaults on maintenance orders, and would just perpetuate the number of children who are currently living in poverty in single parent households.

The Minister's explanation talked about limited retrospectivity, and I suggest the word 'restrospectivity' is inappropriately used in this case. We are aiming to protect all children, irrespective of when their parents separated. The Minister's comments about limited retrospectivity have cast doubt in my mind on whether the report that I read in the *Advertiser* was correct. Will the new system apply to non-custodial parents who separated before the introduction of the scheme and who are defaulting on payments, but not to the others who are meeting payments, or will it apply only to those who separate after 1 July 1987?

The Hon. J.R. Cornwall: The clear desire and intention of the Federal Minister is that where the non-custodial parent is meeting the obligation to pay maintenance of the agreed amount, or the order of the Family Court to pay a specified amount, that will be an end to it. The Minister and the Federal Government are trying to be careful not simply to shift the burden of poverty from one area to another. In other words, if there has been a stable arrangement for paying maintenance over a period of years, and the non-custodial parent has moved into a new domestic situation or relationship or may even have remarried and had more children, and has arranged the personal budget in such a way that he or she can meet those maintenance payments, and at the same time maintain the new domestic living circumstance, most people agree that it would be unfair to impose a new additional burden on somebody who had been scrupulous in meeting his or her obligations.

With regard to the other question on retrospectivity it would be best if the Director-General, who spent far more time in Darwin than I did last week—there was a meeting of senior officers during the week preceding the Ministers' conference—were to take up some of the more detailed explanations.

Ms Vardon: I am sure that Ms Cashmore is concerned about South Australia. We are still negotiating with Dr Meredith Edwards on the nature of the contract for South Australia and a national scheme. I spoke briefly about our concerns regarding people who had already gone through the South Australian system and on whose behalf we followed up any default in maintenance. She said that it was clear in her mind that she would honour any arrangements that had happened in South Australia, and would continue to pursue the system as we had set it up, although it might change in the national framework, contracts made under our system would continue to be pursued, so defaulters between now and then who are known to our system would continue to be pursued. In the other States that have never had a national maintenance system, they will not go backwards through it. They will have a new date from which to start fresh, but South Australia and Western Australia will be different.

The Hon. J.R. Cornwall: That has raised doubts in my mind. We will pursue defaulters under the proposals?

Ms Vardon: Yes, on whose partners' behalf we have taken action already.

The Hon. J.R. Cornwall: Will the formula be used and will the payments be levied through the taxation system so that there will be retrospectivity to that extent where they have defaulted? The pursuit will be through the taxation office?

Ms Vardon: Yes.

The Hon. J.R. Cornwall: That was my understanding of it.

The Hon. JENNIFER CASHMORE: My concern, and I am sure that of the Hon. Diana Laidlaw, and all South Australians is that all defaulters should be pursued, irrespective of when they separated. My concern goes beyond

South Australia, because it is something about which we should all be concerned, wherever a child lives in this country: if it is possible for the parent to maintain it, that matter should be pursued.

The Hon. J.R. Cornwall: It goes beyond South Australia to the extent that if somebody has children in South Australia, or the custodial parent is in South Australia with those children, there must be a national scheme, and it must be possible for the taxation system to catch up with the non-custodial parent, whether he is living in Queensland or in the Kimberleys.

The Hon. JENNIFER CASHMORE: Before the Estimates Committee last year, it was noted that one of the urgent issues being addressed by the Director of Human Resource Management is the recruitment of people with a second language or who can understand another culture. This is relevant to the yellow book, page 360, relating to the overview objectives, issues and strategies of a multicultural department. What special initiatives, if any, is the department taking to attract applications from persons with a second language or an understanding of another culture, and what progress did the department record in fulfilling its goal last year? For example, what proportion of recruits had a second language or an understanding of another culture?

The Hon. J.R. Cornwall: I do not think the program has gone as rapidly as I would have liked. However, the principles and objectives are well established, and we have a strategy for implementation. With regard to how we intend to implement that over the course of the next three years, I ask the Director-General to respond.

Ms Vardon: I cannot find the percentage of people in our department with a second language, but it is very high. In one of our offices 14 languages are spoken among 15 people. We have actively pursued people with a second language being recruited, and we have recently had our first meeting of bilingual workers to encourage them to share their skills, and so on. It has been one of our great wishes that the shape of our staffing should reflect the nature of the community that we serve.

There has been one barrier to our proceeding in this, and I hope that that barrier has broken down in the past week or two. We were very concerned that the essential qualification for many of our front line staff was a degree. That prohibited people from other cultures from being employed, as they may have come from war torn countries and did not go to university or from cultures where higher education was not accepted. Whatever the reason, they were clearly disadvantaged and could not get into our system.

A number of workers whom we have managed to slip in are absolutely excellent. For example our Cambodian and Vietnamese workers do not have qualifications but they certainly break down the barriers. By a combined professional team we can provide a much better service. So, we have been trying to break down the barriers without reducing the professional standards in the department. I hope that, as a result of the important work between the PSA the old Public Service Board—now the new Department of Industrial Relations—and ourselves, we have worked out a formula that will allow us publicly to recruit people who can demonstrate that they have the necessary skills without necessarily having the qualifications. We will not lower the professional standards in our department, but this will allow us to get in people who are more capable of providing a relevant service. With that barrier down, I hope we can move faster on our proper recruiting campaign.

The Hon. JENNIFER CASHMORE: In February 1985 the Government established, with quite a bit of fanfare, a poverty task force and, after a few months of sitting, despite promises to the contrary, no interim reports were issued and no recommendations were forthcoming. Then the Chairman of the task force, Peter Travers, became ill and the task force was disbanded. Subsequently, the Government established a different version of the poverty task force called the Social Justice Consultative Committee. Why was it considered desirable or expedient to abandon the poverty task force following the illness of the Chairman? Why was not another Chairman appointed to take over Father Travers place?

Why did the Government, in establishing the Social Justice Consultative Committee, consider it desirable to deny the committee a public advocacy role? In the light of that denial of a public advocacy role, is the Social Justice Committee required (or is it planning) to release interim reports or a final report, and is there any timetable for either course of action?

The Hon. J.R. Cornwall: The poverty task force was disbanded on my initiative. The Chairman, Father Peter Travers, had become ill. However, I am happy to say that he has since made a rather good recovery. The task force issued an interim report which was useful and pointed to some of the directions. I wish to expand it into a far more pro-active role. I did not particularly like the term 'poverty task force'. One thing that I am very anxious that we should do is develop a role which sees active intervention in the poverty cycle so that we can use the trampoline affect to get people out of poverty traps and back into the mainstream of life.

There is abundant evidence that poverty in many cases is an event in the life cycle: for example, when marriages break down and the custodial parent is left with young children, they find it very difficult to work and to find employment. Yet that is a circumstance which places that person and her young family in extremely difficult circumstances, trapped into dependency of social security. If we have an interventionist policy which can get that person out of that trough or trap and take her family with her during that period then, of course, it is not only a very fine strategy from a humanitarian point of view but it is also a very hard-headed and sensible policy from the point of view of straight financial considerations. For that reason it was my view that the poverty task force should be replaced by the Social Justice Consultative Committee, which was established with the endorsement of Cabinet.

At the same time, in March this year, Cabinet endorsed a broad 11 point strategy for the development of a social justice program. That program will be given a charter for five and 10-year strategies. The Social Justice Consultative Committee is chaired by Dr Andrew Parkin. In many ways the membership is similar to that of the former poverty task force. The committee has met on a number of occasions and it has done some very valuable work. The executive officer to the consultative committee is a senior and valued member of the Department for Community Welfare.

As part of a package going to the Human Services subcommittee of Cabinet in November, along with the coalition strategy, the social health strategy and the five-year social welfare strategy, there will also be major recommendations concerning the social justice strategy. At the moment, in broad terms, I will be recommending that we should establish a social justice secretariat and a South Australian social justice council. The exact way that that will be done, the location and personnel of the secretariat, its size and the charter of the South Australian social justice council are all matters that are currently receiving attention. I do not think it would be wise for me to canvass it in any finer detail

than that. However, in a sense the consultative committee must be viewed as an interim measure in the evolution towards a major social justice strategy.

The Hon. JENNIFER CASHMORE: To make sure that I understood the Minister correctly, when I asked whether there was any timetable for the committee to release its recommendations, did the indication of a November Cabinet decision confirm that that was when the committee would report to the Minister with its recommendations?

The Hon. J.R. Cornwall: That is basically the way I would view it, yes.

The Hon. JENNIFER CASHMORE: On page 360 of the yellow book there is a statement about working with families. The 1985-86 'Issues' of the Department for Community Welfare stated that the department's objective was to give priority to working with families where children were being maltreated. Considering the fact that the department's number one priority is child protection, why is this deleted from this year's list of priorities? Does the deletion indicate that the department's approach to the management of children who are victims of abuse will no longer incorporate efforts to maintain a child within the family network?

The Hon. J.R. Cornwall: No, that is a gross distortion.

The Hon. JENNIFER CASHMORE: It is a question.

The Hon. J.R. Cornwall: Let me put that to rest. It is a question with an inference, and it must be laid to rest immediately. That is quite wrong. I will ask the Director-General to respond specifically to that question.

The Hon. JENNIFER CASHMORE: And perhaps indicate why it is not identified as a departmental objective.

Ms Vardon: Certainly, I would like to answer that. I cannot quite understand the reference. I am surprised that the word 'family' has been deleted. I will read from the five-year plan for child-care and child protection that we are developing. It has three goals, the first of which is:

> To provide helpful and practical assistance to families to enable children to be nurtured in the family environment.

That is the No. 1 objective of the plan. The plan continues:

2. To intervene when this care is not being provided.
3. To provide adequate protection and care for the child.

The whole spirit of our first set of strategies is to determine how we can support families and develop neighbourhoods, respite care services, home aids and child-care services. It goes on to talk about working in maternity wards, identifying children at risk with their mothers and giving those mothers lots of help in the very early stages. We learnt from overseas experience that often we can move in with the best support when the baby is born. So, our whole stance on this issue is about supporting families, and we have said that out loud in our internal documents. If it is not out loud in the document mentioned by the member, I will go back and make sure that it is said loudly.

There is an interesting second phase. Some families choose not to care for their children adequately. It does not matter how much support they are given: they choose not to nurture their children. We believe it is at that point that we have a responsibility to find an alternative family for those children, but not unless we have tried everything else. A recent decision, known as the Gillick decision, of the House of Lords in England (and I cannot quite put my hands on it at the moment) says that parents have a responsibility to raise their children and nurture them, but they do not have the right to be cruel to them.

They do not have rights to own them. They have responsibilities to give them every care and every nurturing they possibly can. It is a very important decision, because the House of Lords has come out and said very strongly that parents do not own children and therefore cannot do whatever they like to them. That makes us feel more comfortable at our second phase strategy, which is to always look after the rights of children. The State has the responsibility to do what some parents do not do. I wish to put the honourable member's mind at rest—the family is very much a fundamental plank in the department's strategies.

The Hon. J.R. Cornwall: I wish to express my gratitude to the member for Coles. We have turned to page 360 and discovered that there is a very important sentence missing. In last year's yellow book it states, 'To improve the department's working relationship with other departments in the human services.' This year we have added, particularly, 'Through the coalescence with the South Australian Health Commission.' The next sentence in last year's yellow book was, 'To give priority to working with families where children are being maltreated.' In the printing this year, that sentence has been omitted, which I must say is a grave and serious omission. I would draw it to the attention of the Committee and I thank the member for Coles for bringing that to our attention. I am sure that she will forgive me if I appeared to overreact. We are always very clear that the family is of paramount importance—except, naturally, where children are being abused. We are progressively involved more and more in early intervention in keeping families together as workable units. Again, I am very grateful.

Mr ROBERTSON: Can the Minister inform the Committee whether the Service to Youth Council will be assisted with extra funding to resolve its current financial difficulties?

The Hon. J.R. Cornwall: In response to that, I was approached on behalf of the Service to Youth Council late in May 1986 and advised, as I recollect, through the Office of the Minister of Youth Affairs, that they were in what was said to be dire financial straits, and I was asked to assist. I want to make it clear that it is not my custom to pick up deficits of organisations, particularly when they have received a relatively large allocation, in this case, $69 500. The amount by which I supplemented their funds was $9 000, which was the last of the moneys I had in my Minister of Health special grants line.

I certainly recognise that some of the work which the Service to Youth Council does is important, but I was keen that, before any further commitment was made by the State Government, a role and study function needed to be undertaken. I gave a commitment that in addition to the $9 000, which was the last of the 1985-86 money, the first call on the 1986-87 money in the Minister of Health special grants line would be to fund a role and function study. Ms Kate Barnett, an experienced person in the youth affairs area, did that role and function study. She has now provided a report to me and my colleague the Minister of Youth Affairs (Hon. Barbara Wiese) on her review of the Service to Youth Council. She makes some very interesting recommendations, perhaps the four most important of which are as follows. First, the SYC should reduce its staffing to the level at which it was funded. Secondly, it should suspend the youth inquiry service as the funds for its operation have run out.

Thirdly, they should terminate the 'Look Before You Leave' and 'Message Home' projects; and, fourthly, they should reduce the number of projects they now undertake, in order to consolidate the efforts of the past two years. The consultant, Ms Barnett, also recommends that I should consider picking up some of the deficit. At this stage I have not made up my mind about this: in principle, I am not anxious to provide budget supplementation in any circumstance where financial overruns have been incurred without prior approval.

One has to adopt a hard line about that, otherwise any number of organisations could simply run away with the idea that they could meet every demand made upon them and simply come to Government and have it made up. At the present time my Director-General has agreed to meet with the Service to Youth Council, go through the recommendations and report to me. I am concerned that an organisation with a management committee of such eminent businessmen and others should have allowed this organisation to extend itself way beyond resources available to it. I can understand the motives, but I simply cannot understand how people who are skilled in financial management in their own affairs could be so loose with the spending of public funds. It is a common problem in the welfare field: people open their hearts and their organisations to every need and throw away simple principles of cutting one's suit according to the cloth.

Fortunately, most other organisations in the non-government sector have learned to balance the demands placed on them with the resources available to them, and it is hoped that the Service to Youth Council will mature and understand this important principle. In spite of some direct hints from me, I observe that its application for this year's funding totals $292 000, an increase of 400 per cent, which is clearly beyond the realms of rational thought, given that there is a 4 per cent increase in the community welfare grants fund, and 4 per cent as against 400 per cent which the SYC is looking for, and there are 126 new and very worthwhile applications for funding from the community welfare grants. That situation must be considered to be in a state of flux at the moment. There is no question, however, that the SYC will have to have a very hard look at itself and, as I said, cut its suit according to its cloth.

Mr ROBERTSON: In relation to the child protection programs, there is an increase in funding from $861 000 last year up to $1.6 million this year: would the Minister care to indicate what impact this might have on staffing within the child protection program and how the department proposes to use that additional funding to cope with the needs of that service?

The Hon. J.R. Cornwall: To some extent the additional funding was made available by Budget Cabinet in anticipation of the report of the Child Sexual Abuse Task Force. To that extent I would not like to give exact details of what additional staffing might be in place from the beginning of the new calendar year. However, the funding was made available on the basis of one submission from the DCW as to where they would like to go and the other following an interim submission from the Child Sexual Abuse Task Force as to where they were likely to report our priorities should lie in the health and welfare areas. So, the funding is a somewhat reduced line of best fit, based on those two submissions. The Chairperson of the Child Sexual Abuse Task Force, Elizabeth Furler, and the Director-General have had some discussions, and I understand they are scheduled to have some more in the immediate future.

In the meantime, the Director-General will give the Committee not only an outline of where those positions are most likely to be but also the developing strategy for the protection of children. We are in the process of actively developing a five year strategy, which we believe will enable us at the end of five years to say that the great majority of children in South Australia will be safe in their own homes in terms of physical, psychological and sexual abuse.

Ms Vardon: As the Minister has said, we are still negotiating the exact nature of the new positions, and we are very grateful to have 14 additional staff. With the rapid escalation of child protection notifications, those 14 extra staff will be very important. The one thing we are very clear about is that they will be especially for child protection work. We are considering the areas of greatest need with the use of our computer and our workload measurement data. Ms Furler and I will consider specific job functions. I believe that we are achieving reconciliation so that very quickly we will have one line to ensure that the recommendations of the Child Sexual Abuse Task Force can be implemented and the demands of our department can be met.

This year we are keen to broaden the nature of our child protection program, and we hope that one or two of those staff will take on the function of community education, particularly in the area of prevention. Recently the Minister and I and many others attended a conference in Sydney on child protection and neglect, and we learnt that we are a long way behind in educating the community about how to look after kids at risk. One of the big strategies into which we will move this year is prevention. We will educate people to raise their awareness, focusing away from the casework model and towards a community development style of operation.

As I said, we will concentrate on the early intervention point where children are at risk when they are born. We have learnt that any child in the family who is different—whether handicapped, adopted, fostered, where the pregnancy was unwanted, or where there is a foetal alcoholic syndrome—is at risk. With that knowledge, we can get in early and help the mothers at that stage. We are very keen to support the self-help groups that are developing around the city and to ensure that they stay on the right course. Some of them need a lot of help. We will work with Domiciliary Care to ensure that adequate home support services are available to families where there are early signs of trouble.

One of the great moves this year will be much better cooperation between health and community welfare and, in fact, a coordinator will be appointed to coordinate health and welfare services in child protection. That is a breakthrough. That person will be responsible to both the Director-General of Community Welfare and the Chairman of the Health Commission. That will be a real test for coalescence. We hope that this year the roles of the police, CAFHS, DCW, and so on, will be clarified and that those bodies will adopt the same procedures for looking after children at risk.

Another thrust of our program this year will be to adequately develop professional education. We know that teachers, nurses, doctors and lawyers have a lot to learn, as do social workers and psychiatrists, and we hope to get better information into undergraduate and postgraduate courses. We are very impressed with the clinical services provided within the Health Commission, and we are working hard with the doctors to ensure that the evidence that we send before the courts is excellent and that it stands the tests that various judges apply to it.

The Minister has foreshadowed the work of the Child Sexual Abuse Task Force and other legislative programs of review. One of the big strategies this year will be legislative reform. In all of that, we will be working very hard with the non-government sector to ensure that there is no competition in the area of child protection and that we work for the same good—to protect the children in our society.

We are concerned that our own work needs to be excellent and we have already started extensive training programs for our child protection workers. We are not always sure that the work we do is perfect; in fact, often we think that it might do some harm. We want to ensure that no harm is done by the people who help and we have put a strong

emphasis on upgrading our service. One of the big thrusts this year is that we will evaluate our work to ensure that it is effective.

The Hon. J.R. Cornwall: I hope that we can develop a bipartisan approach in the matter of child protection. Based on the document that has been prepared by the shadow spokesperson, there is every indication that that may well be possible—it is certainly highly desirable. It is regrettable that when that document was recently released the Leader of the Opposition entered an area about which I believe he is not terribly well informed. He suggested that all our resources tended to be concentrated in the area of child sexual abuse, but that is simply not so. We regard that as being a very important area but it is simply not true to say that our resources overwhelmingly go to that area.

This year the Government provided the DCW with expansion funds for 14 new child protection worker positions, plus three clerical positions. That involves an allocation of $205 000 this financial year (and that is half year funding), which of course is $410 000 in the full financial year 1987-88. Because of what can only be described as a dramatic increase in the notification of child abuse (and I stress child abuse and not simply child sexual abuse), more of the social workers' time in the district offices is being spent on child maltreatment. Therefore, inevitably, there is an increase in the apportionment of their time and salaries being shown against this program. In fact, child abuse now accounts for more than 50 per cent of the total activities of the department.

To give an indication of the exponential rate at which the notification of child abuse is increasing, in 1985 the department investigated 1987 notifications of suspected abuse involving 2 600 children and that was a 57 per cent increase on the previous year. This year we anticipate about 3 000 notifications, and our best guess is that that will probably continue to increase at a rapid rate until plateauing at about 6 000 notifications a year. Now that the lid is off and the taboos have been removed, the reporting of child sexual abuse in particular, and child abuse in general, is increasing very rapidly.

There does not seem to be any hard evidence that the incidence of child abuse has increased markedly but, rather, people are now reporting it far more commonly. Child sexual abuse notifications as a proportion of the total abuse notifications represent only about one third and, while the media tends to focus on this aspect only (and it is the media that tends to do that rather than the department or the Minister), it is salutary to remember that 40 per cent of abuse notifications involve physical abuse, broken bones, cracked ribs, severe bruising and burns to mention just some of the more dreadful things that come to our attention. About 24 per cent of the notifications involve neglect and inadequate care—the more extreme of those cases being the sort of thing that was reported in Sydney about six weeks ago—while 3 per cent involve emotional maltreatment.

I thought it was important that we put those percentages on the record to look at the projected notifications as we see them and to put it all in perspective. I must confess that when I became the Minister of Community Welfare I thought that we were in danger of being overwhelmed by this great tide of notifications; I thought there was almost an obsession in the department. However, I have looked at it very calmly. Indeed, I am sure that the Director-General, the Deputy Director-General and the Assistant Director-General would be the first to say that I have played devil's advocate sometimes in an uncharacteristically abrasive way—only in private, mind you—because I had to convince myself absolutely that we had the priorities right.

After a very careful examination of all the facts from my perspective, I am convinced that the department has got its priorities right and that it is embarked on a course of child protection in this five-year program that I completely endorse as the Minister. As I said earlier, I think it is doing a first class job. I would repeat, as I have said many times during the past nine months, that a society that does not love its children and is not prepared to care and protect them where needs be through an organisation like the department is not much of a society. Fortunately, the South Australian community is a splendid community in that respect.

Mr ROBERTSON: In relation to the need for budgetary advice from certain groups of people, it is clear that when economic times are most stringent the people most affected are those at the lower end of the socio-economic scale. For them financial counselling of one kind or another is extremely important. What steps is the department taking towards delivering high quality budget advice to these people? How much effort has gone into preparing that advice?

The Hon. J.R. Cornwall: One of the major planks in the 11 point strategy that was approved in the preliminary development of the social justice strategy was financial counselling and advocacy. I know that the member for Coles foreshadowed at the beginning of the Committee's sitting that the Opposition also had a special interest in this. Everyone probably knows in general terms at least about the budget advice service that has been offered by the department now for many years. It is provided by 41 part-time budget advisers, many of them being retired people with commonsense and some financial background. They represent something in excess of nine full-time equivalent staff. They have done a very good job over the years and are mostly employed in the department on a sessional basis.

There are two difficulties basically. One has been that they tend to have client contact after the event, that is, by the time the client is referred to the budget advice service they are already in desperate trouble. If a client has liabilities of $160 a week and an income of $110 a week no amount of counselling in the world will get them out of their difficulties, short of completely rearranging their affairs and going voluntarily into bankruptcy. We believe it is important that there be earlier intervention than that—that there be financial counselling again in a pro-active way at an earlier stage. We also believe that in the medium to long term it is important that that financial counselling be provided by the non-government sector.

That is for a number of reasons, not the least of which is that if one is to have an advocacy role, a consumer protection role, as part of that financial counselling, then one tends to compromise oneself by placing it in a Government department. That is particularly so since part of that advocacy, at least, would be with Government instrumentalities.

It is well known that there is an implied, if not explicit, restraint placed upon one Government agency in trying to act as an advocate against another. So, that will be developed as part of the social justice strategy. I regret to say that we have not been able to find any additional funding to develop that for 1986-87. It is my intention that it be very high on our list of initiatives for the next financial year.

Mr ROBERTSON: In the area of concessions, which go hand in hand with financial counselling, very briefly, the department has picked up a number of the concession areas from Australian National and other places. I wonder whether the Minister can give the Committee a brief run-down of the areas of concessions that are being undertaken by the

department and how much it is proposed to outlay on each of those.

The Hon. J.R. Cornwall: Does the honourable member want a run-down of all of the concessions?

Mr ROBERTSON: No, the broad classes, because you have picked up the rail freight concession from AN, as spelt out on page 367.

The Hon. J.R. Cornwall: It is interesting, and ought to be on the record, that the State Government, one way or another, will provide concessions estimated to cost almost $130 million in 1986-87. I constantly remind my Federal colleagues of this when they say we are not into funding welfare, because that is $100 for every man, woman and child in South Australia; that is a very big amount indeed.

There is a long and fairly extensive list which includes, of course, the Spectacles Scheme, the Pensioner Denture Scheme and transport for the sick. I would thing it best to have these facts incorporated in *Hansard*, as they are of a purely statistical nature and this would save a considerable amount of time.

THE VALUE OF STATE CONCESSIONS

		1984-85	1985-86	1986-87 (estimated)
(a) Utilities and Rates—		$M	$M	$M
E&WS/DCW	Water/Sewer Council Rate Remissions	21.3	22.3	23.6
E&WS	Water/Sewer Rate Remissions to Organisations	6.1	5.7	6.0
DCW/ETSA	Electricity Concession Scheme	5.4	5.6	5.9
		32.8	33.6	35.5
(b) Remissions of Fixed Fees and Charges—				
Transport, Dept Motor Registration	Rebates on Vehicle Registration, Driver Licences and Stamp Duty	9.6	9.9	12.4
Education	Government Assisted Students Scheme—assistance towards books and school fees	1.5	1.5	1.5*
TAFE	Fee exemption for Stream 6 courses			
Fisheries	Exemption on commercial fishing licence fee and remissions on registration of gear	0.3	0.3	0.3
Lands	Concession on licence fees for pensioner occupiers of Crown land on old mining areas at Wallaroo			
		11.4	11.7	14.2
(c) Admittance and Fare Concessions—				
STA	Eligible persons are entitled to free or reduced fares on public transport	19.3	19.8	19.9
Transport Department	Fare Concessions for eligible persons on intrastate and country town private bus services, intrastate ANR services and MV *Troubridge* service	0.7	0.7	0.8
Education Department	Conveyance of Students Allowance—assistance for travel for students who live more than 5 km from their school or school bus route	0.5	0.5	0.6
Education Department	Conveyance—disabled children	1.0	1.1	1.2
Lighthouse Theatre	Concession on seat prices for eligible persons			
State Opera	Concessions on seat prices for eligible persons			
History Trust (Constitutional Museum, Birdwood Mill and Schubert Farm)	Concession on admittance for eligible persons	0.2	0.2	0.2
National Parks and Wildlife Service	Concession on admittance fees to facilities, parks, reduction in hunting and fauna permit fees			
		21.7	22.3	22.7

THE VALUE OF STATE CONCESSIONS

		1984-85	1985-86	1986-87 (estimated)
(d) Other—		(1)	(2)	(3)
Housing Trust	Rent Reductions	36.5	33.8	44.0
	Rent Relief	6.2	7.6	7.5
	Mortgage Relief	0.4	0.5	0.9
Health Commission	Spectacles Scheme	1.6	1.9	1.8
	Pensioner Dentures	2.2	2.2	2.0
	Transport	0.8	0.7	0.8
		47.4	46.7	57.0
Total (a), (b), (c) and (d)		113.6	114.3	129.4

*Scheme currently under review.
(1) Excludes $M 19.0 recovered through Commonwealth grant.
(2) Excludes $M 12.2 recovered through Commonwealth grant.
(3) Excludes $M 20.3 expected to be recovered through Commonwealth grant.

Mr OSWALD: The Minister recently appointed an independent consultant to review the operation of the South Australian Council of the Ageing. Has the Minister seen the consultant's report, what action does he plan to take to implement the recommendations of the report, and will he release the report so that it becomes a public document?

The Hon. J.R. Cornwall: Yes, I have seen the report. I have asked for a response from the council of SACOTA. I have also asked the Commissioner for the Ageing and the consultant, Dr Leon Earle, to prepare a formal and definitive situation for me following discussions that I have had with both of them. I do not believe it is desirable, at this stage at least, to consider releasing the report. I am extremely anxious that the good name of SACOTA should be protected. The basic problem was that there was a clear financial conflict of interest that involved one of the members of the board who was also chairman of the finance committee. That person has now resigned.

It will be recommended that there should be considerable change so that SACOTA is able to take maximum advantage of the wide range of sponsorship that ought to be available to it. In turn, that will alleviate the financial worries that it has had in terms of its recurrent budget. Also, I hope that the role of the council as an active advocate for issues for South Australia's ageing and aged people will again become the No. 1 priority and that financial counselling—important though it may be—will not be a direct concern of the council. There are a number of matters administratively that need to be put into place. I think some new faces and a bit of fresh blood on the council itself may be desirable. I do not want to take the matter any further than that.

I think that perhaps they have had a period of acne in their adolescence. That might be the best way to put it. Acne, as we all know, tends to resolve itself once we get past that adolescent period. It might seem strange to talk about a council on the ageing going through a period of adolescence, but it is part of the growth process. I am confident that in the near future it will resume its robust role as the peak council for the ageing in South Australia.

Mr OSWALD: When the member for Bright asked his question about concessions the Minister said that he would incorporate certain material in *Hansard*. When he does that, I would appreciate his giving additional information because I had intended to ask a series of questions about concessions. When the Minister is obtaining that information, as a supplement, will he include for each category of concession the number of people receiving the concession and, if possible, a breakdown in each category of the number of people who are pensioners, beneficiaries, unemployed or other?

Does the increased provision for the rates and taxes concession, which is $1.336 million, and the electricity concession, which was $.263 million, reflect a projected increase in the number of people applying for concessions, or an increase in the level of concession made available to each eligible applicant?

The Hon. J.R. Cornwall: It is not intended to lift the ceilings at this stage, so the increase represents two things: a natural addition for increased charges up to the ceiling and also the increased number of people receiving those concessions. I have a four page issues paper which, although it could not strictly be said to be purely statistical, I will undertake to incorporate it in a reply that I will prepare for the Committee.

Mr OSWALD: We are happy with that. South Australia has the fastest growing rate of elderly population increase, with 12 per cent of our population retired compared with 10 per cent nationally, and within a generation it is estimated to be 20 per cent compared with 15 per cent nationally. Has any study been undertaken on the projected increase in the need and level of concessions for the next five, 10 or 15 years? If so, what do these studies reveal?

The Hon. J.R. Cornwall: The short answer is 'No'. I have before me now a proposal for a major longitudinal study into the needs of the ageing. I will not describe it in great detail as I am not sure that I could, but the basic idea is to do a cross-sectional study in the first instance of, say 65 and 75 year old people and follow them over a period of two, three or even five years. We would use South Australia as a population laboratory in that sense. Studies like this have been done. I refer, for example, to the Manitoba study, which is quoted frequently as being a way to get a mine of information, not only in terms of what the financial demands might be in terms concessions and a whole range of other areas but also in relation to what sort of demands are likely to be placed on nursing homes, Home and Community Care schemes, hostel accommodation and all those services. That is before me for active consideration now.

I am trying to get the Federal Government to become involved on a dollar for dollar basis, because that work would be of national, and indeed international, significance. It is a good deal more money than we normally provide for research projects within the charter of the Health Commission. Certainly it is an amount of money that would cause the Department for Community Welfare to fall about and faint—it is of the order of $300 000 per annum. In terms of our future planning, it may be necessary to spend

that sort of money in the near future so that we can get our sums right for the next 15 to 25 years. It is a matter that should be dear to the hearts and minds of all members of this Committee because we are going to be part of that statistic in the not too distant future.

Mr OSWALD: I refer to page 362 of the yellow book and 'Substitute family care for children'. On 11 February the Minister announced the establishment of a review of adoption practices and procedures in South Australia with the promise that a public discussion paper would be available in April, which is six months ago. What is the Minister's justification for the long delay in the release of this paper? What timetable is proposed for the release of the paper, the calling for submissions and the consideration by Cabinet of the introduction of legislation to Parliament? Considering that the South Australian Aid Panel has among its functions the authority to 'make recommendations to the Minister generally upon matters pertaining to the adoption of children', will the Minister explain why he elected to ignore the panel as the vehicle to review adoption practices in South Australia and prepare the discussion paper?

The Hon. J.R. Cornwall: I must confess that I did not follow the question terribly well. I will ask the Deputy Director-General to respond directly but not on the aspect of what I may have done or neglected to do. The business about reporting in April is not within my recollection.

Ms Wighton: The adoption review consists of three persons and is chaired by an independent chairperson, Dr Geoff Scott, from Lincoln College. It was given the brief of preparing a public discussion paper on legislative change and review of the policy and practices of the department in relation to adoption. It was charged with the task of reporting with this paper by the end of June. It has not succeeded in meeting its deadline, like many other review groups. I think the persons on the review panel are busy people in other areas of their lives. It will be reporting to the Minister in the next couple of weeks and through him to the Human Services Subcommittee of Cabinet, I believe.

The Hon. J.R. Cornwall: The simple explanation is that the adoption panel did not want to do it, so we set up an independent and separate group of people to conduct the review.

Mr RANN: Following on from that question about adoption, I think all of us would recognise the magnificent work done by foster parents in South Australia. I ask the Minister to provide some detail about the resources to be devoted to subsidies for fostering teenagers in 1986-87.

The Hon. J.R. Cornwall: The need to find foster care placements for teenagers has always been very difficult because of their behavioural problems and independence issues. The member for Briggs has not yet had that experience with teenagers, but let me tell him as one who is vastly experienced in these matters that they can be very difficult during what is for them a very difficult time of their lives. It requires great patience and prudence, sometimes beyond the ability of some of us.

Many teenagers who cannot live with their own families (and this genuinely does happen) crave the opportunity to live with another family, and that is often done quite successfully. In many cases that is not a reflection on the teenager's true family: he or she may well be in a caring home and have loving parents, but there comes a point where there is a breakdown in the relationship between the child and the parents. It is often very useful in those circumstances for them to be fostered, and they do well in the alternative home.

On the other hand, of course, many of the children who come to the attention of the department requiring fostering are victims of abuse or neglect. We all like to think that everyone plays happy families, but the reality of course is that there are families where children are very poorly treated. The department, I might add, is not in the business of breaking down happy families. We do hear that allegation occasionally from some of the more extreme elements; but it is quite the contrary. We are in the business of keeping families together, or, as I said earlier, there is interactive intervention to keep them together where it is possible to do so.

Programs such as Teenage Care have been established to meet the needs where fostering becomes the preferred or desired option for teenagers. One of the barriers has been the cost of caring for teenagers—they are pretty expensive. In the past, the Government has paid the same basic subsidy for a six month old baby as for a 16 year old teenager. Obviously, that is not based on reality. Foster parents of the teenagers have inevitably found themselves out of pocket. Approx 500 of the children receiving foster care subsidies are over 12 years of age. So, there is a significant number of them. The subsidy payment for teenagers in South Australia has been the lowest of the range applying to any mainland State and, until very recently, it was $5 behind the next lowest State, which is Victoria.

I am happy to say that the subsidy for foster parents providing support for teenagers in foster care has now been increased (from 1 October this year) to $64 for 12 to 14 year olds and $65 for 15 to 17 year olds. That is much more realistic. That includes basic subsidy, pocket money, wear and tear, clothing allowance—it an increase of $10 per week over the old rate. The new rate brings South Australia into line with the other States in this matter. The case must have been well justified, because both the Treasurer and the Under Treasurer agreed without demur with the submission on this matter that I put to them.

Mr RANN: My second question in general terms relates to a matter that has come up in my electorate several times. Can the Minister tell the Committee whether moves are being made to upgrade the provision of information on welfare services to people with a non English speaking background?

The Hon. J.R. Cornwall: I have those facts at my fingertips, but perhaps the Director-General has a little more detail and therefore I ask her to respond directly.

Ms Vardon: One of our great concerns is that we are a mono-cultural and mono-lingual organisation. The Migrant Welfare Task Force told us that we had to work on language presentation in relation our pamphlets, literature, and staff training. We have worked very hard this year to get money. We have some money for interpreters and translators. I think our literature is going to be printed in six languages and, it is hoped, our signs for the front of our buildings will be printed in six languages. We would hope the image that we create in our offices is one where people who are different will feel accepted. We may not get translations into every language possible but at least we can get a range of languages in everything we do. The Committee may be interested to know that we are reviewing all our departmental forms and we are getting rid as many as we possibly can. We have already disposed of about 260. Of those that remain, each and every form will be considered in relation to turning the details on it into simple English and then translating that into all the languages possible so that every process and system in our department will, it is hoped, reflect a multi-cultural society.

Mr RANN: What moves are there to decentralise Crisis Care, and in what way will it be done?

The Hon. J.R. Cornwall: That is a very pertinent question and one that is certainly being asked in the Iron Triangle at the moment. There will not be any significant moves in that area this financial year. The Director-General will respond as to future directions.

Ms Vardon: We would dearly like to regionalise Crisis Care. We would like to have a branch in Noarlunga and a branch in Elizabeth. One of the options that we considered this year was to break up Crisis Care, but it does not matter how hard we try, it is difficult to do because a 24 hour shift has to be run. For safety's sake, two people must be on each roster. People go out at night into violent situations, and I have said that they must not be alone any more in those circumstances. People must go out in pairs. In every other place that I know of, workers must double up.

A number of staff have been assaulted. In fact, there have been three bad assaults in the last few weeks—not with Crisis Care—but there is some aggression around. We have had to shore up Crisis Care. With the additional staff and the new jobs that we have taken on, we cannot break it down this year. It takes 20 staff to decentralise just one unit of Crisis Care. We thought we might be able to do it at Noarlunga in the Noarlunga Health Village where it would be open for 24 hours but, unfortunately, we do not have sufficient staff. It is a top priority for next year to get a branch of Crisis Care at Elizabeth or Noarlunga, both of which could be justified immediately.

The Hon. J.R. Cornwall: The Domestic Violence Council, which is chaired by Ms Vardon, is due to report to the Premier and thence to the Human Services Committee and Cabinet fairly early in the new year. Certainly, that should be in time for inclusion in the prebudget considerations. Without in any way preempting what the Domestic Violence Council might recommend—and I have had no sneak previews whatsoever—I will still be surprised if it did not tend to sharpen the minds of politicians with regard to the funding needs in this very important area when it does report.

The Hon. JENNIFER CASHMORE: On page 360 of the yellow book under the heading, 'Grants and Loans', it indicates the department's corporate management objectives of granting loans of money or commodities to individuals or families in need or distress. Can the Minister indicate how much was loaned in 1985-86; what were the criteria to be met by applicants; how many applicants received loans last financial year; what was the average loan; and what was the success rate in terms of repayment?

The Hon. J.R. Cornwall: There is a good deal of detail required there. I will take that question on notice and give an undertaking that the answer will be returned in time for inclusion in *Hansard.*

The Hon. JENNIFER CASHMORE: On page 360 of the yellow book is an item under 'Strategies' that the department will continue to monitor and review services to young offenders with particular emphasis on reducing the number of Aboriginals in care. How many young Aboriginals are in care; what is the proportion of Aboriginals in care compared to all young offenders; and what initiatives does the Minister contemplate to help reduce the numbers of Aboriginals in care?

Ms Vardon: The present proportion of Aboriginal children in care is about one-third, and it gets down to a quarter. Over the past year we have seen a major reduction in the numbers of all children in care and particularly Aboriginal children. In the March quarter of 1986 Aborigines constituted 23 per cent of the total children's detention population compared to the representation of 1 per cent in the general population, so we still know that they are well and truly over-represented.

We have been very interested in the research work done by Prof. Fay Gale, of Adelaide University, who has been trying to identify the reasons why this is so. A number of things we have done recently have been concerns of mine. We have had a major seminar of all our workers with Aboriginal young offenders to spread the information around. We have noticed, for example, in areas like Berri and around Oodnadatta that the numbers of Aboriginal kids coming into care, particularly into detention, have been reduced. In fact, I do not think from the northern region there have been more than one or two Aborigines in detention for some time, because of the success of our Aboriginal community work program and our group workers, and we have actually started to employ Aboriginal people.

I think I said last year that people like Arnold Fewquandi and others in our department are actually keeping the kids out and providing many alternatives on site, back on their own home ground. We still believe that in the justice system they do not get the same kind of deal the white people have. Based on a calculation of about 23 per cent, the number of children we had in SAYRAC yesterday was 20 and, therefore, there would have been about five Aboriginal children in SAYRAC. In SAYTC there were 32 children, and about seven or eight would have been Aboriginal, so we would be looking at 12 all up. That is a small figure, but it is a large over-representation.

The CHAIRMAN: I declare the examination of this vote completed.

The CHAIRMAN: We have in front of us a list which requires a resolution of the Committee. It is merely a list of the items that have been discussed, and Committee members will have a chance to further discuss these matters when Parliament resumes.

Mr HAMILTON: I move:

That the draft report be adopted.

Motion carried.

The CHAIRMAN: I declare the Committee closed, and I thank everyone for their cooperation.

At 9.58 p.m. the Committee concluded.