HOUSE OF ASSEMBLY

Wednesday 23 September 1987

ESTIMATES COMMITTEE A

Chairman:
Mr D.M. Ferguson

Members:
Mr H. Becker
The Hon. Jennifer Cashmore
Mr M.G. Duigan
Mr T.R. Groom
Ms S.M. Lenehan
The Hon. D.C. Wotton

The Committee met at 11 a.m.

The CHAIRMAN: I intend to open all the health lines so that questions can come over the whole gamut, and we will put those lines before 6 p.m. That, I think, is the agreement reached. I declare the proposed payments for Minister of Health, Miscellaneous, $800 665 000 and Works and Services—South Australian Health Commission, $36 524 000, open for examination. In accordance with the rules of the debate, the lead speaker for the Opposition has 15 minutes in which to make an opening statement if he so desires, and the Minister has 15 minutes in which to reply. Does the member for Hanson wish to exercise that prerogative?

Mr BECKER: No. We have a program of questions, but I did want clarification. You have moved the first line of $36 million—

The CHAIRMAN: I have moved all the health lines.

Mr BECKER: What did you say about $36 million?

The CHAIRMAN: We are referring to page 190 of the estimates, South Australian Health Commission, Works and Services, and the figure I have here is $36 524 000.

Mr BECKER: That refers to the capital works program?

The CHAIRMAN: Yes.

Mr BECKER: You are including that in the $800 million?

The CHAIRMAN: I am opening up the whole lot, so that you can ask questions from any area up until 6 p.m.

Mr BECKER: That will be appreciated.

Minister of Health, Miscellaneous, $800 665 000;
Works and Services—South Australian Health Commission, $36 524 000

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

Departmental Advisers:
Dr W.T. McCoy, Chairman, South Australian Health Commission.
Mr R.J. Sayers, Deputy Chairman, South Australian Health Commission.
Dr D. Filby, Executive Director, Planning and Policy Division.

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

The Hon. J.R. Cornwall: Just a very brief one. I do not want to take up too much time of the Committee, but I would like to get one or two things on the record. Members of the Committee are probably aware that, as Minister for both Health and Community Welfare, I am responsible for a combined expenditure in excess of one billion dollars—$919 million in health and $127 million in community welfare. It is my view that in South Australia we deliver both health and social welfare services which are of a high calibre by world standards.

The funding of health services has been a problem for the governments of all industrialised nations for some years, and it is important in setting the climate that we take that on board. The impact of developments in medical technology, population growth, community ageing, and refinements in medical care, have resulted in the cost of health services rising more rapidly than the general rate of inflation. Australia now spends 7.5 per cent of its gross domestic product on health in all its aspects, that is, both public and private expenditure. This places us at the lower middle range compared to other Western democracies. The United States, Sweden, Canada, and France spend more, with the United States filling the top position at 10.9 per cent of GDP. Japan, United Kingdom, and New Zealand spend less, with the United Kingdom figure being something less than 6.5 per cent.

As members are no doubt aware, the Chairman and I recently visited the United States, United Kingdom, Sweden, Denmark, and Holland, and found that all of those countries were considering measures to reduce the rate of increase of health care expenditure. On the other hand, in the United Kingdom—and remembering that the United Kingdom spent something less than 6.5 per cent of its GDP in total on health and hospital care—there was substantial pressure from the health professionals and health administrators to increase the expenditure. It is important to put the whole question of health expenditure in a national and international perspective.

National economic policy in Australia has led to a reduction in Commonwealth outlays which has, of course, had an inevitable effect on State budgets and the amount which they can allocate to State health services. Members will be aware that the level of general revenue assistance available to this State from the Commonwealth has been reduced in 1987 by around $190 million. Fortunately, the overall reduction in specific Commonwealth funding for health has been substantially less, although in the Commonwealth budget we received less in some specific areas than we would have liked. No doubt one or two of those will be matters for discussion as the Committee proceeds. The South Australian Health Commission has been asked, along with other agencies, to make real savings in its overall expenditure.

The Government has ensured as far as possible that reductions in recurrent expenditure are targetted to areas which will have little or no impact on patient services. It has required the commission to make its managed savings through increases in efficiency and productivity. In addition, the Government has been able to target moneys at areas of special need, such as the booking lists.

I would hope that one of the members of the Committee will take the opportunity soon to ask the Chairman of the commission, through me, to outline in more detail the budget strategy adopted by the commission in 1987-88—in other words, the overall view of how the budget was planned—and specifically ask about the booking lists strategy that has recently been further refined and put in place.

Mr BECKER: On 14 August 1986 (page 351 of *Hansard*) the Minister made the following statement:

Over the next 12 months the Health Commission will make up to $850 000 available for the private system to treat public patients who are on public hospital waiting lists and who hold health entitlement cards. Priority will be given to those who have been waiting longest. The surgeons who perform the surgery will be those with visiting specialist surgical appointments in the respective public hospitals as well as visiting rights in the private hospitals selected.

Payment will be on a 100 per cent fee for service basis, and processed through the public hospital on whose booking list the patient was originally listed.

In the *Advertiser* today a letter from Michael Hone, who, I understand, is a senior orthopaedic surgeon at the Royal Adelaide Hospital, states:

Concerning your news item (*Advertiser* 17.9.87) 'Cornwall vows to cut waiting list', I would like to make the following comment:

For many years I have consulted and operated at the Angaston Hospital for the convenience of the people in the Barossa who find it difficult to travel to the city to visit patients in hospitals.

Over the past two years I have been stopped from doing any joint replacements at the Angaston Hospital, and was informed by the Health Commission that these must all be done at the Royal Adelaide Hospital.

As the theatre and facilities at Angaston Hospital are so much better than those provided at the Royal Adelaide Hospital I cannot understand this directive.

The theatre at the Angaston Hospital is cleaner and better equipped and the chances of infection are less. The changing rooms for the surgeons are pleasant and there are toilet facilities.

Given that there are better facilities at Angaston one wonders at the Health Commission directive to take the joint replacements from Angaston and put them on the waiting list at the Royal Adelaide Hospital and so increase this waiting list, when they state that they are going to cut the waiting list.

The average orthopaedic waiting list for January to January 1985-86 was 375; average January to January 1986-87, 459; and January to July 1987, 535, which shows a rapid increase. Will the Minister explain why the Health Commission has directed Mr Hone to stop providing this valuable service to patients at the Angaston Hospital in view of his purported commitment to the treatment of public patients in private hospitals and made in August 1986, and particularly as the waiting list for orthopaedic patients at the RAH is at an all time high and nearly double 1985 figures.

The Hon. J.R. Cornwall: I am most grateful to the member for Hanson for raising this question; had he not done so I am sure that one of the diligent members on the other side of the Chamber would have done so. The question of Mr Hone's on-going disputation with the Angaston Hospital and related matters I will ask the Chairman to respond to in a moment. I simply make two points. The first is that the Angaston Hospital is not a private one, so any reference to the $850 000 available as one of the proposals in 1986-87 to get patients waiting for elective surgery off our lists would not have applied to the Angaston hospital.

We regard to that proposal, it was an offer that was available, and not an offer that was taken up by the surgeons to anything like the extent that I would have liked. It is very difficult to have surgery performed in the private sector, or anywhere else, unless one can find a surgeon to do it. The offer was to transfer public patients who were card holders—to that extent we were prepared to compromise the Medicare principle. The idea was to transfer public patients who were either pensioner health benefit card holders or health card holders, or at least some of them, from the booking lists in the metropolitan public hospital system to private hospitals. At that time the offer was for a full fee for service.

In the event, that was not a strategy that was taken up with any enthusiasm. There was some surgery done. The Western Community Hospital, with which the Chairman is fairly familiar, took up the offer and indeed still does some surgery on public patients under that original proposal. However, we learn as we go along, and there are a number of strategies that have been refined and devised which are now being implemented and which, as I said in my opening statement, I would like the Chairman to have an opportunity to expand on soon. It is not directly relevant to this question, however, I ask the Chairman in his response to confine his remarks specifically to the Angaston Hospital and to the ongoing negotiations and relations between the Angaston Hospital Board, the Chief Executive Officer, Mr Hone, other visiting specialists, and the South Australian Health Commission.

Dr McCoy: In relation to the Angaston Hospital issue, for the commission it began in June 1986, when the administrator of that hospital wrote to the commission requesting additional funds to pay for orthopaedic prosthesis to be used in a hip replacement operation. The central sector Director at the time replied to the hospital on 21 July stating that it was unable to provide additional funds. As members will recall, it was a tight financial year and no funds were earmarked for that type of operation in country hospitals. Nor was there a policy that could be used to govern the performance of major operations in small country hospitals; nor had a role and function study been performed at the Angaston Hospital. However, a role and function study had been performed at the nearby Hutchinson Hospital in Gawler, where the board and the commisison had agreed a list of surgical procedures that would be appropriate for a hospital of that size. The Hutchinson Hospital is considerably larger than the Angaston Hospital.

That recommendation was provided to the board and the commission by a large group of commissions representative of surgical colleges to the effect that hip replacement operations would not be appropriate at Hutchinson. We could extrapolate from that therefore that it would be inappropriate for Angaston, but the commission has not done that formally because it has not looked specifically at the Angaston situation. On 5 August last year the central sector Executive Director (Des McCullough) wrote to Dr Michael Hone. In part, the letter states:

At no stage has there been any indication that orthopaedic procedures could occur only in major teaching hospitals, rather, it is suggested that it would be appropriate for certain specialist facilities to be concentrated into larger hospitals in country areas on quality of care grounds.

So, specifically in answer to one part of the honourable member's question, I point out that the Health Commission did not direct the Angaston Hospital nor Dr Hone not to perform hip replacement operations at the Angaston Hospital. However, the commission did refuse to give additional funds for that purpose. There is a related matter concerning the role of a country hospital, and I have already referred to the situation at Hutchinson.

Mr BECKER: In the Minister's Address in Reply speech of 14 August 1986 he made the following statement on waiting lists (page 351 of *Hansard*):

However, this is not simply a 12-month program. I emphasise that the funding for the strategy has been specifically earmarked for an initial $7.64 million two-year program . . . $3.82 million has been provided each year for two years to fund the strategy from compensation money provided by the Commonwealth for additional costs under the Medicare agreement . . .

Is the $3.82 million still to be allocated in the budget, and is the $2.3 million matching amount announced by the Minister on 17 September when he reportedly said, 'The State would match the $2.3 million grant in Tuesday night's Federal budget to reduce waiting lists,' an additional sum on top of the $3.82 million announced 12 months ago, or is the only additional amount to be spent this year $800 000, which is the difference between the $3.82 million and the $4.6 million announced on 17 September? An article in the media also states:

Dr Cornwall said yesterday that the $4.6 million would be allocated to the six major hospitals.

The Hon. J.R. Cornwall: I am very happy again that the member for Hanson has raised this issue, and I hope he continues to be helpful like this all day. The member for Hanson has highlighted the fact that, instead of a $7.6 million program over two years to specifically tackle those classifications of elective or non-urgent surgery for which the waiting times are unacceptably long, we have a $13 million three-year program. I will ask the Chairman of the Commission to provide more specific details.

Dr McCoy: The Minister's initial program involved a $7.6 million expenditure over the two financial years 1986-87 and 1987-88 entirely provided from State funds. The scheme that has now been announced provides for expenditure over three years, as the Minister said, of $13 million: $8.4 million from State resources and $4.6 million from Commonwealth funds. The $8.4 million is an increase of $800 000 over the previously announced State program of $7.6 million.

Mr BECKER: Does this means that the State has had to put in $2 for every $1 from the Commonwealth Government to help reduce waiting lists?

The Hon. J.R. Cornwall: No. Last year's money has already been spent. In fact, that was State money. I further qualify that by saying that it was money held by Treasury as part of the various compensations that were paid to us as part of the Medicare agreement. Directly, it was Commonwealth money originally held by State Treasury and allocated to get the booking/waiting list strategy going last year. That is spent. Of course, what we have now is a matching program for a further two years. Instead of having only one year to go at $3.8 million, we now have two years at $4.6 million.

Mr BECKER: On 14 August 1986 (*Hansard* page 351) the Minister stated:

(a) that there were 6 286 people on elective surgery waiting lists in the metropolitan area;

(b) that he had earmarked $3.82 million per year to fund extra sessional employment of senior specialists in public hospitals;

(c) that he was making $850 000 available for fee-for-service payments for surgery on public patients in private hospitals;

(d) that these initiatives would result in an additional 3 000 elective operations and reduce the public waiting lists by 1 800 over the 12 months;

(e) the Royal Adelaide Hospital will be funded for additional sessions in orthopaedics, plastic surgery, ear, nose and throat, eye and general surgery;

(f) the Queen Elizabeth Hospital will be recommissioning severe additional cuts specifically for elective surgery patients, plus two additional operating sessions;

(g) Modbury Hospital has been funded for an increase in orthopaedics and urology;

(h) the Lyell McEwin Health Service will increase sessions in general surgery orthopaedics, urology and ear, nose and throat.

What impact will the $800 000 extra funds have on the current waiting lists when in fact this amount represents a small increase in real dollar terms and there was no impact on waiting lists last year?

The Hon. J.R. Cornwall: In fact, there was a very substantial impact on waiting lists last year. We had 2 000 more operative procedures carried out because of that specific allocation of money than would otherwise have been the case. That has been documented. In fact, instead of the number of persons waiting for elective surgery blowing out from around 6 000 to 8 000 we have at this time been able to put a cap on it. Also, we have learnt a number of things along the way.

We have in South Australia one of the highest rates of surgery in the world. We should not be carried away or blinded simply by the ongoing debate about who is on what list, for what length of time and for what procedure. We certainly need to be addressing—and we are addressing—the question why we have some of the highest rates of operative procedure in the world. The second point I make is that we are very actively investigating and beginning to instigate specific quality assurance and medical management assessment programs. In fact, when the Chairman and I were in the United States recently we visited a 150-bed community hospital at Naperville just outside Chicago to actually see this specific quality assurance and medical management assessment program in action. Dr Joyce Craddock had been to Australia; in fact, she had been to Adelaide shortly before our visit to the United States.

We were able to attend at a hospital and see this practice in action. It involves the review of every inpatient who is actually in the hospital, not retrospectively. One of the questions we must address is why, in some areas at least, an extremely high number of procedures is carried out in comparison with some other States and certainly many other parts of the Western world. Having said that, I ask the Chairman to respond specifically to the matters raised by the honourable member concerning the list.

Dr McCoy: Since January 1986 the number of people on the waiting lists for the major metropolitan hospitals has reduced from 6 467 to 6 068 as at 20 July 1987. That is a small reduction but, as the Minister has already said, it includes a considerable increase in activity at the hospitals because of additional moneys provided specifically to them for booking lists, so had that not occurred the number as at July 1987 might well have been considerably greater. In fact, in 1986-87 hospitals reported to the commission that 2 131 additional procedures were performed: 774 at the Royal Adelaide Hospital; 614 at the Flinders Medical Centre; 191 at the QEH, 477 at the Lyell McEwin Hospital; 23 at Modbury Hospital; 28 at the Adelaide Children's Hospital; and 14 at the Queen Victoria Hospital, plus 10 at the QEH using the private system.

In 1986-87 the private system was not used to a great extent. The commission has a number of concerns about the booking list strategy, the major one being that, while the throughput in hospitals has increased, the number of people who are still waiting a considerable period of time has not altered significantly. Therefore, the commission has specifically targeted those who have been waiting for more than 12 months with the objective of eliminating that number as well as the number of those waiting from between six months and 12 months. It is also fair to say that the commission has some concern about the way in which hospitals have used the booking list money. There are considerable differences in the cost per operation reported from the hospitals. Dr David Blaikie, the newly appointed Executive Director, Metropolitan Health Services, is taking up this matter very seriously and has initially allocated funds for 1987-88 on a six-month basis with a proviso that there will be a review of the situation at the end of three months and six months and that it may be necessary for different strategies to be used in relation to the remainder of the booking list. No decisions on that have been made at this stage.

Ms LENEHAN: I would like to ask a relatively general question relating to the Minister's opening remarks. On page

2 of those remarks the Minister referred to the reduction of $190 million made available to the State this year, and said that the overall reduction in specific Commonwealth funding for health had been substantially less, although, in the Commonwealth budget, we received less in some specific areas than we would have liked. Further on in the statement the Minister said that the Government had ensured that reductions in recurrent expenditure were targeted to areas which would have little or no impact on patient services. Can the Minister outline for the Committee in greater detail the overall budget strategy against this backdrop of a substantial reduction in funds available from the Federal Government to the State Government?

The Hon. J.R. Cornwall: May I say in general terms that I have been very pleased with the response we have had from the health system generally. I refer to the commission in the first instance, and to health units as well, specifically the metropolitan public hospitals which have cooperated in a most constructive way. As to the details of how the budget was constructed in consultation with the individual health units, I think that it would be more appropriate if the Chairman were to give those details.

Dr McCoy: The Minister has already outlined the macroeconomic environment, if you like, in which the health system is operating in Australia and in South Australia at present. In the context of the South Australian Health Commission, we were required to make managed savings of $9.1 million in the 1987-88 budget. In addition, it was necessary to provide $2.3 million for urgently required reallocations and initiatives. In considering this matter, we first had regard to the background information that impinges on health in this country and on the health system in South Australia.

There are some facts which I would like to relate to the Committee which directly impact on the cost of health care in South Australia. These include the very high doctor to population ratio in South Australia which is at the moment, I believe, one doctor to every 437 people in this State. That is the highest ratio of any State in the country and is amongst the highest, if not the highest, of any country in the world. In addition, South Australia is richly provided with hospital beds. There are in acute hospital beds six per 1 000 population in South Australia as against the national average of 5.3. We also have a very high number of nursing home beds per 1 000 population, a figure of 5.5 in South Australia as against the national average of 4.7.

With these beds we have a very high admission and utilisation rate—by far the highest in the country. I have facts here for 1985-86 from a recent study conducted by the Australian Institute of Health that show that the figure for occupied bed days per 1 000 population in South Australia is 1 865, compared to a national average of 1 610. High beds per 1 000 population and high occupied bed days lead inexorably to high expenditure on health per head, and I have figures on that.

The health expenditure per head by State and Territory by major category in 1984-85 (the latest data available to me) shows that in South Australia we spent $993 per head of population against the national average of $922. That $993 is considerably above all other State levels. There is a lot of other information which I think it is not appropriate to talk about at this time, but there is a general view that the health system in South Australia is well endowed with human and physical resources. It is in that context that the commission approached the matter of providing $9.1 million of savings to the Treasury, and finding an additional $2.3 million for reallocations and initiatives.

The priority areas identified were to reduce central administrative costs. The commission believes very strongly that it must bear the pain of reductions itself to a greater extent than is applied to any operating health unit. It has targeted particular hospitals for reductions, and those selected in this year are the Royal Adelaide, the Queen Elizabeth, the Adelaide Children's Hospital, and Kalyra. Having applied those specific reductions, it provided a uniform and fair over-the-board reduction of .75 per cent.

In fact, the detail of the reductions is that the expenditure of central office of the commission was reduced by 5 per cent; the metropolitan health services were reduced by an overall budget cut of .75 per cent in addition to the four targeted savings that I have mentioned, and country and Statewide health services were reduced by a general .75 per cent.

I have the details that make up the $9.1 million and the $2.3 million for initiatives: the ACH, QEH, and RAH, $700 000; Kalyra, $800 000; .75 per cent across the board in metropolitan health services, $5.1 million; in country health services, $1.3 million; in Statewide services, $1.4 million; and in the central office of the Health Commission, $700 000. The total is $9.1 million plus $2.3 million, making $11.4 million.

Ms LENEHAN: Mr Chairman, would it be in order for me to request that the table from which Dr McCoy read, I think in relation to the spending per head of population from various States, could be incorporated in the appropriate section of *Hansard* if it is a statistical table, as I think it will be a valuable asset for the Committee members?

The CHAIRMAN: The Chair is in this position: the member may request but, if that request is refused, the Committee can do nothing further.

Ms LENEHAN: I am only requesting it, because I think it will be a valuable adjunct to information.

The Hon. J.R. Cornwall: Is this the per capita spending State by State?

Ms LENEHAN: Yes, the document from which Dr McCoy quoted some of the figures.

The Hon. J.R. CORNWALL: We do not have any difficulty with that, although I would like a point of clarification since we will be referring to documents all day. I take it that we cannot be forced to table them on demand.

The CHAIRMAN: Any member of the Committee may ask for any document, but the Minister has an absolute right to refuse.

The Hon. J.R. Cornwall: Using my absolute right in this matter, I am very happy to have those tables incorporated in *Hansard.*

Beds per 1 000 Population Australian States and Territories, 1985-86

	N.S.W.	Vic.	Qld	S.A.	W.A.	Tas.	N.T.	ACT	Aust.
Total acute hospitals (including public repatriation and private)									
Beds/1 000	5.1	4.6	6.4	6.0	5.7	5.9	4.5	3.9	5.3
Total psychiatric (including public and private)									
Beds/1 000	1.2	1.0	0.6	0.7	0.4	1.5	0.0	0.0	0.9
Total nursing homes									
Beds/1 000	5.3	3.8	4.7	5.5	4.4	5.4	0.9	2.1	4.7

Source: Australian Institute of Health Hospital Utilisation and Costs Study, 1986.

Occupied Bed Days per 1 000 Population by Institution Type, Australian States and Territories, 1985-86

	N.S.W.	Vic.	Qld	S.A.	W.A.	Tas.	N.T.	ACT	Aust.
Acute care hospitals									
Total	1 363	1 228	1 385	1 524	1 395	1 442	1 312	1 087	1 345
Psychiatric hospitals									
Total	352	317	177	199	107	510	—	—	275
Nursing homes									
Total	1 860	1 304	1 623	1 865	1 518	1 726	312	726	1 610

Source: Australian Institute of Health Hospital Utilisation and Costs Study, 1986.

Health Expenditure per Capita by State and Teritory by Major Category, 1984-85

	N.S.W. $	Vic. $	Qld $	S.A. $	W.A. $	Tas. $	N.T. $	ACT $	Aust. $
Public hospitals	336	316	277	333	345	314	497	355	323
Private hospitals	43	60	72	68	56	51	—	43	56
Repatriation hospitals	17	15	17	20	20	19	—	5	16
Mental hospitals	33	60	20	33	40	56	—	36	39
Total hospital	428	450	386	453	462	440	497	439	434
Total nursing homes	86	94	73	116	72	76	19	86	87
Other	444	378	358	424	383	369	422	409	401
Total Recurrent Expenditure	958	922	817	993	917	885	938	934	922

Source: Australian Institute of Health Hospital Utilisation and Costs Study, 1986.

Ms LENEHAN: That explanation has certainly provided a wealth of information from which we can find out some very interesting things about the sort of services and kind of things that are happening in South Australia in the health area, and I thank the Minister and Dr McCoy for that extensive answer.

In the *News* of 21 September (page 35) an article entitled 'Millions mentally ill' states:

> About three million Australians suffer from a mental illness which is serious enough to interfere with daily life. The general public is misinformed and unaware of its extent of mental illness in society . . .

On page 282 of the Program Estimates under 'Major Resource Variations' I note that there has been a significant increase in the amount of money that has been made available for adults with mental and behavioural disorders—about an 8.6 per cent increase. One of the main components of the variation that is contained in the yellow book states:

> Managed savings from existing programs in order to reduce the overall expenditure level and to reallocate some resources to high priority areas.

Does the commission intend to allocate some of the saved resources to ongoing community education to inform the community of the extent of mental illness and the need for the provision of resources? To what extent has the mental health accommodation program been increased? To what extent are we informing the community about the need for a knowledge of the degree of mental illness in the community, and therefore a commitment to the allocation of resources? The second part of my question relates directly to the provision of those resources to people with mental illness, specifically the provision and accommodation in the mental health area.

Additional Departmental Adviser:

Mrs J. Hardy, Principal Planning Officer, Mental Health.

The Hon. J.R. Cornwall: I will ask the Chairman and Mrs Hardy to address some of the specifics of those questions in a moment. We will try to do it as succinctly as possible, because it could take a three-day seminar to go

through some of the finer detail. The figures referred to by the member for Mawson I have heard previously. It suggests that one in four of us either fit into the category of being mentally ill or, more likely, of being one of the worried well. Therefore, at any given time it is suggested that one in four of us is not coping at our optimum. This is an enormously important area. To give but one example of an area of serious concern, it is estimated that 1 per cent of the adult population is schizophrenic.

In South Australia that means that in the community, to a much lesser extent in institutions, an estimated 10 000 plus people suffer from varying degrees of schizophrenia, which is perhaps the most debilitating long-term chronic disease of all and which certainly causes innumerable problems not only to the system but more importantly in neighbourhoods and communities.

It can be tremendously stressful in families when the care and support of the schizophrenic falls back on the family or the extended family circle. In relation to how we might allocate resources and what we might be doing about community education and the mental health accommodation program, I will ask the Chairman and Mrs Hardy to respond.

Dr McCoy: I will refer briefly to the financial figures, and ask Mrs Hardy to address some of the practical points that were raised. The community mental health services has been a priority for development in the commission for the past three years. In 1985-86 the Director of Psychiatry retired, and the funds were not used for the reappointment of a director. However, two additional social worker positions were created. In 1986-87 new initiatives to funds of $300 000 were specifically directed to community mental health activities, and these included the employment of a coordinator to work with the voluntary sector; assessment and support services for St Vincent De Paul; joint residential assessment and training programs with GROW, a dispersed housing network mainly for young people with schizophrenia; one occupational therapist; three additional community houses also for young schizophrenics; and another social worker.

In 1987-88 an additional $150 000 has been specifically earmarked to community mental health. To summarise the community system that is now provided, the number of persons who are maintained in hostels and boarding houses is 552. These are people with chronic mental disease, most of whom have been discharged from either Glenside or Hillcrest and are being cared for in those hostels and boarding houses. The recent initiative money has gone into the establishment of community houses and 17 young schizophrenics are maintained in houses with a moderate level of support and 21 are maintained with a lower level of support.

However, these levels of support are much greater than that available to the 552 in the hostels and boarding houses. There is an eight-person transitional program between a supervised living environment and independent living. The total of people maintained by the commission in accommodation of those various types is 598. Mrs Hardy will address the questions about the emphasis on community education and the hostels.

Mrs Hardy: It is a very appropriate question. This week is Mental Health Week, where the emphasis is on education. In the past couple of years the commission has put significant time and effort into ensuring that support is provided to the voluntary mental health groups that provide the front-line care of a number of people who have been discharged from the hospital to the community over the years. We have provided funds to establish a mental health resource centre on Fullarton Road, Kent Town, where six of these groups share accommodation and provide extensive educational programs and an activity and drop-in centre for particularly young schizophrenics. The other group that plays a major part in that organisation is the Anorexia and Bulimia Association. Funds have also been provided for research and education into anorexia and bulimia in the past couple of years. I understand that in the new initiative funding will be made available for a specific worker to provide education from community health centres, and direct treatment as well.

The mental health accommodation program has in fact existed for over 20 years—it commenced in the early 1960s and even at this stage is the only system in Australia of privately owned, Government subsidised psychiatric hostels. Until 1984 the program consisted of 22 hostels, 18 in the metropolitan area and four in the country, so within that system accommodation was provided for approximately 600 people at a cost to the South Australian Government of something less than $800 000 per year. If this is compared with what it would cost to maintain these people in hospitals, there is a significant difference.

There was, in fact, little or no change in that system for its first 20 years, and in 1985 a review of it confirmed the fear that the hostels were providing quite a poor quality of accommodation for middle aged and elderly people who had chronic schizophrenia and the program was unable in its current form to provide any activity programs, or activities suitable for young people with chronic schizophrenia. It was so poorly staffed that each social worker was attempting to provide a service for 150-plus clients when accepted levels were one to 50.

Following the review, the Government health policy at the last election stated that alternative accommodation programs would be developed as a matter of priority. That has occurred with the new initiative funds that the Chairman has described. At the same time, the need for hostel beds, which are really mini-institutions in the community, has decreased and there are now, in fact, 18 hostels. In addition, significant resources have been devoted to the development of activity programs in the Semaphore area where there are a number of people living not only in hostels but also in boarding houses.

Unfortunately, local government approval was ultimately refused for a special facility there. However, an activity program has commenced that rotates from one location to another but is now available five days a week. Hospital bed numbers have decreased over the years and patients who once stayed in hospitals for 20 to 30 years now have approximately three admissions per year of an average 21 days duration. These people are now in the community. The Minister mentioned the extent of schizophrenia in the community—1 per cent of the population. Even a conservative estimate of one-third would require assistance with community support and accommodation at any one time. Unfortunately, community care is now recognised as being more expensive than institutional care, so mental health accommodation will need to continue to expand if it is to adequately address the needs of this group that remains severely disadvantaged.

The Hon. J.R. Cornwall: I add, because it is extremely topical, that the program *60 Minutes* on Sunday night presented a segment specifically directed at bulimia which painted a horror picture. It is a very sad, extraordinarily distressing disease and is part of the anorexia nervosa and bulimia complex. What they failed to do—and *60 Minutes* is now developing something of a reputation for this—was point out (and it was filmed, I might say, in South Australia) just how many advances have been made and how much more optimistic we can be in this area than we could have been as recently as five years ago. We have in this State

Professor Ross Kalucy, who is probably the authority in the country on eating disorders. Also, we have at the Repatriation General Hospital Dr Ben Tovin, who is an authority by world standards on eating disorders and specifically anorexia and bulimia.

As a Government and a commission we fund the ABNA organisation, which is a voluntary one. We have provided a specific research grant for Dr Ben Tovin to survey the incidence of anorexia and bulimia in the community. I cannot recall the exact figure, but it is around $40 000 and in this budget we have provided funding to ABNA to employ a full-time therapist; so the position is significantly better than it was. I felt that it was grossly irresponsible of *60 Minutes* not to provide the information that it is possible to be optimistic. They showed bulimia in all its horror, as it were, yet did not put the countervailing case, which they should have done in any balanced program, that successful therapy is now available.

Ms LENEHAN: I have a short supplementary question relating to the answer given by Mrs Hardy. Will you briefly outline for the Committee how you see the supervised, independent living community houses and say how effective they are at the moment and whether you believe that there is some change in community attitude? You mentioned the situation at Semaphore regarding, if you like, a refusal by the council. I guess that could be said for most councils, in some cases reflecting community attitudes. Do you think that that is slowly changing?

The CHAIRMAN: The rules of debate very clearly state that a member must address questions to the Minister, and if the Minister desires to pass those questions on to one of his officers to answer then he is quite at liberty to do so. The honourable Minister.

The Hon. J.R. Cornwall: I thought for one moment I was up for a red rose. I was going to draw this to your attention, Mr Chairman, but, ever astute, you raised the matter first. It is obvious that members on the Government side do not accept these inducements, as I understand it. I think I can address the question generally, in the first instance. We have had some very bad experiences in the past 12 to 18 months in a whole range of areas of accommodation for disadvantaged groups in the community.

We have had a long and ongoing battle with residents at Ashbourne, near Strathalbyn, while attempting to set up a drug free therapeutic community. I am happy to say that that is now going ahead and I anticipate that we will have residents there within weeks. We had an ongoing battle with residents at Joslin when we updated the facility in Fifth Avenue, which has been in one way or the other a private psychiatric hospital or an alcohol and drug therapy unit, or a family living unit which was established by a former distinguished Minister of Health in a Liberal Administration. We had a battle with the West Torrens council about a group of flats which were established for young schizophrenics for community living.

Mr Becker interjecting:

The Hon. J.R. Cornwall: We are not having active trouble at this moment, but they did object after the facility was established, I might say, and supported. We have had problems with the Port Adelaide council over the proposal to establish a day centre to cater for the people who live in either psychiatric hostels or boarding houses in the Semaphore area. I know the Semaphore area very well, because I lived at 19 Claire Street, Largs Bay for five years back in the 1970s, at a time when we were a very tolerant community, and there are still many tolerant people down there. Unfortunately, we were forced to revise that program, and that was a great pity.

It is in general a matter which communities simply have to address. If we are going to shun the schizophrenics of this world, if we are going to shun people who are undergoing active rehabilitation with substance abuse programs, or from substance abuse problems, whether with alcohol or drugs, and if we are going to shun the mentally ill or the disadvantaged generally then we will reach a very sorry pass.

I understand and can appreciate the general attitude, 'It is all right if it is not in my street or my district': it is easy to be tolerant when it is in someone else's suburb. I place on record that, given the traditional tolerance and the civilised approach of South Australians generally and South Australia's reputation around this country for tolerance, we really will have to look closely at the prevailing community attitude, and if need be we will have to revise the planning legislation.

Ms LENEHAN: I refer to the southern community and something that I have long been involved with, that is, the provision of a range of health services and specifically the provision of a public hospital facility within the southern community. Can the Minister provide an update on progress in relation to the provision of a hospital at, say, Willunga within the southern community? I am particularly interested in the provision of public hospital beds in such an establishment.

The Hon. J.R. Cornwall: I am amazed that we are now an hour into the Committee and this question has only just arisen. The question of a public hospital or public hospital facilities in the south has been an ongoing saga of considerable dimensions since the mid-1970s. Many things are now happening which cause me to be optimistic. In fact, before my stewardship in the health portfolio concludes (unless I am called to higher places in the meantime) we should actually see some public beds in the Noarlunga area.

Very briefly, the Southern Vales Private Hospital will be partly commissioned and operating in the near future. The Noarlunga Health Village has been commissioned and is operating, providing arguably the most comprehensive range of primary health care services in the State for some considerable time. The question of a hospital on that site has specifically occupied our minds for something in excess of 12 months. There is a proposal to have a joint hospital complex involving both the public and private sectors. That has necessitated some very long but I am happy to say constructive negotiations with the unions. We had to be at pains to ensure that we did not build a complex and then find that we did not have industrial agreements in place which would enable the smooth functioning and smooth interchange between public and private parts of the complex. The last thing we wanted to do was build a monument to demarcation disputes.

Those negotiations literally went on at varying levels of intensity for almost 12 months. The position has now been reached where there is broad agreement (although some details still need to be filled in) that the public beds and the joint services will be operated by the public sector and the private beds will be operated by the private sector. The joint services will embrace everything from catering and cleaning and general hotel services through to operating theatres. The original intention and the intention to go into a joint hospital arrangement was announced, from memory, in August 1985.

The original intention was to find a joint venturer whereby the Government would finance its share from the normal capital works program and the joint venturer—the private partner—would finance the private part of the complex. We have been forced to revise that original position for a num-

ber of reasons, the most compelling of which is the reduction in capital allocation by the Commonwealth and the restriction on alternative fund raising placed on us by the Commonwealth. We have called for expressions of interest and have looked at a variety of permutations, combinations and possibilities. In an ideal world we would like to find a consortium that would be prepared to build the entire complex and for the public beds and joint facility part of the complex to be leased back to the Government through the commission with an option to purchase at some time specified in the future, and for the private facility to be leased out or indeed constructed by the consortium. It is not necessary for the consortium—that is, the builder—to also operate the private facility.

We have received a number of expressions of interest and we are currently negotiating. I am a little frustrated by the fact that I have not been able to take a firm proposal or a firm range of options to Cabinet by now. Originally my announced intention was to take firm options to Cabinet by the end of August or the beginning of September. That date has necessarily been revised and we are now looking more realistically at mid to late October. However, an amount of $1.5 million has been allocated to the Noarlunga project in the capital works program of the 1987-88 budget. We are proceeding apace with all the planning and, in the event that we are able to finalise a deal with one of the parties with whom we are currently negotiating, it will still be possible and I hope probable that we can turn the first sod on the site in around April or May next year.

Mr BECKER: The Minister claims that 2 839 new operation procedures are carried out because of the additional moneys provided to reduce waiting lists. Does that amount cover the reduction in budgets forced on major hospitals by the Minister this year?

The Hon. J.R. Cornwall: The number actually given by the Chairman was 2 131, and that was in 1986-87. If we are looking prospectively at the impact of the global budget allocations to the major metropolitan public hospitals this year, I was at pains to point out in my opening statement that in constructing the budget we looked specifically at areas that would have no impact or at worst minimal impact on patient services. In fact, what we have achieved in these negotiations by and large is productivity improvements and savings through productivity increases. For example, in looking at the way the budget is constructed you must take on board the fact that we have put in place an improved clinical career structure for nurses, which has meant that there are 200 additional senior nurses in the system. So they have been taken on board. There has been no reduction in the professional staffing area. We have looked at a whole range of areas from catering to cleaning, to give just two major examples where productivity savings were achievable.

The budget has been constructed principally on that basis. The additional money that has gone in to reduce or to target those categories of elective surgery for which there are unacceptably long waiting times will and must be specifically targeted to those areas. It is probably fair to say that one of the things that we learned from the strategy in 1986-87 is that unless one is specific some of that money at least seems to be absorbed into the global allocation or budget of individual hospitals. In order to ensure that that does not happen this year the hospitals are being given half of their allocations: that is, the allocations will be to 31 December.

They are being asked to meet specific targets and, in the event that particular hospitals do not meet those specific targets, we will want to know why, and one of the options that will be available to us will be to transfer funding to other areas or to other hospitals that are meeting their targets. At present with the commission and in consultation with the metropolitan public hospital group I am redefining a few important ground rules.

In future in matters of policy such as booking lists and waiting times, they will clearly be matters of responsibility for the Government, the Minister, and the commission. However, once we have agreed on strategies within hospitals they will have the responsibility not only morally but also publicly to meet their targets and, if they do not perform, questions will be asked of individual hospitals.

We are about to change the unworkable situation that arose during the past decade. I know that my predecessor suffered from this to the same extent that I have because of the ridiculous situation of holding the Minister of Health literally responsible for every trivial event or every event that happened in every hospital. Clearly, that is unworkable and it has to stop. The example that I now use—it may seem an extreme example in the South Australian context—is the Hospital for Sick Children in Toronto, Canada. I am sure that members will recall that a few years ago there was a mistake made in making up infant feeding formula, and salt was used instead of lactose, as a result of which several small infants died.

If that were to happen now in South Australia there would be immediate calls for the resignation of the Health Minister, and I have not the slightest doubt that the Minister would resign within hours. Yet it is foolish in the extreme to say that the Minister of Health can be responsible for the person who is mixing formulas at Adelaide Children's Hospital. What happened in fact in Toronto was that the only criticism that the then Minister of Health attracted was for not being tough enough on the hospital.

I do not want to change the rules around to the extent that the Minister is called on personally to publicly berate or kick every hospital in the State that fails to perform at top level. Seriously, we have to change some of the rules, because ministerial responsibility is a precious thing in the Westminster system, but we must be rather careful that we do not bastardise it to the point where the system becomes unworkable, specifically in health. I think that the Chairman of the Health Commission would like to comment specifically on the question of strategy for individual hospitals with waiting lists.

Dr McCoy: I simply comment on the level and accuracy of information that is available now to the commission, and then ask Dr D. Blaikie to comment on specific hospital programs.

Additional Departmental Adviser:

Dr D. Blaikie, Executive Director, Metropolitan Health Services.

Dr McCoy: First, I remind members that prior to 1985 no record of booking lists was maintained in the commission, nor were they easily obtained within hospitals. Since 1985 there have been manual collections and we have earlier reported on the numbers. In 1987-88 that information will be on a computer. I think $130 000 has been provided to develop a computer system; micro computers at Lyell McEwin, Adelaide Children's Hospital, Modbury and Flinders Medical Centre, and modifications to the admissions, transfers and separation systems at Royal Adelaide Hospital and Queen Elizabeth Hospital.

All of the waiting lists information is now on computer. I am advised that the first report should be available at the end of this month and that then the commission will have accurate and up to date information on the numbers on the

booking lists, the categories within which each patient is on the list, and the length of time that the patient has waited. This will enable the commission to have a much greater ability to direct activities to areas of significant need. I ask Dr Blaikie to comment on specific aspects.

The Hon. J.R. Cornwall: Before that, I have already announced my intention to release those figures every six months on a hospital by hospital basis. They will be computerised, they will be available readily and, as I have said, if the hospitals have not met their specific targets, I will want to know, the commission will want to know, the Opposition will want to know and, I hope, the media will want to know why that is so.

Dr Blaikie: I have been in my position for only a brief period and I was not involved with last year's strategy. As the Minister has already said, I can assure members that the strategy and implementation of the strategy will be a major priority this year. The significance is that hospitals will be required to demonstrate that they are taking the strategy seriously and are achieving results. That has been mentioned. It might be worth while to read from the letter that went out under my name to the CEOs of the major hospitals, as follows:

> To ensure that the Health Commission will achieve the stated objectives, it is intended to conduct a mid year review of each hospital's performance. Should your hospital be unable to demonstrate substantive progress towards the stated goals, the commission may transfer funds to another hospital in order to maximise effectiveness.

That has been referred to. I would like to give one additional piece of information. Part of the strategy this year is to transfer patients between hospitals where that is appropriate. In that regard I can point out that two hospitals that can demonstrate extreme efficiency in the treatment of patients from booking lists are Modbury Hospital and Lyell McEwin Hospital. They have been given increased allocations this year, for example, last year Modbury Hospital used only $33 500 of booking list funds but this year it has been given $451 000.

Lyell McEwin Hospital last year had an allocation of $272 000, and this year it has been given $499 000. Those two hospitals, and all hospitals, have been given extra computer funds, and Dr McCoy just referred to that. For the sake of the record, about $64 000 is going towards the computerising of the booking list at the hospital level. This morning I talked to Dr Kearney from Royal Adelaide Hospital, and I am pleased to say that the transfer policy is already beginning to germinate. Dr Kearney has already been through patients on the waiting list at Royal Adelaide, particularly targeting those patients waiting over 12 months.

Patient lists have been referred to the Modbury Hospital for ENT surgery and the Lyell McEwin Hospital for orthopaedic surgery. Given Dr Kearney's telephone call this morning, he expects that at least 50 patients in either category will be able to have procedures carried out at those hospitals. I can also say, without absolute proof at present, that the Flinders Medical Centre has agreed verbally with the Queen Elizabeth Hospital and also, I think, the RAH to perform eye surgery and ophthalmic procedures there. With the formation of a metropolitan division and a metropolitan hospitals coordinating group, there will be much greater cooperation between the hospitals this year. If I could be so bold as to say that we need it in the area of booking lists, we also need it in other areas. I am certainly looking forward to that sort of cooperation.

Mr BECKER: Of the promised $3.8 million, how much has been spent in the following disciplines at the Modbury, Lyell McEwin, Queen Elizabeth, and Royal Adelaide Hospitals in the past 12 months: general surgery, eye surgery, ear, nose and throat surgery, plastic surgery, and orthopaedic surgery?

The Hon. J.R. Cornwall: Dr McCoy will respond in relation to the $3.8 million.

Dr McCoy: I have a table that shows, by hospital, the breakdown of the 2 131 operations performed in 1986-87. Earlier today I cited the numbers for each hospital: 774 for the Royal Adelaide Hospital; 614 for the Flinders Medical Centre; 191 for the QEH; 477 for the Lyell McEwin; 23 for the Modbury Hospital; 28 for the ACH; and 24 in the private system. The total expenditure was $3.1 million. Moneys were also spent on the computer systems, to which I have referred, and the manual survey, bringing the total to $3.2 million.

I have information only on the number of operations. In general surgery 473 procedures were performed at the RAH, the FMC, the QEH and the Lyell McEwin; 207 eye surgery procedures were carried out, 68 at the RAH, 91 at the Flinders Medical Centre, and 38 at the QEH; 322 orthopaedic procedures were carried out, 141 at the RAH, 77 at the Flinders Medical Centre, 81 at the Lyell McEwin Hospital and 23 at the Modbury Hospital; 367 ENT procedures were performed, 110 at the RAH, 68 at the Flinders Medical Centre, 11 at the QEH, 150 at the Lyell McEwin Hospital, and 28 at the Adelaide Children's Hospital. I do not have the monetary figures for each category.

The Hon. J.R. Cornwall: They are the additional procedures we are talking about, those which could not have been done had it not been for the additional funding. Members should note that the amount expended was $3.212 million, as against the full year allocation of $3.82 million. Various strategies were developed by the hospitals in the period July to October, some being later starters than others, so the total amount in 1986-87 was not expended.

Mr BECKER: Supplementary to that, what are the details of surgery in the disciplines of general surgery, eye surgery, ear, nose and throat surgery, plastic surgery, and orthopaedic surgery at each of the Government hospitals?

The Hon. J.R. Cornwall: Does the honourable member want to know the total number of procedures performed for the entire year 1986-87?

Mr BECKER: Yes, and I would be grateful if the table that Dr McCoy used could be incorporated in *Hansard*. Will the Minister obtain details for each of those disciplines at each hospital in the last financial year? How much was spent at each hospital?

The Hon. J.R. Cornwall: The table is headed 'Number of people admitted as a result of additional funding financial year, 1986-87'. It shows a number of surgical categories, to which the Chairman has referred, the number of procedures by hospital, the total by procedure and both the total cost and the cost by hospital. I would be perfectly happy to incorporate that table in *Hansard*. At this stage I do not have a table that shows the total number of general surgical, ophthalmic, or neurosurgical procedures right across the board. About 700 are performed each week, every week, with the exception of the traditional Christmas shutdown for elective surgery.

At this stage that information would not be computerised, and it would take some time to obtain. I cannot give an absolute guarantee that we would have all of those figures by 9 October, the last day for incorporation of information in *Hansard*. However, I can give an undertaking that either the information will be provided and incorporated in any supplement to *Hansard* or alternatively, if it is not fully collated by that date, I would be perfectly happy to write to the member for Hanson and provide him with the details. I would be happy to provide them one way or another.

Mr BECKER: I would be grateful if the statistics could be tabled.

The CHAIRMAN: Can the Minister assure me that the table is purely statistical?

The Hon. J.R. Cornwall: Yes, it is, and I seek leave to have it incorporated in *Hansard.*

NUMBER OF PEOPLE ADMITTED AS A RESULT OF ADDITIONAL FUNDING FINANCIAL YEAR, 1986-87

HOSPITAL

Specialty	RAH	FMC	TQEH	LMc	MOD	ACH	Use of the Private System		IMVS	TOTAL
							QVH	TQEH		
General surgery	93	133	1	246						473
Ophthalmology	68	91	38					10		207
Neurosurgery	15	2								17
Orthopaedics	141	77		81	23					322
ENT	110	68	11	150		28				367
Urology	119	50	53							222
Gynaecology	82	122								204
Vascular surgery	49	36	23							108
Plastic surgery	77	30	43							150
Thoracic surgery	7									7
Cranio-facial surgery										
Other/Unknown	13	5	22				14			54
	774	614	191	477	23	28	14	10		2 131
Cost	$1 205 000	$1 200 000	$268 195	$272 000	$33 500	22 700	$10 000	$19 497	$67 300 (for Mod. LMc and RAH)	
Cost/Procedure	1 557	1 954	1 404	570	1 457	811	714	1 950		1 422
Total cost										$3 098 200

TOTAL EXPENDITURE 1986-87—BOOKING LISTS

	$
Procedures IMVS fees and private work	3 098 200
Computer booking lists	99 900
Manual survey	14 200
Total	3 212 300
Allocation 1986-87	3 549 000
	$336 700 not expended.

Mr BECKER: How many public patients were operated on in private hospitals under this scheme, in which hospitals were those operations performed and, in each of those private hospitals, how many operations were performed?

The Hon. J.R. Cornwall: In 1986-87, there were very few; I believe the total was 24. I think most of them were carried out at the Western Community Hospital, but I would not like to stake my ministerial career on that. There are two parts of a multi-pronged strategy that, we would have to say, were not taken up by the surgeons in 1986-87, and they are Saturday morning surgical sessions and the use of private hospitals. That does not mean that we have abandoned the potential of the private hospital system. A number of things could be pursued, including the calling for tenders from both surgeons and hospitals, and that is something we may pursue among many other options.

Saturday morning surgery simply did not suit the surgeons, not because of a lack of diligence but because most surgeons do their rounds in the public and private hospitals on a Saturday morning, in a sense tidying up the work of the week. I do not know how many surgeons are good golfers but on a Saturday morning we find most of our surgeons in the hospitals and not on the golf course. The proposal did not involve an organised 3½ hour session; surgeons wanted to use that time to do other things within their surgical practice, and the scheme did not commend itself to them.

The Hon. J.R. Cornwall: I do not believe that there will be any successful Saturday morning strategies. That does not mean, of course, that there are not other things which are beginning to work and which could work very well, I believe, in 1987-88 and beyond. At the end of the day, of course, I cannot stress too much that one cannot do surgery without surgeons, so we have to rely to a significant extent on the cooperation which we receive from the surgeons. I would like to be on the record as saying that, by and large, the cooperation has been fairly good. There are still one or two areas in which it could be better but, by and large, cooperation has been good.

Mr BECKER: Why are there small numbers of operations in private hospitals?

The Hon. J.R. Cornwall: I could speculate on that and perhaps allow myself that luxury, but I would then ask the Chairman to be more specific about it if he is able. To some extent, it is clearly an ideological thing. We have a profession and we have the surgeons who are anxious to maintain a balance between the public and the private sector. We have Medicare, which I enthusiastically support. I think it is the great social reform of the 1980s and I am happy to have been Minister during the period in which we have instituted it. The basis of Medicare is that you pay your levy and you are then entitled to treatment as an inpatient or outpatient free of direct cost at any one of our public or recognised hospitals.

A large number of doctors and a significant number of surgeons do not agree with that principle and do not agree with the principle of universal health insurance, in fact. They claim that, if you are in receipt of a reasonable or good income, then somehow or other we should be making it mandatory for you to insure privately and to use the private system to have your elective surgery. In the event, there are even those at the extreme—fortunately, not many—who have a vested interest in seeing the waiting lists burgeon, because they can then claim that the Medicare system is not working. I stress that that is a small number.

Certainly, there are some ideological obstructions. I think that is a pity in this State, particularly, because we have about as near as we can possibly get to a very good balance between the public and the private systems. At any given time there are a significant number of private patients in our public hospital system. That number varies between 20 and 35 per cent, depending on which hospital we are talking

about, but we are in that sense very flexible and anxious to cooperate with the profession to ensure that we have a mixed system. I might say that people who visit South Australia from overseas are very impressed by the balance we attempt to strike. By the same token, the occupancy overall in our private hospital system is not very much better than 60 per cent, so at any given time there is an excess capacity in the private system.

It seems to me that, subject to being able to prove the cost effectiveness of using the private sector, in the cooperative spirit for which South Australians are notable, we ought to be able to contract out to the benefit of everyone but, most particularly, to the benefit of the patients—who always must be and always will be my primary concern. I think that Dr McCoy might wish to add specifically to that.

Dr McCoy: I will add two points: first, I am told that by 6 p.m. this evening it will be possible to specifically answer the question of at which hospitals those 24 operations were performed, so we will be able to provide that information. To quickly add to what the Minister has said about the problem of having accepted the use of the private system, there is a money problem that I want to have further investigated, but the advice I have so far received is that the cost per operation in the private system would be considerably above most marginal costs in the public hospitals. I believe that there is room for further negotiation in that area, and I know that Dr Blaikie and others will work on that in this financial year.

Mr GROOM: I would like to congratulate the Minister on the very fine and sensitive way in which he handles this portfolio. I noticed that in his opening statement the Minister said:

> It is my view that in South Australia we deliver both health and social welfare services which are of a high calibre by world standards.

I think that that is commonly accepted in South Australia. One way of ensuring that those high standards are maintained is the provision of funding programs for medical equipment. Can the Minister outline to the Committee details of funding programs for medical equipment in hospitals?

The Hon. J.R. Cornwall: I will pass that to the Chairman for a specific answer in a moment. May I, however, respond to that somewhat fulsome praise from the honourable member. I will do it very briefly. I take no great credit for the fact that we have one of the finest health and hospital systems in the world. However, I do deplore what I sometimes refer to as the village mentality, which sees us almost continually getting into self-deprecation. The tendency to be self-critical to the point of destruction, both in the media and sometimes in the hospital system, is most regrettable.

Let us leave politics aside for a moment: we have overall one of the finest public and private health and hospital systems in the world, and I could not help but reflect when I was in Boston with the Chairman quite recently, in the complex of hospitals and institutions which comprise the Harvard Medical School complex, that—and we are not yet in the Harvard class, I have to make quite clear—because of the cooperative effort we can engender in South Australia, I think we are uniquely placed to not only create additional centres of excellence but also to promulgate the excellence of our centres. In terms of not only the organisation and delivery of health care generally but in the excellence of our hospital system, we have substantial opportunities (as yet unexplored) to play a major role in medical education and research on the world scene. With regard to the specific figures which the honourable member seeks, I ask the Chairman to respond.

Dr McCoy: The problem of technology and health care is one of which members would be well aware. The technological advances are all very expensive: most of the hospitals are wishing to keep up with technological developments, and it is a major factor in the increasing cost of health care. The injection by the Commonwealth Government of $12.6 million over three financial years has been a marvellous contribution to upgrading, replacing and expanding the technological base in our major teaching hospitals. The $12.6 million is over three financial years—1985-86 through 1987-88. An amount of $4.284 million was spent in 1985-86, $3.762 million in 1986-87, and $3.693 million will be spent in 1987-88, making a total program of $12.6 million.

There have been major contributions to the Adelaide Children's Hospital, the Flinders Medical Centre, the Queen Elizabeth Hospital, the Queen Victoria Hospital, the Royal Adelaide Hospital, and the Institute of Medical and Veterinary Science. Two major units, each costing $2.2 million—one at the Royal Adelaide Hospital for coronary arteriography and one at Flinders—have been funded through the program. A recent Public Accounts Committee report on the total asset replacement for Government indicated that in health there was a need for expenditure in the order of $50 million per year to be able to replace the capital plant and equipment that presently exists in the health system. I am pleased to say that we are now very near that level of expenditure.

In addition to that Commonwealth program, there is a smaller State program, and in 1987-88 an amount of $703 000 has been allocated for special items of equipment at Mount Gambier, at country laboratories of the IMVS, at Port Pirie, and at the Red Cross Blood Transfusion Service. That is not the end of the story. All hospitals have a substantial part of their operating budgets allocated to items of equipment costing lesser amounts. For example, it is estimated that in the budget of the Royal Adelaide Hospital—which is in excess of $100 million—at least $1 million annually would be spent on small items of equipment.

Additional Departmental Adviser:

Mr D. McCullough, Executive Director, Corporate Services, South Australian Health Commission.

Mr McCullough: Within the budget allocations of all health units, in particular hospitals, significant funds are available for equipment expenditure. The source of the considerable funds for equipment expenditure for the teaching hospitals, in particular the Royal Adelaide Hospital, is the Commissioner of Charitable Funds who has a responsibility for passing on to the Royal Adelaide Hospital in excess of $500 000 per year, the source of which is interest from bequests to that fund.

Mr DUIGAN: I was interested in the Minister's answer to questions asked by the member for Hanson about cooperation between public and private hospitals and the contracting out of some procedures from the public sector to the private sector, and I look forward to that process developing in the next few years. I was also interested in the figures given by the Chairman of the commission about the per capita expenditure in South Australia on a variety of programs. Obviously, those figures can be interpreted in two ways, and often are. The first way concerns the substantial allocation in South Australia to a number of very important programs, and suggests that the allocation to those various health programs is better in South Australia than elsewhere—and that is the positive aspect of it.

Is there any down side to an evaluation of those figures in terms of the establishment at a national level of standards

in the health area where South Australia might be seen to be over-servicing, so that the standard of services provided in South Australia might result in a reduction of specific purpose grants set out on page 23 of the receipts (there being 13 specific purpose programs there)? Are there any consequences to funding for the State of what could be seen as a high level of service of programs within the South Australian health system? Will the Minister, in responding, refer to one matter raised by the Chairman of the commission, namely, the allocation of hostel beds for the elderly, which is seen in South Australia to be much higher and is provided at a better standard than elsewhere in the country, and say whether that might lead to a reduction in support by the Commonwealth for South Australia's program?

The Hon. J.R. Cornwall: Basically two matters have been addressed by the member for Adelaide. One is the question of overall funding. There are a number of historical reasons why South Australia does enjoy some advantages. I always find myself on the horns of a dilemma on budget estimates day: do we come in and tell the world about this relatively high level of per capita funding, thereby prejudicing our negotiations potentially with the Under Treasurer and the Treasurer in subsequent budgets, or even drawing our Federal colleagues' attention to it? The answer to that is that the Under Treasurer and the Treasurer already know, and quite specifically as a Government we have taken decisions that the human services areas in these difficult times will be given priority. If one looks at how I have fared in this budget as Minister of Health, and particularly how community welfare has fared, one will see that the Government took a deliberate decision in framing the budget to ask for greater savings in other areas and to give a high priority to health and welfare. There are a number of other historical reasons, as I said, and one would hope that we would be able to maintain that advantageous position.

The provision of nursing home beds, in particular, and the funding of nursing homes, has always been a Commonwealth responsibility; they are funded 100 per cent by the Commonwealth. The directions in which it is moving for national uniform standards, and the measurement of those standards on outcomes rather than inputs, will have a significant effect on South Australia. There is no doubt that South Australia, and to very much the same extent Victoria, by regulation demand significantly higher levels of staffing, particularly nursing staff. Our standards are very much higher than Queensland's and significantly greater than those in New South Wales.

It is not our intention to pick up the tab for the difference as that would set a precedent that we simply could not live with. If we were to maintain or insist that we maintain our levels of staffing *vis a vis* the other States, and if we were to pick up the tab for that, it would cost the State an estimated $15-16 million. For obvious reasons we cannot do that. Hospitals are our responsibility and we service them well. Nursing homes are a Commonwealth responsibility. These matters are currently being negotiated. I think that the person in the best position to add anything more specific to what I have said is Dr David Filby with regard to the nursing home and hostel situation because in recent years he has represented the commission on any national planning bodies and has been most recently our officer involved in Commonwealth negotiations, so I will ask Dr Filby to comment specifically with regard to nursing homes and hostels.

Before he does that I must say that we in this State, in particular, are now leading the country in development of the home and community care program. There is a real revolution going on in this country in terms of home and community care for the young disabled and the frail aged. The joint Commonwealth/State contribution to home and community care this year in South Australia will be $25 million. That is money that simply was not there three years ago and is a lot of money by State standards in anybody's language. The administration of the HACC program has now been transferred administratively to the Department for Community Welfare and specific questions about that subject ought to be asked when the DCW representatives are here. Having said that, I ask Mr Sayers to comment on budget standards and then Mr Filby to comment on nursing homes.

Mr Sayers: I have a few comments in relation to the overall funding of the State's health services. I believe that there is always concern when the overall cost of health services in a particular environment, in this case the State, is above the national average. I am concerned because the high cost areas are, in fact, quite often subjected to very detailed scrutiny by financiers, in this case the Commonwealth Government, in particular. We are currently going through a Grants Commission hearing and next year we have to renegotiate the Medicare agreement. It is on those two counts that the commission is analysing the reasons behind the apparent high cost of the provision of health services in South Australia.

I believe that it must not be accepted that high cost means that there is a better standard, and it is in that context that the commission is trying to analyse the detail to understand where the money is being spent so that it is able to address each of the components where the costs are high. It must also be understood that the high cost does not represent in particular the high cost to the State Government for its component of hospitals and other State funding areas. The high cost referred to by Dr McCoy earlier referred to the total expenditure on health for South Australians including Medicare agreement payments, nursing homes and hostels referred to by the Minister, and other Commonwealth schemes such as the pharmaceutical benefits scheme. They reflect the total funding of health in South Australia.

It is on that basis that we must understand the statements in relation to the high cost. It is against that background that the Health Commission is concerned, but not overly concerned until detail has been analysed, and that is a high priority for the commission in the next year.

Mr Filby: As the Minister has indicated, the Commonwealth has expressed concern about the number of nursing home beds and the level of resources that it has to provide for those beds. It is worth noting that those beds have Commonwealth approval—the State does not approve them. Historically we have had more beds funded by the Commonwealth per head than have other States. As the Minister has said, there have been differing standards particularly in the nursing and personal care areas. The Commonwealth indicated in the budget 12 months ago a desire to move to uniform standards across the country and, in so doing, to establish a working party with the States to look at the issues associated with that. As part of the work of the working party, concern has been expressed about the way in which residents are classified in nursing homes and therefore about the level of resources applied for their care.

There are concerns about the components of the standards, what things should be included and what things should not and, of course, concerns about the level of resources that will be applied to individual nursing homes. It is anticipated that results of the work of that committee will be provided to Commonwealth and State Governments in the early part of the next calendar year. As I understand it, the Commonwealth proposes to make decisions on the level of

resources and the national standards to be applied in the year beginning 1 July 1988.

In addition, the Commonwealth has provided new guidelines for the number of nursing home beds it is prepared to fund. Those guidelines have been altered from 80 to 40 beds per 1 000 people aged over 70 years, on a regional basis. On that basis it has indicated its unwillingness to fund any new nursing home beds in this financial year and a limited number of those beds next year. It has, in respect of hostels, introduced for the first time the maximum number of hostels that it is prepared to fund. In that context, if I recall correctly, there are about 200 additional hostel places to be funded in this financial year.

The CHAIRMAN: If the member for Adelaide can ask his question in 2½ minutes, we will get the answer after lunch.

Mr DUIGAN: Can the Minister tell the Committee what is being done in terms of hospital based or employee based child-care facilities at major public hospitals and, ancillary to that, are any places able to be reserved for staff in community based child care centres located in hospitals in order to attract people with nursing qualifications back to the nursing profession?

[*Sitting suspended from 12.59 to 2 p.m.*]

The Hon. J.R. Cornwall: I believe that the member for Adelaide's question relates to hospital based child-care centres on the one hand and, on the other, the accessibility of community based child-care centres to hospital employees. I will ask the Deputy Chairman of the Health Commission (Mr Sayers) to respond.

Mr Sayers: Presently, the Royal Adelaide Hospital, the Queen Elizabeth Hospital, the Flinders Medical Centre and the Glenside Hospital each have a community child-care centre on site. Each of those are community centres and are not formally recognised as hospital based centres. The commission has undertaken much research and planning on the provision of child-care facilities at hospital sites in the past three years in particular, and more particularly over the past two years facilities at these four hospitals have been developed.

In addition, approval has been given for a centre to be built at Modbury during the current financial year, and some committees that are in place at the Adelaide Children's Hospital, the Queen Victoria Hospital, the Lyell McEwin Hospital, the Whyalla Hospital and the Julia Farr Centre are preparing plans for the provision of child-care centres. Further, the commission has formed a consultative committee on child-care so that it is appropriately advised on the needs of the hospitals. That committee is representative of the management committees of the existing centres and of the committees for the proposed new centres.

We have established a formal policy which has emanated from the consultative committee. It is in draft form and will be considered by the commission within a month. We have also recently surveyed hospital staff at the Royal Adelaide Hospital, the Queen Elizabeth Hospital, and the Glenside Hospital to ascertain the need for overnight and weekend child-care services. We are undertaking an additional survey of those health professionals who are presently not employed. It has been difficult for the commission to have a feel for the needs of health professionals who are not currently employed in the system so as to determine whether the lack of child-care facilities is a contributing reason for their not seeking gainful employment.

A joint Commonwealth-State review is under way, and the commission is participating in it as regards extended hours, in the sense of such extended hours being an extension of the day shift and not going into the night shift or the weekend. Extended hours currently operate within the Queen Elizabeth Hospital, the Flinders Medical Centre and the Glenside Hospital. From that it can be seen that much effort has been put into the provision of child-care facilities over the past three years. We are well advanced with our planning, and we hope in the next two or three years to be able to extend child-care facilities even further.

The reservation of places for hospital staff, especially nurses, has not been formally recognised at this stage. It is part of the draft policy and, once that policy has been adopted by the commission, the commission will pursue that aspect to have places in those community centres specifically reserved for hospital staff. That is not a reality now, but we are certainly working to achieve it.

The Hon. JENNIFER CASHMORE: How many people are on the waiting lists of the metropolitan teaching hospitals and the Lyell McEwin Hospital in the following categories: general, orthopaedic, urology, plastic, ophthalmology, and ear, nose and throat surgery? Can the Minister give the Committee the figures currently held by the hospitals as well as those currently held by the Health Commission? I gather that the two sets of figures are not identical. In each case, what was the comparable waiting list figure 12 months ago, again providing both hospital and Health Commission figures?

The Hon. J.R. Cornwall: At the outset of this post-lunch session, may I say that before lunch the member for Coles complained that the Committee had asked only a certain number of questions. However, I point out that the sort of question that she has just asked could easily be placed on notice. Such questions ask for great detail and we have been at pains to provide such detail this morning. Indeed, we have provided details of operations by category and by hospital, and we have provided just about everything except the doctor's name and residential address.

If this line of questioning is to be pursued, we will continue to give all the considerable detail that we have, but let there be no complaint at the end of the day that the time has been taken up in supplying scrupulous detail. I suggest that Committee members might consider putting at least some of these questions on notice. Regarding the alleged discrepancy (and this allegation has been made in another place by the Opposition spokesman on health), reference was made to a list produced by one hospital, the Royal Adelaide Hospital, and two procedures were involved, one being endoscopy and the other I cannot recall immediately. However, they are not surgical procedures in the generally understood sense of the term, and it is political nonsense and game playing to suggest otherwise.

Our criteria and categories are the same in the commission as in the hospitals. To the best of my knowledge, no discrepancy or query has ever been raised with the commission. If there has been, I should be pleased to hear about it, and I should also be pleased if the Chairman of the Health Commission would comment specifically on alleged discrepancies between the criteria used in respect of surgical procedures at the Royal Adelaide Hospital and those used by the commission, as well as presumably the great detail required by the member for Coles in her first question. Perhaps the Chairman could comment first on the alleged discrepancies between the criteria used by the commission and at least some leaky surgeon's criteria at the Royal Adelaide Hospital.

Dr McCoy: The figures before me have been prepared by the commission from information provided by the hospitals. I am unaware of any discrepancy between these figures and the hospital figures. Dr Filby advises that Dr Kearney

has recently confirmed with him that the figures I am quoting for the Royal Adelaide Hospital are those that he uses within the hospital. It may be that other people have other figures but, if that is the case, I am unaware of them. I will answer the question in detail, and quote figures as at July 1987.

First, in relation to general surgery, the figures are: Flinders Medical Centre, 217; the Royal Adelaide Hospital, 250; the Queen Elizabeth Hospital, 115; the Lyell McEwin Hospital, 102; and Modbury, 121. Secondly, the ophthalmology, figures are: FMC, 78; RAH, 411; QEH, 65; and no figures are shown for Lyell McEwin or Modbury. Thirdly, in relation to orthopaedics, the figures are: FMC, 239 (and that figure includes 124 kept separately in the centre's records and not given to the commission, so that number has not been included in the comparative waiting list figures that I reported earlier); RAH, 555; QEH, 334; Lyell McEwin, 72; and Modbury, 99. Fourthly, in relation to ENT surgery, the figures are: FMC, 219; RAH, 322; QEH, 305; Lyell McEwin, 249; and Modbury has none, according to this report. Fifthly, in relation to plastic surgery, the figures are: FMC, 221; RAH, 280; QEH, 117; none are shown for the Lyell McEwin; and Modbury, 19. Finally, in relation to urology, the figures are: FMC, 222; RAH, 121; QEH, 384; Lyell McEwin, 58; and Modbury, 65.

The Hon. JENNIFER CASHMORE: I point out to the Minister that the Opposition may have various reasons for asking questions in various ways, but all we really want is an answer. I refer to Kalyra. I have in my possession a copy of a letter to the Chairman of the Health Commission from the James Brown Memorial Trust Incorporated dated 15 September 1987 which in summary states that the commission failed to have prior consultation with the management in regard to relocation to Windana. Within two weeks of indicating that decision to relocate, the commission withdrew its decision and the Government then decided to use Daw House at the Repatriation General Hospital without consulting staff at the Repatriation General Hospital or at Kalyra. Evidence produced in the letter clearly indicates that the claim that $12 million was needed to raise Kalyra to an acceptable standard was false—

The Hon. J.R. Cornwall: Who signed the letter?

The Hon. JENNIFER CASHMORE: The letter is signed by Dr Lawson, as I recall.

The Hon. J.R. Cornwall: Who is the Chairman of the trust?

The Hon. JENNIFER CASHMORE: W.S. Lawson is the Chairman of the trust and the letter was sent to the Chairman of the Commission. As I was saying, evidence was produced in that letter indicating that the claim that $12 million was needed to raise Kalyra to an acceptable standard was false and misleading, that only $175 000 was needed, and that the James Brown Memorial Trust was prepared to meet this. The letter also indicated, as the Committee and the community would know, that Kalyra compares favourably with any palliative care institution interstate and can be regarded as a model for Australia.

Why did the Government make the original decision that Kalyra was unsuitable for hospice care, and will the Minister table all documentation and advice that led to that decision? Why did the Government not discuss with Kalyra management its decision to relocate patients and staff from Kalyra to Windana, and why did the Government abruptly change its mind two weeks after the announcement and decide that Windana was unsuitable? Will the Minister indicate the source of advice that led to that change of heart?

The Hon. J.R. Cornwall: I will respond briefly to some of the allegations in the letter and some of the inferences in the honourable member's question, and I will then ask the Chairman of the Health Commission, who has had primary carriage of these matters, to respond. First, the figure of $12 million which has been used quite recklessly by Dr Lawson and members of the Opposition is the estimated replacement value of that part of Kalyra which is now used as a hospital. The figure of $175 000 in terms of a complete refurbishment of the hospital is laughable.

As to the suitability or otherwise of Kalyra for hospice care, I point out that hospice care is not about and must never be allowed to be about institutional care. Institutional care is part of the hospice movement, but hospice involves a multi-disciplinary approach and, above all, it involves keeping people in their own homes, in their own communities, and with their extended families and loved ones for as long as is reasonably possible. It is all about keeping them comfortable, it is about death with dignity and, as I have always said, it is the hallmark of a caring and civilised society. I would have thought that this would be the last thing that should be dredged up and dragged about as some sort of base political issue. I do not treat it as such but, if others elect to do so, they have the problem—not me.

With regard to tabling all correspondence, this matter has been touted about again by the Opposition at some length as though there was something to fear or something to hide. I assure the Opposition that there is nothing to fear and nothing to hide whatsoever. However, I am not about to set a precedent by tabling all the information on every subject that it cares to raise before this Committee or in either House of Parliament. I hasten to assure the Opposition that there is absolutely nothing sinister about it. The decision to defund Kalyra—and it is not a question of cutting it by $800 000; it is a question of defunding the hospital operation of $3.4 million—was taken on the grounds of cost saving.

We happen to have spare accommodation at Julia Farr which is suitable, as I am advised, for rehabilitation and convalescent patients, and there are certain clinical advantages in relocating to Julia Farr. We happen to have been negotiating developing closer links between Flinders and the Repatriation General Hospital ever since the member for Coles was an interim Minister of Health. If there is one advantage above all others in the proposition to have the services organised about the pain clinic at Flinders, about Daw House (which is the proposed area for relocation) and to have all outreach services organised about those two institutions, it is the fact that it cements the developing relationship between Flinders and the Repatriation General Hospital.

It is not a matter of opinion but a matter of policy that both this Government and the Federal Government hope to see in practice a twin hospital campus within five years between Flinders and the Repatriation Hospital. That makes an enormous amount of sense from every possible point of view. It will be essential in that arrangement that the veterans continue to be given the preferential access which they were promised and which they have always enjoyed. That is by no means difficult.

It is also most important that the veterans, who in the next 10 to 15 years will become the frail aged and a significant percentage of the frail aged in our community, have access to the best possible hospice services. It is a reality of life and a fact that the RSL Congress earlier this year passed a resolution urging that none of its members be sent to Kalyra. That resolution refers specifically to the fact that Kalyra physically was in poor condition. That is not to suggest by any means that the services provided at Kalyra have been other than first class but, when there is a genuine

full year's saving of $1 million to be made without any detriment to patient care, that is called managing the system. As to the specifics of how the proposal was developed, is being developed, and who took the significant decisions—clinical and otherwise—at various points. I ask the Chairman to respond.

Dr McCoy: I earlier referred to the requirement placed on the commission to make managed savings of $9.1 million. Also, I earlier referred to the strategy that the commission adopted and recommended to Government in meeting that objective. Part of that strategy was to relocate the services from Kalyra in order to make savings of $800 000 in 1987-88 and $1 million in a full year. This is an imporant rationalisation in the provision of health in hospital services in South Australia that the commission believes will lead to a maintenance of existing services at a large saving to the taxpayer.

The commission also believes that it will lead to significant improvements in patient care. The commission holds those views because transferring the rehabilitation beds to Julia Farr Centre will provide excellent physical facilities in a centre that has spare capacity. Julia Farr Centre is a major State nursing home with on-site medical and other professional back-up support. The Julia Farr Centre is convenient to Flinders Medical Centre and Royal Adelaide Hospital from its location, and it has recently affiliated with Flinders University.

The relocation of hospice service from Kalyra to the Repatriation Hospital at Daw Park will see it being placed in a hospital that is progressively integrating its services with Flinders Medical Centre. That strategy conforms with the longer term objective to integrate the whole Repatriation Hospital system into the State health system sometime in the 1990s. That program has been foreshadowed by the Prime Minister and has been discussed at ministerial committees by the Minister for Veterans Affairs.

The development of a hospice service, as the Minister has said, is a high priority. Indeed, it is the highest priority—development of the Repatriation Hospital at Daw Park—and it is supported enthusiastically by the management of that hospital. It will be located in a very congenial environment, one that is almost unique for a major metropolitan hospital. It is located in an environment that is very centrally located in the southern suburbs. It is very well served by public transport and it will provide an appropriate location. It has the ability to provide an appropriate location for the staff of the Southern Hospice Care Association, and for the proposed share in paliative care.

Of course, it is sited in a larger general hospital that can provide full back-up support and a 24-hour medical emergency care service. For all of those reasons the commission believes that the rationalisation is sensible and will save a considerable amount of operating costs, and ultimately will lead to improvements in patient care.

As to the questions, I will address them separately. The first question is why the commission believed that Kalyra was unsuitable. The decision made by the commission was not based on any assessment that the services provided at Kalyra were sub-optimal. As I have already said, it was simply based on the fact that a substantial saving in operating costs could be made and more appropriate locations for the two services could be put in place.

The second question asked why it was not possible to discuss this matter with Kalyra before the decision was made. The commission was required to present to Government a range of options in the 1987-88 budget strategy. It was not possible for the commission to discuss those options until Government had decided on the strategy to be implemented. As soon as Government made that decision discussions were held with the Chairman and the Administrator of Kalyra Hospital and with other interested parties.

As to why there was a change in mind, I am not absolutely sure that I understand to what the change in mind referred. The commission has not changed its mind. On 20 November 1986, I had a meeting with Dr Bill Lawson and Mr Mike Bendyk, Chairman of the board and administrator, respectively, of Kalyra to discuss its future. It was a general discussion, but at that time I suggested to Dr Lawson and Mr Bendyk that in the longer term it would be desirable for Kalyra to seek a role in extended care and to progressively withdraw from the acute hospital service area.

During 1986 and earlier in 1987 there had been numerous written and verbal discussions between representatives of Kalyra and the commission that had generally focused on the need for Kalyra to reconsider its role and to consider a new role in extended care and to withdraw from hospital service provision. At that time I might say of that discussion in November 1986 with Dr Lawson, the commission was not aware of the financial climate for 1987-88 and had not developed a special plan for the change in Kalyra's services in this financial year.

Further, on 23 January 1987 I had a meeting at Flinders Medical Centre with Professor Geffen (the Dean of Medicine at Flinders University), Professor Chalmers, Dr Maddocks, and Mr Blandford (the Administrator of the Flinders Medical Centre) to obtain advice from Flinders University and Flinders Medical Centre about their desire to develop an academic position in palliative care. That meeting was held over lunch, and during the discussions it was suggested that the ultimate destination of the hospice at Kalyra would be better placed at the Daw Park hospital. That view was supported by all those present at the meeting.

I should say again that at that meeting in January 1987 there was no formal commission plan to make major changes in the context of the 1987-88 budget and, therefore, it was discussed as a future rather than an immediate possibility. The answer to the question, 'Why has there been a change of mind?' is that there has not been a change of mind by the commission regarding the future role of Kalyra. The honourable member asked who provided the advice, and the answer is, 'The commission.'

The Hon. JENNIFER CASHMORE: How much will it cost to alter Daw House and the Julia Farr Centre to a point where they can provide suitable accommodation for hospice care and rehabilitation care respectively?

Dr McCoy: The estimates of cost have not been finally worked out. Members may know that a number of alternative plans have been considered in relation to the relocation of services from Kalyra. Only last week a firm decision was made to relocate the rehabilitation service at Daw Park into another part of that hospital and, therefore, not to transfer it to the Julia Farr Centre. It has been estimated that the capital expenditure on the Julia Farr Centre would be about $135 000, and capital expenditure at Daw Park may well have to be made in two phases, the first phase involving about $300 000 and the subsequent phase involving about $120 000. If those figures were correct, there would be a total capital expenditure of $555 000. I repeat that these are not estimates that have been derived from careful architectural assessment of either location, and no quotations have yet been received for the work.

The Hon. J.R. Cornwall: That must be seen against a recurrent saving of $1 million a year in 1987 dollars, and that is not bad value—and without any reduction in nursing hours.

Ms LENEHAN: I noted recently in the media some disquiet and discussion about the provision of services in relation to Aboriginal health. I also note that the Minister has expressed concerns about the provision of services in this area. I relate my question to two areas of the budgetary process. The first is preventive and enabling services (page 286 of the yellow book), and I note that one of the specific targets for 1987-88 is the provision of funds for a study of the water supply for the Oak Valley Aboriginal community. Can the Minister delineate some of the concerns and problems he sees in relation to the provision of health services in the Aboriginal community in South Australia? Secondly, does the Minister see the future provision of services encapsulated in a preventive health model, and to what extent does he see the whole question of the social justice strategy being part of the provision of services for the Aboriginal community in South Australia?

The Hon. J.R. Cornwall: The position in 1987 is that all of the non-metropolitan Aboriginal communities of any substantial size in South Australia (and I refer to communities of 500 or more people), with the exception of Whyalla, have Aboriginal community health services. Specifically, there is the Nganampa Health Service, which provides services to the communities in the Pitjantjatjara lands in the North-West for an estimated population of about 2 000; there is the service at Yalata/Maralinga; there is a service at Ceduna/Koonibba; there is the Pika-Wiya service based on Port Augusta and Davenport, providing outreach services to Nepabunna; there is also a network of services in the metropolitan area; and there are a variety of individual services to small Aboriginal populations around the rest of the State, whether at Gerard, Point Pearce, in the South-East or in other places.

In 1983 there were literally no Aboriginal community health services; there were literally no doctors in the Pitjantjatjara lands; there were certainly no services comparable in any way with Nganampa, Pika-Wiya, Ceduna/Koonibba, or Yalata/Maralinga. There was an Aboriginal Health Organisation, which was a body incorporated under the South Australian Health Commission Act with its own board comprised mainly of Aboriginal representatives, although, from memory, at that time there was still two very supportive European members—and that is no reflection on them whatsoever.

We have now reached a point where, with the exception of Whyalla (and I believe that that area could be adequately serviced by an extension of the Pika-Wiya health service), the remaining small communities could best be served by ensuring that there are either Aboriginal health workers or Aboriginal liaison officers attached to the local hospital, with Aboriginal representation on the boards of those hospitals and with those services being conducted primarily, wherever practical, by Aboriginal people as an outreach, as we conduct many of our community health services generally from country hospitals. In that way we are now well placed to be able to say that outside Adelaide we would have a comprehensive, well organised series of Aboriginal community health services.

At this stage might I draw the attention of the Committee to the fact that I have been joined at the table by Mr Tim Agius, the Coordinator of Aboriginal Health Services within the South Australian Health Commission. As I see it, that is the way we ought to go, the way in which we must go in the next 12 to 24 months. At the same time we can and will ensure that Aboriginal health services in the metropolitan area continue to be expanded and coordinated. That raises four further points. First, how should the health services be organised so that they can be community controlled in the active and positive sense of the term rather than manipulated and rather than being controlled communities?

I have not the slightest doubt that the most effective and efficient services are run by organisations like Pika Wiya, which is, in fact, incorporated under the South Australian Health Commission Act and, as such, enjoys the same status as, say, a country hospital or community health centre. It has its own all-Aboriginal board. As does any other board in an incorporated situation, the board enjoys a very significant degree of independence while at the same time enjoying the very considerable support of all the resources of the South Australian Health Commission in organisation and management. At the same time there are clear lines of accountability so that the taxpayers, as well as the Aboriginal communities, know precisely where the money is coming from and where it is going at any particular time.

This is a personal view I express at the moment, but I certainly am initiating discussions with the Regional Officer for the Department of Aboriginal Affairs, and intend to put this proposition in general terms, at least, to Gerry Hand, the new Federal Minister for Aboriginal Affairs, as soon as we can reasonably get together. I think Nganampa Health and Yalata/Maralinga ought to be incorporated under the Health Commission Act, which would give them a chance to function as well as Pika Wiya and Ceduna/Koonibba.

In the event that we then have a well organised system which is very responsive to local Aboriginal communities, and each of those services has a board of directors or a representative on a board of directors so that the local Aborigines are genuinely heard—and not someone who purports to speak for them in Alice Springs, Adelaide or, specifically, in Norwood—then I think we can start genuinely talking about Aborigines controlling their own destiny in terms of health. It is for that reason that I believe very strongly that the Aboriginal Health Organisation, which served as a very useful organisation when we were in that period of transition from the old Aboriginal Health Unit to the current situation, has now outlived its useful life, in general terms. Within my proposition something like 20 Aboriginal health workers and others are involved in direct health delivery out there in the small populations scattered around South Australia. They would continue but would be directly responsible to the local organisations.

As to the people who currently are at Norwood in administrative and planning capacities—and some of those capacities, I might say, are not particularly well defined at this stage—it is my strong view (and I shall put it to the State Government and the Federal Minister for Aboriginal Affairs) that the sensible thing to do would be for DAA to subcontract to the South Australian Government and, through the Government, the South Australian Health Commission; that we should put Aborigines in the heart of the commission where it matters; that senior Aborigines like Tim Agius ought to find senior positions in the Planning and Policy Division of the commission, for example, where the real decisions are taken; that a person of the calibre of Tim Agius—and I am not nominating him to the position, I make it clear—ought to be on the executive of the commission, where the real action is. It is the executive, after all, which tells the Minister what he ought to do—and, just occasionally, we reverse that process. The executive, apart from the commission itself and the Commissioners, is where the real action is, and that is where the Aborigines ought to be represented, not sitting out in Beulah Street, Norwood. I hold the very strong view that that is the way we ought to go, and that is the way everybody, particularly all of those Aborigines, will get the best value.

With regard to the general state of the health of the Aboriginal population in South Australia at this time, it remains something which is a matter of very deep and serious concern to me. I hope that it is a matter of deep and serious concern to every South Australian who thinks about it. There are a number of reasons why, in some areas at least, there has been no significant improvement despite the fact that we have had both federally and at State level more goodwill at Government level than we have had since Federation, in the period of four years since 1983.

The simple fact is that we will never substantially improve the health status of Aborigines if we simply provide them with a medical service, or if we make them—as I believe Nganampa Health has, by and large—dependent on going to the doctor. There is a general feeling that you always get sick, you have to go to the doctor, you get your medicine and then, hopefully, you get well. Nganampa, considering that in this coming year it will have a budget approaching $3 million and a total staff of around 60 people (including five doctors), has clearly failed to do enough in the area of preventive health.

That is one point. The other point is that, until we improve the environment and take a social view of health for the Aborigines, just as we are developing the social view of health in our policies for the white population, progress will be very slow and very frustrating. We must do more about a timely and relevant education. We must do more about basic and essential services, such as clean water, waste disposal, transport, public housing and public shelter that is appropriate. I am not talking about three-bedroom brick veneer housing which might be perfectly appropriate in the member for Mawson's area but, I think, are not particularly relevant in the Pitjantjatjara lands, Yalata or Maralinga. So, all of those things need to be addressed by both the State and Federal Government. Neither of us can eschew our responsibilities in all those areas.

Until such time as we do, there is no point in the State Minister of Health sitting at the end of the line and picking up all of the pieces, all of the failures, because we are not coordinating our services in all those other areas. We have reached a very interesting watershed. It seems to me that there is general agreement at Government level—both State and Federal—that that is the way we must go. That is the general scenario.

It can and will involve Aboriginal communities in having a very significant say in their own destiny. It will not—and I cannot stress this too strongly—whenever I have any say in it, involve asking communities of 200 or 250 people in remote areas to act in a way or at a level of sophistication which would not be possible in Burnside, Norwood or Springfield. The notion that community control somehow means that you get a small group of Aborigines and tell them that they are responsible for everything that moves in their own community quite clearly has to be a nonsense.

One can imagine what our reception would be if we went tomorrow to the Kensington and Norwood council or Noarlunga council and said, 'From this moment on you will be responsible for running the Flinders Medical Centre, all the schools in your area, all the medical services in your area, the roads, the sewerage works and so on.' They simply would not have the resources or the sophistication to do it. If they cannot do it in Noarlunga, quite frankly, they cannot do it in Mimili, Fregon or Nepabunna or any of the other remote Aboriginal services.

We now know how to do it, and people who have put obstructions—for whatever reasons—in the way of our achieving that will be removed. They will not be permitted any longer to obstruct, and we will get on with the whole business of looking at environmental health, taking a social view of health, and reorganising with the local communities in close consultation with the local communities the way in which that is developed. It is also my intention, in 1988-89, to recommend to my colleagues in Government that Aboriginal health, social welfare, and Aboriginal affairs generally, be made a priority issue for the Social Justice Unit and the Social Justice Advisory Council.

Ms LENEHAN: The yellow book at page 283 deals with 'Services mainly for mothers, children and adolescents'. I note that in this morning's paper the Minister last night commented, at the Family Planning Association's Annual General Meeting, about families, children, love and marriage. Under '1987-88 Specific Targets/Objectives' it states:

> Continued development of the approved Child Adolescent Mental Health Service in metropolitan and non-metropolitan areas.

This is one of the 'Major Resource Variations' in the last section on that page. What further developments in CAMHS will take place? What is planned in the southern region for the coming 12 months?

The Hon. J.R. Cornwall: The Child Adolescent Mental Health Service is a service in which I had a fairly direct hand and is something of which I think we can be reasonably proud. In the south CAMHS is organised from the Flinders Medical Centre, but it is increasingly a State-wide service, and in the north it is organised from the Adelaide Children's Hospital, but again not only operates in the suburbs to the north and west of the ACH but is increasingly a State-wide service. Dr Blaikie will explain how the CAMHS teams are organised, where they are placed, and how they deliver the services.

Dr Blaikie: The origin of CAMHS dates back to 1983 and this service has received a high priority since that time. This current year additional funds of $170 000 will be allocated to CAMHS and the full year's funding will be $250 000. Since 1985-86 something like $1.7 million has been allocated to CAMHS. As the Minister explained, there are two CAMHS teams, one in the north and one in the south. The southern team is based at the Flinders Medical Centre and the northern team is based at the Adelaide Children's Hospital. It is a true integration of community services and hospital services, and although it is a very new model it is a model that I am assured is working very well. The CAMHS outfits in the south and north are quite different in their organisation structure. As a bureaucrat even I can tolerate that. I think that that is a good thing and I think that we will be able, in time, to evaluate the performance of both teams and perhaps learn from that.

In the southern area there are multi-disciplinary teams at Oaklands, Morphett Vale and the Flinders Medical Centre. The overall operational budget for those teams this current year is somewhere in the order of $1.2 million. Besides their service roles, they have a teaching role and they are involved with medical students at the Flinders Medical Centre, clinical psychology students and psychiatric students. Both the south and north have country outreaches. Specifically, the southern area provides services through visiting Department for Community Welfare officers at Mount Gambier, Mount Barker and the Murray Bridge Hospital.

The Hon. J.R. Cornwall: Five years ago CAMHS in this State was in a mess, and we shared that with the rest of Australia. I am not making any particularly derogatory remarks about South Australia at that time. It was very difficult to recruit child psychiatrists, and the services in some areas were at best rudimentary and in other areas did not exist. Not only do we now have a fully organised and expanding CAMHS, but I am pleased to say that we have recruited to the first Chair in Child Psychiatry in this State

Dr Robert Kosky, from Western Australia, who has an outstanding national reputation. We have come a long way since the end of 1982 in child and adolescent mental health.

Mr DUIGAN: At the end of your answer to the question asked by the member for Mawson you referred to the Social Justice Advisory Committee. I notice that in program 3 on page 279 of the Program Estimates the major components for the price variation between 1986-87 and 1987-88 were for the development of a social justice strategy within the Health Commission. Will the Minister link the identification of that item (on page 279) to the reference he made to the Social Justice Advisory Committee?

The Hon. J.R. Cornwall: The social justice strategy is not a social welfare strategy. I cannot say that often enough, and all of us should keep repeating it. It is about every Government agency, whether it be departments, commissions or authorities, making their contribution. They will be required, at the end of the budget cycle each year—this year it will be 30 November, but in subsequent years it will be 30 September—to report to me as Chairman of the Human Services Committee of Cabinet (for the time being) on what they have done in their agency for that particular year.

We were at pains to explain in a very early seminar at which each of those agencies was asked to send a senior representative—whether Mines and Energy, State Development, the Health Commission or any other agency—that they contribute, participate and prepare their annual report for the Human Services Committee, and thence to Cabinet. The social justice strategy at the State level is about redistributing opportunity. I do not want to go, tempting though it is, into a long policy statement, but basically that is what it is about. In order to see that every Minister made a commitment to this and that every Chief Executive Officer understood the depth of that commitment, the Social Justice Unit, which is the biggest unit in the Cabinet office, is being funded by a contribution from every agency in the State Government ambit.

The exact formula eludes me for the minute, but it is of the order that agencies with budgets up to $20 million contribute a certain amount as do agencies with budgets of $20-$50 million, $50-$100 million, and over $100 million a pro rata amount: so the budget (with one exception of an AO1 project officer who was transferred to the unit from community welfare, which picked up her salary), including the rest of the salaries, on-costs and administrative costs, something in excess of $200 000, is contributed to pro rata by every agency and every ministry in the Government, and that includes, particularly, the Premier.

The Hon. D.C. WOTTON: Will the Minister say why the Premier, in a letter dated 20 August 1987, made the following statement:

> The physical facilities at Kalyra are very poor and in need of replacement whereas the facilities at Julia Farr and Windana can provide patients with good quality care in more modern surroundings—

when that was quite obviously untrue? I have a copy of the architectural advice which indicates quite clearly that it was untrue.

The Hon. J.R. Cornwall: That question is verging on the unparliamentary. It is also stupid. The Premier wrote that letter having taken the best advice available to him and it is factual. Kalyra is an old tuberculosis sanitorium which has been showing its age. One can have a deep affection for it, and I respect anyone who has, but physically it is very ordinary. If the honourable member wants to pursue this matter further, I am happy to refer it to the Chairman for further comment because he and members of the commission would be more *au fait* with the specific details of the physical condition of Kalyra. I do not think that we will get anywhere if we pursue this line of political questioning. I am shocked that members of this Committee are attempting to use it as a political forum.

I ask the Chairman of the Health Commission not to comment on the allegations that the Premier told untruths, because they are beneath contempt and I do not ask my professional officers to comment at that sort of level because it is totally improper, but in terms of the physical facilities at Kalyra *vis-a-vis* Julia Farr, I ask the Chairman to make an objective assessment.

Dr McCoy: I have not previously talked of capital costs in relation to this matter, because they are not known. I can report that Mr John Milliken, Principal Architect in the commission, who has enormous experience in the restoration and building of country hospitals, which are very similar in a physical respect to the hospital at Kalyra, has advised the commission that to bring that 70-bed hospital up to a standard that we normally require in a country town would cost millions of dollars—the figure of $12 million has been used.

I must say that that is not a precise costing of the development plan that is being presented, but it is clear to him, as is clear to me from my experience in working with country hospitals for a long period in restoring their fabric—and I am not talking about tarting up a country hospital but rebuilding the fabric, that is, replacement of the infrastructure of the sewerage pipes, electrical systems, introducing modern fire detection systems, and the like—that it would cost of the order of millions of dollars. One of the considerations of the commission in its decision on Kalyra was that by withdrawing funds from that hospital it was avoiding the inevitable need for major capital expenditure on that site.

The Julia Farr Centre is a very fine building. The required changes to its structure are of a minor nature. Daw House, which is part of the Repatriation Hospital, is earmarked for hospice development and needs funds spent on it. I have already given a preliminary and rough estimate of those costs, which certainly fall far short of the amount required to bring Kalyra up to modern-day standards.

The Hon. D.C. WOTTON: On 9 September 1987 the Minister advised this Parliament that in the scheme presented by Kalyra Hospital savings would be achieved by reducing by one hour the number of nursing hours per patient per day for all of the convalescent and rehabilitation patients. This in his view would involve a significant reduction in the level of nursing care. Will the Minister detail the methodology by which the hospital's management intended to achieve this efficiency which in their view would not compromise the high standard of patient care provided at Kalyra? Will he also advise the basis upon which the Kalyra Hospital methodology has been rejected by the South Australian Health Commission?

I believe that the St Margaret's Hospital located at Semaphore operates a rehabilitation and convalescence service like Kalyra, utilising around 3.2 nursing hours per patient per day which is some 41 per cent below the level that the Minister maintains is a suitable standard and some 16 per cent below the level recommended by Kalyra. Why, then, is the Minister reducing the budget allocation to St Margaret's by some $20 000 this year when he should be increasing it by hundreds of thousands of dollars to upgrade it to a level of patient care that the Minister considers appropriate for rehabilitation and convalescent care?

The Hon. J.R. Cornwall: Let me make perfectly clear that, in matters involving administration, I obviously do not get involved in the day-to-day conduct of health serv-

ices—it is a spurious and ridiculous notion. If this Kalyra business is to continue, then one has to presume that it is, *de facto*, a vote of no confidence by the Opposition in the Chairman and Deputy Chairman of the Health Commission, the Executive Director of the Metropolitan Health Services Division and in all of the other most senior officers of the commission who have advised on this matter and who put forward the rationalisation of Kalyra as part of the management and productivity plan in devising the 1987-88 budget—it is called 'managing the system'.

It seems to me quite incongruous that we have a Liberal Opposition which at every opportunity talks of cost savings and at every opportunity talks about taxes and charges that are imposed upon the citizens of South Australia in order for us to deliver at least minimum standards in areas such as health, education and welfare—they never relent. It is like a broken record all the time—it is about cost savings; it is about waste and inefficiency—yet, here we have a classic case in point of a building that is past its useful life and would cost millions of dollars to restore and adequately refurbish—as the former Minister of Health would know because I have seen her plaque on the Kapunda Hospital.

That is a magnificent old bluestone building which has been fully restored and refurbished, but that was done at a colossal cost. One of the things that I have determined will come to an end (and it has virtually come to an end) is that we do not provide Rolls Royces any more when we can get away with Holden Commodores. We certainly do not reburbish, at a cost of millions of dollars, buildings that have come to the end of their useful life, when we have other facilities with excess capacity. We have vacant beds at the Julia Farr Centre.

By and large because of the positive management of the system, we have the capacity to put those patients into locations where there is already senior management and senior administration and where the fabric of the buildings simply cannot be compared to an old tuberculosis sanatorium that has reached the end of its useful life, unless taxpayers are willing to spend many millions of dollars on its refurbishing. That is what it is about at the end of the day.

It is not just a decision by an officer or officers of the Health Commission to inflict pain and suffering on the James Brown Trust or on any individual member of it. There are no conspiracy theories. There has been no attempt suddenly or uncharacteristically to mislead the Minister into taking action that is other than in the interests of the good management of the system. It is as simple as that.

I wonder whether members of the Opposition have not at some stage pondered why the Royal Australian Nursing Federation has been so silent in the matter; simply because the RANF realises that it is in the interests of its membership to be working in situations that are physically superior. The federation also realises that we have guaranteed preference in employment to any staff at Kalyra who wish to transfer either to Daw House or to Julia Farr Centre. Obviously, if there was this spontaneous protest arising from everyone, the RANF, which is a strong and sensible professional and industrial organisation in this State, would be knocking my door down to get in. I ask the Opposition to ponder that.

We have had sensible cooperation because we have explained what we are about. We have guaranteed that the staff will have continuing employment, and we have explained to them, because at least as health professionals they can understand, what we are about in managing the system for the benefit of the patients, the health professionals, and the taxpayers of South Australia. Regarding the specific proposition put forward by Kalyra to effect cost savings, such savings fell far short of what was claimed. It certainly did not save $1 million as we are doing by managing the system in the way that we propose. It certainly involved a reduction in nursing hours per patient. I ask the Deputy Chairman, who has considered this specifically, to explain the two issues: the reduction in hours, and the actual financial cost savings available as a result of that reduction in service.

Mr Sayers: First, concerning a comparison of patients between hospitals, the patients in every hospital differ, so direct comparisons cannot be made without a dependency study. The method of assessment of patients' requirements in relation to nursing hours (that is, the patient dependency level) is measured by the system operated by the Community Systems Foundation, a Sydney based non-profit organisation that most of our metropolitan hospitals use for the assessment of nursing hours per patient per day.

In relation to patients at Kalyra, the CSF system has been used and the patient dependency assessment has been made at 4.3 hours per patient per day. The Kalyra hospital in one of its alternative plans has recommended that it reduce the number of hours from 4.3 to 3.75 nursing hours per day: that is, 0.55 hours per patient per day below the accepted standard in metropolitan hospitals. I am unaware of the CSF methodology being used at St Margarets, and the only way in which we could accept that as a true comparison would be if the same patient dependency criteria had been used to enable such a comparison to be made. If 3.2 hours per patient per bed is the standard at St Margarets, I can only assume that the patient dependency is totally different and that a totally different type of patient is accommodated there. However, no direct comparison can be made unless the patient dependency study used is identical.

The Hon. D.C. WOTTON: Can the Committee be provided, on notice, with the funding proposals that indicate that there would be a saving on the relocation of patients to Windana and Julia Farr and, more recently, to Daw House and Julia Farr?

The Hon. J.R. Cornwall: I suggest that, since those questions are specific, they should be placed on notice in the normal way rather than asked through this committee. If the member for Heysen or any of his colleagues would care to put a multiple part question on notice, we should be pleased to respond.

The Hon. D.C. WOTTON: I do not see any difference. The Committee is meeting today, and I ask that the information be made available to this Committee.

The CHAIRMAN: The Chair is in the position that Committee members may ask questions and elicit information, but it is entirely up to the Minister how questions shall be answered. The Chair has no power to order the supply of information.

The Hon. J.R. Cornwall: I was only trying to help the honourable member but, since he does not appreciate the Christian spirit in which my offer was made, I will undertake to get the general information and respond to the general question. However, he will not receive the same sort of detail as he would have received had he had the common sense to put the question on notice in the normal way. In the time available (and there are enormous time contraints) it would have been far more sensible to put the question on notice and, even if it took another three weeks, we could go into the more specific details but, if he does not want it that way, that is his problem, not mine. I have no problems.

The Hon. D.C. WOTTON: Can the Minister confirm that another 25-bed nursing ward is to be closed at the

Hampstead centre as a result of budget cuts, recognising that ward 2A was closed last year for economic reasons? I understand that ward 2D is to be closed from 1 January next year. I am informed that the Royal Adelaide Hospital has appealed twice to have the ward remain open, but its appeal has been rejected on both counts. The RAH has a great need for gerontic services. Will the Minister explain the reason for the closure of this important part of the service to the aged, and will he also explain what he thinks is going to happen to our increasing ageing population, especially as he has talked so much about the desperate need for gerontic services?

The Hon. J.R. Cornwall: The ward will certainly be closed as part of the Royal Adelaide Hospital's own strategic plan to get out of long-term nursing in the medium term. I ask Dr Blaikie to contribute anything that will help the member for Heysen.

Dr Blaikie: As the honourable member said, I know that 25 beds were closed last year with the approval of the Health Commission. Certainly in relation to the allocation, as both the Chairman and the Minister have pointed out, the Royal Adelaide Hospital has suffered a specific cut of $700 000. Part of that cut related to the fact that it might consider closing beds. To the best of my knowledge there was no specific direction that it close beds at the nursing home. As the Minister pointed out, the Royal Adelaide Hospital, as part of its strategic plan (which will soon be finalised), is very adamant that it will get out of the long-term nursing home provision and that the beds that remain at Hampstead will be for rehabilitation, geriatric assessment, and respite care; and the spinal injuries unit at the Morris site at Hampstead will move into the beds that have just been vacated as long-term nursing home beds.

As a newcomer it seems to me that it makes a lot of sense to have a complex out there which concentrates on rehabilitation and those aspects of medical care that a hospital such as the RAH should be involved with, and I have no concern that that is a reasonable and sensible approach. I have spoken with Dr Kearney from the RAH and he tells me that it has specifically employed a social worker to manage the decanting (if I can use that awful term) of patients from those beds. No-one will be forced out of those beds—it will be a progressive closure. The RAH anticipates that, with the help of the social worker and liaison with families and other care providers, the whole process will take at least until Christmas if it is to be done in a dignified and sensitive fashion. I have Dr Kearney's assurance that that will occur, and I hope it does.

Mr GROOM: I go back to elective surgical procedures. Can the Minister say what is a cystoscopy and what is an endoscopy? Are they normally classified as elective surgical procedures?

The Hon. D.C. WOTTON: This is a budget estimates committee.

The CHAIRMAN: Order! The Chair will determine whether or not questions are applicable, and I rule that this question is applicable.

The Hon. J.R. Cornwall: It is a relevant question and anyone with an IQ in excess of 75 would immediately see its relevance.

Members interjecting:

The CHAIRMAN: Order! The Committee will come to order.

The Hon. J.R. Cornwall: The simple fact is that, on the basis of some cooked up document which was delivered in a plain van to the Opposition spokesman on health, it has been alleged that there is a discrepancy between the categories and classifications used by the Health Commission right across the metropolitan public hospital system to assess, on the one hand, booking lists and waiting times and, on the other hand, what is used at the RAH. In other words, the allegation is that the commission and senior commission officers conspired to cook the books. That is why this question is relevant—it is a direct slur on senior officers of the commission. The vast majority of people would not know in specific detail what is an endoscopy or a cystoscopy and indeed some may not even know how to spell them.

I think this question is important because, as I understand it with my simple veterinary training, they are not surgical operations as understood by the ordinary, common, or reasonable person. I happen to have the good fortune to have on my right Dr McCoy who, apart from his primary qualifications from the University of Adelaide Medical School as a radiologist, also has a fellowship as a medical administrator. Dr McCoy has specialist medical qualifications, and I think he can define in simple terms a cystoscopy and an endoscopy, and he may be able to respond in the most objective and non-political way to the allegation that members of the Health Commission have cooked the books.

Dr McCoy: It is a long time since I did an endoscopy so I cannot claim any personal professional knowledge. First, an endoscopy is a general term to describe a procedure whereby a medical practitioner (and I think it would always be a medical practitioner) places a tube into one of the orifices of the body in order to see the inside lining, mainly of the gut but also of the trachea and the lungs. I am advised that it is now possible to put fibre optic guides down those tubes in order to take photographs—and even moving photographs—of the internal lining of organs. It is also possible to take biopsies through endoscopes. It may also become a reality—and for South Australia's sake I hope that it happens quickly—that a laser institute will be developed in South Australia to deliver laser treatment through an endoscope inserted into a body orifice.

Secondly, a cystoscopy is a similar procedure whereby a doctor places usually a narrower tube through the urethra (that is, the outlet to the bladder) into the bladder usually in order to visualise polyps or cancers that have been treated by one means or another to determine whether the treatment has been successful or whether there has been any recurrence.

Referring to the question of booking lists and whether or not they include endoscopies, the booking list procedure that we have been talking about today has arisen from what we refer to as the Kearney report compiled in 1985. The commission has followed the recommendations of that report whereby only operative procedures—that is, procedures that require the attendance of a surgeon (and I think I am correct in saying that they always require a general anaesthetic, although some procedures may be performed under local anaesthetic) are monitored. Under the system we are not monitoring the procedures that I have discussed on a number of occasions today—endoscopies of the gut, which are generally performed by physicians or gastroenterologists, and cystoscopies which are performed by urologists and some surgeons.

Membership:

The Hon. Ted Chapman substituted for the Hon. D.C. Wotton.

Mr DUIGAN: Can the Minister advise what action is being taken by the commission to facilitate discussions between the boards of Queen Victoria Hospital and Adelaide Children's Hospital to effect an amalgamation of their operations and their locations on one site?

The Hon. J.R. Cornwall: I will be brief on this matter, although it is a matter of considerable importance. The boards of the hospitals were probably prompted by the development of diagnostic related groupings (DRGs) and children's diagnostic related groupings (CDRGs) to look objectively at their future viability. In the case of Adelaide Children's Hospital, that was done against a background where the average length of stay is something less than half what it was 10 or 15 years ago. With good management it has come from being a hospital of 300 to 350 beds with a potential for further development to a hospital effectively with about 186 beds. That is because of good paediatric management: it is something that has happened around the world. When one gets a paediatric centre of excellence in a city the size of Adelaide in a State with a population of fewer than 1.4 million people, one really has to assess one's position. The hospital board, management and staff began to look hard at where they were likely to be in five and 10 years time and beyond.

At the same time the catalyst for the Queen Victoria Hospital was not only DRGs and looking at its budget situation in the longer term and its viability in the longer term, but it also had to prepare a submission for the Parliamentary Public Accounts Committee, for what would have been in the event probably not more than a significant but not major refurbishment of the existing hospital at Rose Park. They concluded that that was not going to achieve a great deal and they initiated talks with each other. As I say, the catalyst on the one hand for the Queen Victoria Hospital, was the Public Accounts Committee and the fact that it really had to take a good, hard look at the fabric of the hospital and its future and, for the Children's Hospital on the other hand, looking at its long term viability.

In the event, there were very constructive discussions and they came to the commission and me and started talking about amalgamation. The amalgamation discussions were initiated by the hospital boards, certainly with the enthusiastic support of senior officers of the commission, but at the time they came to me it was their suggestion. It was never mine—let me make that clear. I would love to be able to take all the credit for it, but the credit lies with the commonsense of the boards and with senior health administrators.

The position is ongoing: the discussions are ongoing. I do not want to canvass the specifics of the outcome. Suffice it to say that the way things are progressing I would anticipate that it is entirely possible and indeed probable that there will be one board, an amalgamated hospital on two campuses, with one chief executive officer within 12 months.

As to the building program for the relocation of the Queen Victoria Hospital facilities and other facilities which might be involved in the development of the women's and children's hospital, they are matters that clearly need far more specific planning and discussion. I hope that by 1993 or thereabouts—towards the end of my third term as Minister of Health—we will have a consolidated women's and children's hospital of world class on the campus of the Adelaide Children's Hospital. It is also entirely possible that during that time we will see the development of a world class paediatric research institute on the same campus, so it is all very exciting.

Mr DUIGAN: My second question relates to one of the community health programs in the city of Adelaide, the Second Story. In the supplementary information provided by the Minister for the estimates, I note that under 'Community Health' the allocation for the Second Story for 1987-88 is $429 689, which is just over a 10 per cent increase on the amount allocated in the last financial year to the Second Story. Is the increase related simply to increases in the salaries of the Second Story staff or is there an extension of the programs being run out of the Second Story, for adolescents, and what is the nature of those extra programs?

The Hon. J.R. Cornwall: There are three things. First, the Second Story in its formative years was something of an experiment in adolescent health. We looked at a whole range of areas in which kids needed support and where that sort of support was not forthcoming. We also had to work out our relationship with other agencies which were providing services to adolescents. They ranged through the voluntary sector from the Service to Youth Council to the Hindley Street project. Incidentally, we did find that people involved in services to adolescents tend to be both territorial and proprietorial, that one of the problems that we have in the human services area as to adolescents generally is coordination.

It is for that reason that we have undertaken what is widely known as the inner city kids project, which has run for the past three or four months, pulling all the strands together. As part of that, the Second Story will become an integrated part of wide-ranging services to adolescents. It is fair to say that to date it has played a very useful role. There is now a changing emphasis in some ways towards more specific things such as family planning, counselling, medical services, and so on, and we have also had a couple of additions to the board. There is also a new Acting Administrator. Dr Blaikie will comment specifically and briefly on the types of service that will be provided from and by the Second Story in 1987-88 and on the changing emphases.

Dr Blaikie: I cannot explain the difference in the funding allocation referred to by the member for Adelaide. To the best of my knowledge, the Second Story has not received any initiatives this year. The honourable member is right; I have just looked at the figures. To the best of my knowledge, it should have received the same treatment as every other unit. I will have to take the question on notice.

The Hon. J.R. Cornwall: Might I suggest that some of that might be resources for the Drug and Alcohol Services Council or for extra drug counselling. We will have to take that question on notice.

Dr Blaikie: I can certainly add that the Second Story is receiving capital funds this year for minor modifications to improve client areas, but I cannot explain the recurrent operating budget difference. I have just been informed that extra funds were provided to extend opening hours. The Second Story was established in September 1985 and in the initial period it was open from only 3 o'clock to 7 o'clock on Wednesday and 3 o'clock to 9 o'clock on Friday, but now it is open more extensivly—from 12 o'clock to 8 o'clock Monday to Thursday and from 4 o'clock to 9 o'clock on Friday. As the Minister has said, the Second Story is an innovative and experimental project, and it is fair to say that it has faced some difficulties over the years—for instance the influx of college students into the program. I think the Second Story is going so well that we should consider putting on a third story—I have been waiting for some time to use that joke!

The Second Story is considering its role in relation to youth services in the city of Adelaide. Although it is still in the developmental stages, it is looking forward to and is in the process of targeting the groups identified by the Department for Community Welfare study into inner city kids. It is looking forward to playing a very close role with the Hindley Street project. It has certainly reached the conclusion that it must contract, to an even greater extent than at present, services with other agencies such as the Child and

Adolescent Mental Health Service (to which I referred previously) and the Drug and Alcohol Services Council.

Originally, the Second Story tried to be all things to all people, and it is now realising that it cannot fill all needs. It is one body within an integrated network of youth services throughout the city of Adelaide. The number of client contacts has increased significantly since it has been open. The Second Story has formed close working relationships with the Hindley Street youth project, community health centres, and women's health services, and, from contact with clients and its own questionnaires, it is picking up people who have not had contact with other agencies, clients with multi-problems who have not been picked up in the network. The Second Story sees itself very much as a health facility, and that is important. It has a health emphasis, and its whole basis, its *raison d'etre*, is health education in the broader sense. I hope that that answers the honourable member's question.

The Hon. TED CHAPMAN: Has the Minister or his department considered introducing the diagnostic related group system of reimbursing hospitals in South Australia which, I understand, applies in Victoria and which is widespread practice of reimbursement to Government and Government assisted hospitals in America? I ask that question after noting the Fifty-seventh Annual Report of the Southern Districts Hospital. I believe the Minister and his department would be acutely aware that financial embarrassment has and is currently being experienced by the board of management of that hospital in making ends meet.

I recognise, of course, that a number of district and subsidised hospitals around South Australia are facing difficulties, but one hospital in particular is facing difficulties as a result of its changing service role in relation not only to the local South Coast community but also the ever growing number of tourists who from time to time require services at that institution. I am sure that the Minister, or at least his department, recognises the position. As a matter of policy, has the Government considered, and favourably considered, the DRG system of reimbursement in this State?

The Hon. J.R. Cornwall: We have been involved in adapting and developing the DRG system for use as a tool in a number of areas, including funding allocations, for about two years. The system was developed in the United States. It has particular attractions and involves some difficulties, in the paediatric area, for example (and I referred to this matter some little time ago). With children's diagnostic related groupings there are waiting times because paediatric institutions stand alone and, in particular, are more expensive to run. I will not take up the time of the Committee, because the Deputy Chairman is very much hands on in this area and I would be pleased to have him explain to the Committee how we are developing DRGs and the importance we attach to them.

Mr Sayers: Diagnostic related groups are being used by the commission at present but not as a prospective payment system for hospitals. In the last financial year we used the DRG methodology as a measurement of output performance of hospitals and we used the methodology in association with a new fund allocation model that we are presently developing for the hospital system.

The DRGs relate to the inpatient component, and there are a number of items of expenditure within a hospital which do not lend themselves to the application of the DRG model. Also, the DRG methodology, as presently structured, has some weaknesses in stand-alone paediatric hospitals and in the output measurement for the ageing, and modifications are being worked on, certainly in North America but more particularly in the Eastern States (Victoria and New South Wales), so we are using them.

We do not plan to use them as they are in America at the moment for prospective funding of hospitals, but we plan to progressively introduce DRG methodology into our funding formulas for hospitals over the next five years, using them more and more progressively over that time.

Membership:

Mr Plunkett substituted for Mr Duigan.

Mr BECKER: My question relates to Aboriginal health. In view of the chronic morbidity suffered by the Pitjantjatjara people in the far North-West of South Australia, as has been documented successfully by the Nganampa Health Council, why has the council's funding been reduced progressively over the past three years?

The Hon. J.R. Cornwall: It has not: it has been progressively expanded.

Mr BECKER: Can the Minister say how it has been expanded? The figures I have show that in the financial year 1984-85 the budget was $3 215 000; in 1985-86 it was $2 920 000; and in 1986-87 it was $2 824 000.

The Hon. J.R. Cornwall: You have been severely misled. I trust that it was not the Opposition spokesman on health who gave you those figures. In fact, I am sure it would not have been, because he is usually scrupulously careful with his information. The fact is that since 1983-84, which was not a full year, of course, if we go through to 1987-88 the level of funding from the Health Commission from 1983-84 increased every year until 1987-88. I think that the best thing I can do is read to you directly, because this is the very latest information I have from the commission and the DAA. We ought to put this Glendal Schrader nonsense to rest for all time, because, frankly, it is a gross distortion of the truth.

In December 1983-84, the year that the Nganampa Health Service started, it received $777 000 in recurrent funding from the Commonwealth Department for Aboriginal Affairs. That was for the seven months from December to the end of June, representing a full year total of $1.3 million. Over the next three years funding was increased to $1.7 million, $1.8 million and $2.1 million. In 1987-88 (the current financial year) the Department for Aboriginal Affairs has allocated in the order of $2.2 million to Nganampa, which represents a 30.6 per cent increase in recurrent funding since 1983-84. That is documented fact from the Commonwealth Department for Aboriginal Affairs, and that is after taking into account the effect of inflation.

In real terms, taking the base 1983-84 full funding equivalent of $1.3 million and taking the funding in 1987-88 of $2.2 million, remembering that the Department for Aboriginal Affairs is the principal source of funding for the Nganampa Health Council, the funding has increased by 30.3 per cent. With regard to the Health Commission's contribution, in 1983-84—again remembering that this is seven months funding only—the initial amount was $175 000; in 1984-85 the full year funding was $396 000; in 1985-86 it was $418 000; in 1986-87, $430 000, and in the current financial year, $455 500. Nganampa has had consistent increases in funds both in dollar terms and in real terms ever since it was established in 1983-84. It is wrong and it is mischievous for Mr Schrader or anyone else to suggest that they have had funding cuts.

Mr BECKER: I take it that the figures you have given me are the total amount of funding given to the Nganampa Health Council? The figures I have here indicate that in 1984-85 the Department for Aboriginal Affairs gave Ngan-

ampa $2 739 000; the South Australian Health Commission gave $399 000; and the Department of Employment and Industrial Relations, $77 000, making a total of $3 215 000. That is how they make up that figure.

In 1985-86, the Department of Aboriginal Affairs provided $2 502 000; and the Health Commission, $418 000, totalling $2 920 000; in 1986-87, Aboriginal Affairs, $2 394 000 and the Health Commission, $430 000, totalling $2 824 000. That is why I am having difficulty in reconciling the figures. Do you have a schedule which could be given to the Committee and incorporated in *Hansard* clearly showing what the situation is and what the reason is for all the grants in question?

The Hon. J.R. Cornwall: I can read the figures. I think you have some of Mr Schrader's creative accounting there, frankly. Without having a breakdown of it, you have thrown in Department of Employment and Industrial Relations money, for example. Whether or not that was pertaining to Aboriginal health workers, I do not know. The figures I have come directly from the DAA, and I have no reason to doubt their validity. I am prepared to read specifically into *Hansard* the amounts that have been provided to me and the analysis of funding for Aboriginal health services in South Australia as it applies to the Nganampa Health Council. In 1983-1984, DAA, $926 000 and SAHC, $175 000, totalling $1 101 000; in 1984-85, DAA, $2 072 000 and SAHC, $396 000, totalling $2 468 000.

Mr BECKER: Can I just interrupt there: what I have in Department for Aboriginal Affairs for PHS in 1984-85 is $667 000. What would that be?

The Hon. J.R. Cornwall: Pitjantjatjara Health Service, or whatever that might be. In 1985-86, DAA provided $2 101 096 and the Health Commission, $418 000 totalling $2 519 096; and in 1986-87, DAA, $2 394 300, and the Health Commission, $430 000, totalling $2 824 300. I have given you the prospective figures for DAA in 1987-88 which are not yet finalised but are of the order of $2.2 million. The Health Commission figure is $455 500.

When one puts that together one is looking at something in the order of $2.7 million in total for this year. As to the other sources of funding, whether they might come from the Aboriginal Development Corporation or the Department of Employment and Industrial Relations (or whatever other source) and whether they were one off grants or for whatever reason, I cannot say: all I can tell you is the DAA figures which are provided to me. They are audited figures and have not been invented, and I have the Health Commission figures for which I am able to vouch.

If there are capital moneys or one-off grants from whatever source, I would be pleased to have the figures provided to us so that we can have them analysed. However, it is absolutely untrue to say that there have been funding cuts to the Nganampa Health Council. If the honourable member will provide me with those figures I will have the regional office of the Department of Aboriginal Affairs—which is not my responsibility, but I am perfectly happy to act as the honest broker—look at it. I assure the honourable member that I have been assured—and accept the assurance of senior officers in the Department of Aboriginal Affairs, including the Regional Director—that there have been no funding cuts for the Nganampa Health Council.

Mr BECKER: I will give the Minister a copy of the document so that he can have it checked. It appears to me that the Department of Aboriginal Affairs is combining the figures of the Nganampa Health Council and the Pitjantjatjara Health Service. It has been cut back because it goes from $2.7 million in 1984-85 to $2.5 million in 1985-86 and to $2.3 million in 1986-87. If my information proves correct I will ask the Minister to make representations to the Federal Government to restore the funding level to the Nganampa Health Council so that it is not disadvantaged.

The Hon. J.R. Cornwall: I am not going to make representations to the Federal Government to do anything, except to ask the Nganampa Health Council's coordinator to get their house in order. Once that happens we will be able to start talking about improvements in environmental health and other things. We are not going to have the white agitator—Schrader—descend from the north with horror stories on an intermittent basis, demanding money with menace. That is not the way in which we do business.

The Hon. JENNIFER CASHMORE: I have a copy of an agreement relating to the establishment and operation of the Nganampa Health Council. I assume that the Minister is a signatory to that agreement?

The Hon. J.R. Cornwall: From my recollection the agreement was never signed by all parties. This is the 1983 agreement?

The Hon. JENNIFER CASHMORE: Yes. Was it signed by you as Minister?

The Hon. J.R. Cornwall: It was never signed by all parties. I cannot recollect specifically whether I signed it, but it is not a matter of any moment. As far as I was concerned it was certainly an agreement entered into in good faith.

The Hon. JENNIFER CASHMORE: I prefaced my question with those preliminary questions to establish whether or not it was signed. It binds the Department of Aboriginal Affairs into a funding relationship with the Nganampa Health Council. Does the Minister accept that the 1983 agreement with the Governments is a valid and operable document?

The Hon. J.R. Cornwall: I do not think that it ever had any force at law or otherwise, as I recollect, because not all parties signed it. I invoked one of the clauses which said that the operation of the Nganampa Health Council should be reviewed after a period of three years and earlier this year its operation was reviewed. I sighted an early draft of that report and I would expect that within a month or two a final document will be available to me.

The Hon. JENNIFER CASHMORE: Why has not DAA funding continued as was indicated in 4 *(b)* (ii) of the agreement, that is, that the calculation of funding will be on the same principles, and has the Minister any knowledge of why DAA has unilaterally varied the funding arrangements without giving the Nganampa Health Council 12 months prior written notice, which was a condition laid down in the agreement?

The Hon. J.R. Cornwall: This is the most absurd thing that I have ever heard since I have been attending Estimates Committees. A member is coming in here making quite unsubstantiated allegations about a Federal department and is asking a State Minister to answer—

The Hon. JENNIFER CASHMORE: The agreement binds the State Minister as well. That is why the question is being asked.

The CHAIRMAN: Order! The question has been asked. The Minister can answer in any way he desires.

The Hon. J.R. Cornwall: I just did, Mr Chairman.

Ms LENEHAN: Page 280 of the Program Estimates concerns 'Services mainly for the aged and physically disabled' and states:

> Additional resources for the extension of domiciliary care services were provided through the Home and Community Care Program (HACC)...

It goes on to talk about that. I support the direction that HACC is taking, namely, to ensure that the elderly are maintained in their own home for as long as possible.

However, there comes a time in everyone's life when they need nursing home facilities.

The background papers indicate that the progressive relocation of Magill Nursing Home services and facilities to Elizabeth has commenced. The southern area from Brighton to Victor Harbor—and I will restrict myself to the southern CURB region—has two nursing homes with deficit funded beds, the Perry Park Nursing Home and one at Victor Harbor. I continually have elderly constituents and their families coming to see me about the desperate need for nursing home accommodation in their community. In fact, it is impossible to get anyone into the Perry Park Nursing Home. I note a previous answer by the Chairman that South Australia has 5.5 nursing home beds per 1 000 compared with the national average of 4.7. However, my view is that there is a misallocation of beds.

New and expanding areas, such as in the south, have few deficit funded nursing home beds. I am aware of the Federal Government cutting funding for nursing homes. To redress this we can go in one of two directions: first, we can change the CURB regions to make them more relevant to population distribution and expanding population; or, secondly, the Health Commission could actively encourage the progressive relocation of nursing home services from the inner city areas (which are well serviced)—and this is where we get the 5.5 per 1 000 head of population—into areas where they are needed. I ask this question—and I have been asking it for five years now—not only on my own behalf but on behalf of all Parliamentarians in the southern region, including the Federal member, because we have adopted a united approach to this matter, which is one of grave concern to the southern areas. Can the Minister give people some hope about a couple of proposals that I believe are being examined by a joint Federal/State committee, or is it possible to actively encourage those nursing homes established in the inner suburban areas to relocate their services in the southern community?

The Hon. J.R. Cornwall: It is not a matter that directly impacts on the State Government or the South Australian Health Commission, as I made clear earlier in the day. The provision and financing of nursing homes has traditionally been the province of the Federal Government. I am pleased that the member for Mawson has approached the member for Kingston asking him to make representations to the Federal Minister, because that is where the action ought to be. I find in relation to nursing homes that we really have to be in them or out of them; the State has for a long time been left sitting on the barbed wire fence, as a certain geriatric politician in Queensland would once have said.

The licensing and inspection of these nursing homes is done by local government, financing is provided by the Federal Government, and the State Minister sits on the fence being kicked by all parties. I am happy to make representations about this matter. It is not easy, however, to physically relocate nursing homes. It is one thing to relocate the beds, but if a nursing home of substantial fabric is located in the eastern suburbs and one wants to relocate it in the southern suburbs, then it is not just a matter of saying, 'We want to transfer the beds'; there is real estate to contend with—the cost of buildings, and so forth.

I have conveyed my views on this matter consistently, as has Dr Filby, who was on the Federal/State coordinating committee and who was able through that forum to put my views and the views of the commission, but at the end of the day it is a matter of 'he who pays the piper calls the tune' and, frankly, we do not pay the piper. I am very sympathetic to this cause, which the member for Mawson has now been espousing for a long time, as there is a paucity of nursing home beds in the south *vis a vis* other areas in metropolitan Adelaide and particularly the eastern suburbs. It is something which most certainly ought to be addressed in an orderly fashion. I undertake to raise personally this matter with the Minister of Community Services and Health, with whom I meet on a regular basis, but I am obviously unable to give an undertaking on behalf of the State, because nursing homes are not an area in which I have any direct influence.

Ms LENEHAN: I thank the Minister for his answer. There was no criticism of the State Government intended as I am aware of the circumstances. However, one looks for friends wherever one can find them. My next question relates partly to the other end of the age spectrum. At page 283 of the yellow book there is reference to services mainly for children, mothers and adolescents. In the 1987-88 specific targets and objectives in relation to major resource variations for the coming financial year, the establishment of a basic prenatal genetic diagnostic program, namely, the recombinant DNA technology, a joint project between the Adelaide Children's Hospital, the Flinders Medical Centre and the Institute of Medical and Veterinary Science, was listed as a target. As a member who represents a growing area a large proportion of whose residents are in an age group that is starting families and having children, I would like further information about just what that means in terms of on the ground services for expectant mothers.

The Hon. J.R. Cornwall: I ask the Chairman to respond to that question as it is specifically about allocations to a specific program.

Ms LENEHAN: Can the answer be related to the southern community in terms of the Flinders Medical Centre's involvement in this program?

The Hon. J.R. Cornwall: I do not think we can as it is going to the Adelaide Children's Hospital.

Ms LENEHAN: There is mention that the Flinders Medical Centre is one of the joint participants in the project.

Dr McCoy: I am able to comment briefly. A sum of $80 000 is allocated in the commission's 1987-88 initiatives to develop recombinant DNA technology in prenatal diagnosis and to establish prenatal genetic diagnostic services and counselling services. I believe that initially they will be at the Adelaide Children's Hospital, but there are certainly efforts being made to integrate the genetic functions at the Adelaide Children's Hospital with those at the Flinders Medical Centre, so I hope that there will be some effect for people living in the southern suburbs, although I believe that the major expenditure will be at the Adelaide Children's Hospital in this financial year.

Ms LENEHAN: Does that answer mean that expectant mothers in the southern community will have to travel to the Adelaide Children's Hospital for this type of testing or to be involved in this program, or will the program be operated in some way through the Flinders Medical Centre?

Dr McCoy: I cannot answer that question and need to take advice on it. The main laboratory testing I believe will be done at the Adelaide Children's Hospital, but it may well be possible for specimens to be taken at the Flinders Medical Centre, but I am not absolutely sure of that.

The Hon. J.R. Cornwall: Those answers from me as Minister, and to a significantly lesser extent from the Chairman, were not terribly satisfactory. I am sorry that we do not know about that $80 000 in our $1 927 million budget with great accuracy, but we will find out within days, and I undertake to provide a more comprehensive and accurate answer before 9 October.

Mr PLUNKETT: I congratulate the Minister on the excellent dental service in South Australia and particularly the

service for school children as there is a school in my electorate, Cowandilla, which is dear to me and which does a good job. Will the Minister provide an update on the school dental service including the service provided to school children in country areas, and will he indicate the number of adults treated by community dental clinics throughout South Australia?

The Hon. J.R. Cornwall: I intend to ask Dr Blaikie to answer that question, because he has come to us directly as a former director of the South Australian Dental Service. There are four areas that we should cover, albeit briefly, and one is the school dental service, because it has continued to expand and has reached the point, I understand, where soon we will be able to claim that it is available to every child in the State up to and including the year in which they turn 16 years of age.

The other area in which I think we have done very well is the pensioner denture service, which was established when the member for Coles was Minister, I think from memory in early 1982. The third matter is the way in which we have been able to expand community dental services, in other words, dental services for low income adults. The fourth area is related in a sense to the community services provided by our salaried dentists and is the service that we have been able to negotiate successfully with a signficant number of private dental practitioners in some of the provincial cities and bigger towns in South Australia. I wonder whether, in a fairly condensed way, Dr Blaikie could cover those four years.

Dr Blaikie: It is a pleasure for me to do that. I have been associated with the South Australian Dental Service for five years, and I am proud of that service. Referring back to questions asked earlier today about the relative proportion of funding provided for the South Australian Health Service as compared with that provided in other States, when those questions were being asked I was thinking about the impact on dentistry. Dentistry in this State has been funded at a level significantly above the national average.

If one applied some principles, one could say that South Australia therefore has public dental services in excess of its needs. I am certain, however, from my time in the South Australian Dental Service that that is not the case. What we have are probably dental services in South Australia, whereas the other States have extraordinarily inadequate public dental service. So, it is with pleasure that I look at the areas about which specific questions have been asked and those areas that have been referred to by the Minister.

First, the School Dental Service is certainly well known throughout Australia and indeed internationally. It has been written about in the United States of America and in many international journals. South Australia is leading the other Australian States in the extension of the School Dental Service to high school students both in the metropolitan and in the country areas. In this calendar year, all students in years 8, 9 and 10 will have been covered and about half the students in year 11 in Government and non-government schools. In 1986, the most recent full year in which records have been kept, over 175 000 students from pre-school, primary and secondary schools were treated by the School Dental Service.

The participation rate is well over 80 per cent: that is, over 80 per cent of parents have decided that their children shall use the School Dental Service. In respect of secondary school students, the figure is now up to 70 per cent of parents who send their secondary school children to the School Dental Service. Other advances in terms of reduced dental disease rates are well known. At one time, South Australian children had some of the worst dental health in the world, whereas now they are among the best dental health in the world.

One development in country areas has been the use of what the South Australian Dental Service calls the capitation program—the use of private dentists in areas where there are no fixed clinics, the private dentist being paid a fee on a per capita basis. The Federal Minister of Health talks about health maintenance organisations in the general medical area, and this is a form of dental health maintenance organisation. Abt 5 000 children in remote or distant country areas are treated in this way. That again is a first in Australia: no other dental service in Australia uses private practitioners in that way.

The pensioner denture scheme has been referred to. The Minister said that it began in 1982. It began in November 1981 and, as the Minister said, the member for Coles was instrumental in commencing that scheme. It has been an extremely valuable scheme which has allowed a backlog of care to occur. It would not have been possible had it been attempted to treat the patients through the public dental system, let alone the fact that it would not have involved private practitioners as the scheme has done. It would have been physically impossible. Over 40 000 pensioners and other disadvantaged people have been treated under the pensioner denture scheme, and that represents one-third of the denture wearing population of the State. The expenditure on this scheme has grown rapidly since its humble beginnings, so that in the past three years over $2 million has been spent on the scheme.

The growth in recent times (over the past two years) has been in the general dental area. While there was an enormous backlog of denture needs, I remember that less than five years ago many of the older patients in the population were wearing vulcanite dentures rather than modern plastic dentures. Certainly, in my last years in dentistry I did not see any instances of that, so we can rest assured that, if there are any pockets of age in our South Australian community who have totally inadequate dentures, it has not been the fault of the South Australian Dental Service but because, for some reason or other, those people have chosen not to seek dental care.

We have solved those problems. There are other members of the population who still have their teeth and there is an increasing tendency to retain teeth, so the movement in the South Australian Dental Service has been to develop programs for the population with teeth. The community clinics have grown enormously over the past few years. I suggest that during that period the South Australian Dental Service, from its formation in July 1982 until the last financial year, showed a 1 000 per cent increase in the number of patients treated through community clinics: that represents an increase in numbers from 2 000 to 26 000.

So, there has been an enormous availability of dental care throughout the metropolitan area and in some country regions. Perhaps the most exciting of the recent developments has been the development of the general dental scheme, which is based very much on the principles of the pensioner denture scheme that I have just explained. However, it is for general and preventive care, not just for dentures. That scheme has been offered to a number of practitioners and more than a dozen in country areas have accepted it. So, once again we see this happy mix of public and private based dental care occurring as appropriate.

The Hon. JENNIFER CASHMORE: In response to my earlier question about Commonwealth responsibility, the Minister said, concerning Nganampa, that it was absurd that I should ask him questions about a matter of Commonwealth responsibility and he claimed that under the

Nganampa agreement he had no responsibility. I now quote from the agreement between the Commonwealth and State Governments, as follows:

It is envisaged that similar principles will apply in calculating the amount of direct grants to be made by SAHC to NHC in 1985-86 and subsequent financial years. In the event of the S.A. Minister for Health determining at any time that such principles will not apply in relation to any such financial year, twelve months' prior written notice (or, where this is impracticable, prior written notice of such other reasonable period as may be practicable) of such determination shall be given by SAHC to NHC.

Further, clause 4 *(e)* of the agreement provides:

DAA and SAHC will provide funds to NHC for approved maintenance of NHC's capital items. As between DAA and SAHC, proportions to be borne shall be as agreed from time to time between them.

Has there been any problem in deciding on the proportions to be borne by each department in respect of items of a capital nature? What part of the NHC's obligations as set out in the agreement have not been met? Has the NHC increased the staff available to communities during the time that they have existed?

The Hon. J.R. Cornwall: Let me again say to the honourable member, through you, Ms Acting Chairperson, that I am the Minister who invoked the review of the provision that was written into the original agreement. From memory, I believe that between seven and nine various organisations, especially the Nganampa Health Council, were involved in finalising this agreement. When the committee set up to conduct the review began its work no-one could find a signed agreement. So there does not appear to exist a document signed, sealed and delivered by all parties and the question, like the one asked previously, is irrelevant and redundant.

The Hon. JENNIFER CASHMORE interjecting:

The Hon. J.R. Cornwall: The member for Coles says that the agreement is worthless. It is morally binding as far as I am concerned and we have been scrupulously careful to ensure that the spirit and intent is followed.

The Hon. JENNIFER CASHMORE: In that case, will the Minister answer my question? If he regards the agreement as morally binding, will he say whether there have been any problems in deciding the proportions to be borne by each department on items of a capital nature?

The Hon. J.R. Cornwall: None that have been drawn to my attention.

Mr BECKER: On Monday night on the *7.30 Report* the Minister described the staff of Nganampa, the Aboriginal health organisation, as black activists and militant white advisers. Will you name the staff members whom you consider are black activists and militant white advisers respectively in each organisation, and are you prepared to name such people outside the House?

The Hon. J.R. Cornwall: I certainly can name them.

Mr BECKER: Who are they? I have never heard of them.

The Hon. J.R. Cornwall: I have mentioned Glendal Schrader several times this afternoon, and I specifically mentioned him on the *7.30 Report* the other night. He is the white American adviser to the Nganampa Health Council. There are probably no more than four Aboriginal people whom he manipulates who are members of the Nganampa Health Council, which operates out of Alice Springs and is not representative of the Pitjantjatjara people on the lands in the North-West of this State.

The situation is entirely unsatisfactory, but at this stage I will ask Tim Agius, the Coordinator of Aboriginal Health Services, to comment. He knows more about this than I do and he has said publicly and in my presence on occasions that, while his cousins are out there dying, we have people like Schrader and a handful of black activists—and I must never again call them radicals, because they would give that term a bad reputation and I think there is something fine about radicals. I do not ask Mr Agius to name people under parliamentary privilege because that would be quite unfair. However, I will ask him to explain to the Committee just how the vast majority of Aborigines in this State have been disadvantaged in relation to Aboriginal affairs generally and health services in particular by the actions of a small number of Aborigines and white people.

Additional Departmental Adviser:

Mr T. Agius, Coordinator of Aboriginal Health Services.

Mr Agius: For a number of years, and certainly over the past few years, it has been evident that, prior to the Minister's commitment to Aboriginal health, the health status of Aborigines was appalling. Over the past few years it has become evident that the commitment from both the Commonwealth and the State to provide resources through funding has increased significantly. The health status in some communities is still appalling, but health services such as Pika Wiya, and Ceduna/Koonibba, incorporated with the Health Commission under its legislation, have seen significant changes in their health status. However, other communities not incorporated under the Health Commission Act are controlled by some of the advisers employed there and in my qualified opinion they have gone backwards. As an individual I am concerned about this and I have told the Minister that it upsets and depresses me that these conditions still exist in these communities as a result of the games and politics being played by some people. While I have an opportunity to change this, I will certainly assist the Minister in bringing about these changes.

The Hon. J.R. Cornwall: Tim Agius has been pilloried by some of these people because he has had the courage to stand up to them and work from within the Health Commission to try and bring about the changes that he can see as being so necessary.

Mr Agius: It is also worth pointing out that, while attempting to carry out my responsibilities as coordinator with the commission, another CEO and I were physically assaulted as a result of the games being played by these people. I am not sure how much longer we can put up with this kind of behaviour by certain members of the community.

Membership:

The Hon. D.C. Wotton substituted for the Hon. Ted Chapman.

Mr BECKER: It is a pity that after 200 years we are not really doing everything possible to help the Aborigines of this country and that is why I wonder whether, to assist in this situation, the Minister is prepared to name the other people who are manipulating the system and causing these problems, so that we can get to the core of the issue and provide some benefit for Aborigines, as we should do.

The Hon. J.R. Cornwall: The member for Hanson puts me in a position where I cannot win: if I do name them, I am accused of doing it in coward's castle and, if I do not do it, I am accused of not putting my name specifically to the allegations. I am prepared to identify them to the extent that I have. I have identified Mr Schrader and I point out, in so doing, that a number of audits are being conducted in the North-West at the moment. There are audits on the general financial management of a number of affairs in the Pitjantjatjara lands which in no way must be allowed to reflect on the broad masses of Aborigines in the lands.

Neville Bonner is conducting a review on behalf of the Department of Aboriginal Affairs and $15 million or thereabouts is going into communities with a total population of fewer than 2 000 people. There is somewhere between $8 000 and $10 000 per head per year for every man, woman and child on the lands, yet there is no visible improvement. They are just some of the facts and figures. In my view there is not the slightest doubt that Mr Schrader has successfully manipulated at least three or four Aboriginal members of the Nganampa Health Council. There are a number of so-called black bureaucrats in the State Public Service—a small number, and certainly a single figure, but they are there and they use their position to play black politics, I believe, of the worst kind.

At this stage I do not believe it is productive to say any more but they are there. It is very destructive indeed. What about the sort of thing that Tim Agius refers to? In Port Augusta recently one of the black activists physically assaulted Tim Agius, knocked him over, and physically assaulted the Director of the Pika Wiya Health Service, who had to have seven sutures and ongoing endodontic treatment as a result of that assault.

One of my staff members in DCW was physically assaulted by the same person. As a result of those assaults police action is being taken. Obviously, I am not going to name that person under parliamentary privilege or anywhere else, because it would be improper to do that. Police action is being taken. That is the level that some of this activity has brought us to. The time is past when I can any longer try to negotiate or treat with those sorts of people. I can also tell the Committee that in this State we now have a Regional Director of Aboriginal Affairs—an Aboriginal person, Dawn Allen—whom I regard as one of the most competent administrators I have met in my period as a Minister. She has come to South Australia from Queensland, and it is my very strongly held view that she is probably the best thing that has happened to Aboriginal affairs in this State in the time that I have been in politics, and probably beyond that. Again, this small number of people have set out quite deliberately, it seems to me, to destroy her good name and reputation.

That is the situation with which we are faced. While that is happening, as Tim Agius has said, his cousins—he uses the term in the broadest sense, although the Agius family it is a large Aboriginal family in this State—are out there dying from a whole range of conditions which it is well within our power and our reach to prevent. I believe that we are now relatively well placed in this State to get on with the business. It is going to mean a commitment to additional resources, not specifically in terms of treatment services or even preventive services. Pika Wiya is already producing measurable results because they have been able to get on with the job to a significant extent. Nganampa Health Centre is not at this time producing measurable results. The environmental health survey is clearly going to show that we need more infrastructure and basic services.

Both the Commonwealth and the State will have to take responsibility for more basic services. We will no longer be able to demand of communities that they respond to every public servant who traipses through the lands. There have been months when there have been literally dozens of people from different State and Federal Government authorities doing that. We have now reached the point where I believe we can grapple with this. It has taken time to get there. Many people have been trying to do a lot of good things in Aboriginal affairs for a long time without success. I take my mind back to a good old friend and comrade, Gordon Bryant, who sat in Opposition in Federal Parliament for 20 years and suddenly found himself Minister for Aboriginal Affairs and found that he had a big bag full of $50 notes—not in the literal sense, but the money was flowing. Gordon believed that it was possible to get rapid action by getting out there and literally throwing money at the problem. It did not work, but we now have a much better defined idea and I think we have a unique chance. But with that unique chance there is also a very heavy responsibility, and we have to get on with it.

I make no apology for having to raise the matter and I am certainly pleased at having been given the opportunity, especially by the member for Hanson, to outline some of these difficulties, having earlier outlined the generalities in response to a question from the member for Mawson. I do hope that in this matter at least we can adopt a bipartisan approach, because I can tell the Committee that we still have some problems.

Ms LENEHAN: I relate my question to page 286 of the yellow book in regard to services for the protection, promotion and improvement of public health. One of the strategies outlined in the objectives for 1987-88 is to expand the AIDS program in accordance with the AIDS strategy for South Australia. In prefacing my question I wish to congratulate the Minister and the commission on the development of a strategy for South Australia and the way in which they have responded to this serious problem in the community.

My question is in two parts. First, it relates to the youth of South Australia. Is the Minister able to say how effectively he believes the liaison with the Department of Education and the Health Commission is proceeding? I refer specifically to feedback on the way in which the educational programs are being implemented in some secondary schools. I attended a high school meeting last week where the matter was discussed by the council and there seemed to be general agreement by the school council about the implementation of these programs.

However, while it is hoped that we will be reaching all students at secondary level, what programs are being developed to reach those young people in the work force who have left school and who are probably not so aware of the problems associated with AIDS and the information that is so important for them to have? Are there any programs designed specifically for that group? I am not talking now about adults but about young people in the work force, at home or unemployed. It is a different group to reach and I wonder whether there has been any attempt to do research and develop some programs for these people.

The Hon. J.R. Cornwall: Probably the hardest group of all to reach are young people who drop out of school early. The member for Mawson is right in that observation. It is a problem around the world: they lose contact with the school system and many of them lose touch with the mainstream of society. They are a very vulnerable group. In the Department for Community Welfare we call them adolescents at risk, in broad terms. The sorts of coordinated youth services that we are trying to develop for the so-called inner city kids are part of those initiatives.

The youth networks in adolescent health that we are trying to set up around the suburbs and throughout the State are part of that program. I will not take up the Committee's time talking about the Gully Youth Centre, Salisbury shop front and the services which we have either in place through the Noarlunga Health Village or which we are beginning to negotiate with the Noarlunga-Marion council joint venture, or the Whyalla Sidetrack, and so forth. A whole range of those are being developed and one of their important roles is certainly health education and, more

specifically, it is certainly in education about sexually transmitted diseases and the transmission of AIDS. That is happening across the board.

It is also important to remember that we have a world pandemic of AIDS, and it very much crosses State and national borders. There is no way that we can rest on our laurels in South Australia. We have done extremely well up to date by a combination of good management and other matters upon which one can speculate, but we cannot put up a barb-wire fence around South Australia and quarantine the population. We are part of the rest of the country and the rest of the world.

I might say, when we start talking about reaching at risk and vulnerable groups, that I have a deep concern for some of the things that are going on in other States of Australia, and I have voiced that publicly. I find it appalling. Only a fortnight ago I was in Queensland and found that there is still debate raging as to whether there ought to be sex education in schools. We are talking about secondary schools and not primary schools. There is no question of their conducting AIDS information programs for secondary school students—they are not even conducting basic sex education programs.

Let me revert for a moment to the programs in our secondary schools that we are not developing but implementing: essentially, they are AIDS information programs. Each student should get up to five hours of instruction, thus receiving basic information about what causes AIDS, how it is transmitted, and so on. They will be given a number of options for prevention, and one of the major options will clearly be abstinence. But the course must be conducted without moral judgment. As I found on my recent trip, that is different from AIDS education, which in the broader sense, is really about substantially and fundamentally altering lifestyles. It is one thing to know about AIDS and what causes it and some of the simpler things people can do to reduce the risks of contracting it: it is quite another thing to expose people to enough education to literally get them to change their basic lifestyle. Both of those things must go hand in glove.

The Hon. JENNIFER CASHMORE: I refer to the health budget. What written instructions have been given to Government hospitals and institutions to reduce their budgets this financial year? Will the Minister provide to the Committee a copy of those instructions in relation to all the hospitals and institutions under his control, together with a balance sheet as provided by the Health Commission to such hospitals and institutions? Unless the procedure has changed, the final allocation to hospitals is provided in written form directly by the commission.

The Hon. J.R. Cornwall: I do not want to be pernickety about this, but there are no longer any such things as Government hospitals, not even ex-Government hospitals.

The Hon. JENNIFER CASHMORE: The Minister knows what I mean—the teaching hospitals.

The Hon. J.R. Cornwall: The honourable member refers to recognised hospitals, particularly the larger hospitals.

The Hon. JENNIFER CASHMORE: Yes.

The Hon. J.R. Cornwall: I do not believe things have changed substantially in that respect since the member for Coles was Minister. There have been a lot of other changes for the better, but I do not believe that we have changed that system in any significant way.

The Hon. JENNIFER CASHMORE: Can I point out that all the Minister need do, if he wishes to respond in the affirmative to that question, is to provide copies of the instructions to the hospitals or the detail thereof—the bottom line.

The Hon. J.R. Cornwall: The instructions to the health units as a result of negotiations for those individual budgets total more than 200 and, quite obviously, each one would be different. I think it might be more productive if we were to outline briefly the procedures that have been adopted—

The Hon. JENNIFER CASHMORE: Perhaps that can be put on notice.

The Hon. J.R. Cornwall: —and the targets we need to meet. I am anxious to cooperate in this matter. I have no desire to do anything else. It is a good and relevant question.

Dr McCoy: The process is quite simple. The central office of the commission makes three major allocations to the service divisions—the State-wide services, the country services and the metropolitan health services. The executive directors of each of those divisions then writes to every unit allocating funds for the financial year 1987-88. It is not written in the form of an instruction: it is written as a letter advising the unit of its financial allocation for 1987-88. In the case of the Royal Adelaide Hospital, the Adelaide Children's Hospital and the Queen Elizabeth Hospital, I would imagine (although I did not write the letters) that the $700 000 cut, as well as the $.75 million across the board cut that has been applied would have been identified.

Mr Sayers: As the Chairman has said, the letters are all different. Basically, there are major groupings—metropolitan hospitals and country hospitals. Most of the letters contain fairly similar information, basically advising of the amount of money that has been allocated to the health unit for the year. Attached is a summary sheet showing the calculations for each of the individual health units, and that supports the single allocation figure that appears in the covering letter. The covering letter also advises what specific areas of expenditure have been included and excluded in the allocation, and explains those areas that will or will not be controlled by the Health Commission. A lot of the information is the same, but each of the health units receives its own letter advising its allocation and details of that calculation.

Rather than providing the 200 letters we could provide a copy of a letter to a country hospital that is representative of the sample, one for metropolitan hospitals, and one for those that received specific treatment this year, such as the Royal Adelaide Hospital, the Queen Elizabeth Hospital and the Adelaide Children's Hospital.

The Hon. JENNIFER CASHMORE: I do not think the Committee wants to be burdened with 200 letters, but the information in those letters, namely, the components of the final budget for all hospitals that are deficit funded, is obviously a matter of concern to Parliament and, therefore, of concern to this Committee. I seek the Minister's assurance that, in response to a question on notice seeking this information in summary form, it will be provided.

The Hon. J.R. Cornwall: I do not see any difficulty with that at all, apart from the time and energy that might be required. It is certainly well within our capacity.

The Hon. JENNIFER CASHMORE: What is the increase in real terms in the total health budget as identified by the Commonwealth definition of inflation? As all institutions appear to have had a cut in their budget, what lines in the health budget have been increased? Will the Minister provide details of the program lines where increased expenditure is envisaged?

The Hon. J.R. Cornwall: Generally, there was a .75 per cent reduction or what I choose to call a productivity saving across the board but what the handicapper might call, in the futurity stakes, penalties and allowances. The Deputy Chairman could be more specific about those matters.

Mr Sayers: As the Minister has said, the general strategy has been to reduce all health unit allocations by .75 per cent, making specific reductions in relation to the units referred to previously—the Royal Adelaide Hospital, the Queen Elizabeth Hospital, and so on. Overall, the increase from the 1986-87 actual payment of $837 million, given that the 1987-88 allocation is $918 million, was substantial.

There were quite substantial award increases in this current year, both in relation to the nurse career structure and other general award increases. In general, there was an inflation allowance of 7 per cent on goods and services expenditure. There is a substantial increase provided for in relation to the workers compensation premiums in this year. There are increased insurance costs and increases in relation to a new scheme of patient assisted transport service which has been taken over by the commission from the Commonwealth in this year. There were adjustments for the 27th pays. There are a substantial number of 27th pays in the health industry in 1987-88.

There was the new initiative funding which was referred to earlier in the day, the $3.3 million which has been apportioned across to the health units which are the recipients of the new initiatives and, of course, the general savings of .75 per cent and other specifics we have already talked about. We have the specific breakdown of those, which shows the substantial increase in health expenditure from $837.5 million in 1986-87 to $918.8 million in 1987-88. Those items make up that increase.

The Hon. JENNIFER CASHMORE: I have a supplementary question, although it is more a comment that requires confirmation. Except for the new initiatives of, (did I hear correctly?) $2.3 million, the remainder of the increase is absorbed not in an expansion of services or an increase in the level of service but through increased costs covering inflation, salaries, workers compensation, transport and insurance?

Mr Sayers: That is correct.

The Hon. JENNIFER CASHMORE: My third question relates to the health injury rehabilitation services. Is there any proposal to sell any part of the Payneham Rehabilitation Centre to recover the cost of buying that centre from the Commonwealth and, if so, is there any area of that to be sold which would be both suitable and available for the provision of a day-care centre for head injured people so that a day-care centre for 35 people or more (which I gather is a significant and relevant number) can be established?

The Hon. J.R. Cornwall: There are a number of proposals, some of which are fairly specific, including the one for a day-care centre for the young brain injured. I would ask the Chairman to respond specifically to that question.

Dr McCoy: An officer of the commission, Richard Hassam, has reported on a number of properties owned by the commission which may be surplus to need. That report is being considered by the commission and, after that, recommendations will be made to the Minister and to Government. That report covers the Payneham Rehabilitation Centre and, while I cannot commit the Government to a decision on that, it seems to me quite likely that the Government will agree to the sale of at least part of the Payneham Rehabilitation Centre site. I understand that it is proposed to develop a day-care centre for brain injured people in a house which is part of the complex but not on that site. It is over the road.

Ms LENEHAN: My question relates to the Minister's introductory statement, in the last paragraph of which he states:

> It has required the commission to make its managed savings through increases in efficiency and productivity.

I also noted that there was a reduction in the central office staffing levels and that a strategy was developed in 1986-87 to reduce the staffing levels of the South Australian Health Commission head office. Can the Minister tell the Committee what the reduction was in the 1986-87 levels, and are any further reductions planned for 1987-88 in line with the general statement which he made to the Committee at the beginning of today's proceedings?

The Hon. J.R. Cornwall: There is an old saying that one should never ask people to achieve things one cannot achieve oneself, and it is best to lead by example. The commission, certainly, has been doing that in the central office. If we leave aside the public health division, which, for some reason that has never been clear to me, seems to get lumped in with the central office—they perform a number of very vital and important roles on their own, but I think they ought to be left aside for the purpose of this discussion—and if we look at the central office as involving those who administer the funding to the health services generally, and those who are in a sense both caretakers and minders of the system in consultation with the health units, there has been what one could almost call a dramatic reduction in the numbers of staff at 52 Pirie Street in 1986-87, and we are proposing more substantial savings there in 1987-88. I will ask the Chairman to provide specific details of those two years. I do not want to take up the time of the Committee by going into much detail on 1986-87, although I think it is important to see things in perspective.

Dr McCoy: During 1986-87 numbers in the central office of the Health Commission were reduced by 25.4. The public health service was also reduced by 11.1, giving a total reduction of 36.5. The actual central office figures are 323.2 to 297.8. In 1987-88 it is proposed that there be further reductions in the manpower of the central office. Final decisions have not yet been made, but there is a target of a further reduction in the number of at least 20.

The Hon. J.R. Cornwall: Can we see that in context: it is 45 positions from a staffing establishment of 549 in June 1986.

Dr McCoy: That is central office and public health: 323 in central office, now down to 297 and 513, with a target of a reduction of a further 20.

Ms LENEHAN: My second question relates again to the whole question of efficiency and productivity. In line with this streamlining of the Health Commission, can the Minister tell the Committee what impact the introduction of computing services has had on, for example, increased productivity and efficiency, and can the Minister give the Committee an update on the introduction of computing services into the Health Commission?

The Hon. J.R. Cornwall: Until very recently this is a question I would have regarded with some trepidation. The introduction of computing services into the hospital and health system generally was fraught with difficulties for almost a decade. I am sure that no-one remembers better than the member for Hanson the difficulties encountered with early attempts at computing at the Flinders Medical Centre. That is the stuff that nightmares are made of for Health Ministers. However, I think—cautious person that I am—that we have now reached a stage where we can really stand up and be counted on health computing generally, and I would ask the Chairman to give a brief resume of where we are and where we might anticipate going in the next three or more years.

Dr McCoy: I am happy to do that and to report to the Committee that much of the information being provided to the Committee today has been computer derived. We have talked about the booking lists, the financial management

systems and patient care systems: they are generally computerised but to varying degrees in different hospitals, and I believe we are now getting the policy right. We have a group in the commission who are expert in oversighting the developments of computer applications in hospitals.

Summarising computing investment, $383 000 was spent by the commission in 1984-85, $749 000 in 1985-86, $3 127 000 in 1986-87, and $3 706 000 in 1987-88. It can be seen that there has been a huge increase in computer expenditure in the health system—and I am not talking now about the central office—principally in major hospitals. In addition, the IMVS took out a loan of $1.2 million to upgrade its Burroughs system.

At the Queen Elizabeth Hospital a patient care system is being developed, along with a replacement pathology system. The Royal Adelaide Hospital has an extensive ward terminal patient care system nearing completion. I referred to the IMVS pathology upgrade. The Flinders Medical Centre is upgrading its patient care system—a new commercial system. A finance and patient care computer system (QANTEL equipment) has been installed in Mount Gambier and Whyalla hospitals and is to go into the Port Augusta hospital. There has been a replacement of Modbury Hospital's financial and patient care system. The Lyell McEwin Hospital—where we previously had a lot of difficulty with the accuracy of information—has installed a QANTEL system on finance and patient care. This year at the Adelaide Children's Hospital it is proposed that there be a word processing and patient care system installed. At the Blood Transfusion Service it is proposed to install a donor management inventory system, and at the St John Council it is proposed to install a financial and operations management system.

There has been some standardisation of equipment, although it is not standard through all the hospitals. The commission has moved away from the policy of one supplier. In fact, a number of suppliers are involved at the Royal Adelaide, principally IBM; Digital at Flinders; AWA at the IMVS, Flinders, and the QEH; Burroughs, Hewlett Packard and QANTEL in the country hospitals; and in the Lyell McEwin as I have reported.

Mr BECKER: When will the Flinders Medical Centre car parking be extended by another 278 parking spots? In 1985 the Flinders Medical Centre's Report of the Chairman, Board of Management, made the following statement:

> In November, the Minister of Health, visited the centre to announce some approval initiatives at Flinders Medical Centre for 1984-85. The developments announced were—

and this is but one—

> provision of an additional 278 car parking spaces. The implementation of these projects proceeded according to the schedule with the exception of the car park, which is to be sited on land which is part of the Flinders University playing fields. This project requires the provision of a temporary oval and alternative land in lieu in the Sturt Road triangle which is still being negotiated.

I become frustrated when looking for a car park at the Flinders Medical Centre and can understand the frustration and annoyance of elderly people who in all sorts of weather have to walk up to half a mile after finding a suitable car park. As this was promised in 1985, will the Minister explain the hold-up and say when we will get these additional car parking spaces?

The Hon. J.R. Cornwall: A splendid question, and I wish I knew the exact answer. The Sturt triangle, for many public servants and Ministers, has been a greater trap than the Bermuda Triangle. A lot of players have been involved and nobody has ever been able to sort it out. I have given up. There is another proposal for the Sturt triangle and the people who are interested in it can have it as far as I am concerned. Presently we have before us a proposal for a multistorey car park at the Flinders Medical Centre and it has been the subject of ongoing negotiations with the unions. Those negotiations have reached an advanced stage. I hope—and I put it no stronger than 'hope' in view of the history of car parking at Flinders—that I will be able to go to Cabinet within six weeks with a firm proposal for a multistorey car park at Flinders. In case members are looking for it in the public works program, it is not there. It is proposed to be a self-funding arrangement to be put in by private enterprise.

Mr BECKER: I have a supplementary question. What role do the unions play in this situation?

The Hon. J.R. Cornwall: First, we have to get them to agree to pay for the parking. Since they will use the multistorey car park there has to be agreement as to what contribution the individual workers are prepared to make. In other words how much a week will they pay to use the car park. This situation exists in many other States. This matter at Flinders is trailblazing. It is important to us, because we also will be looking to some form of partial self-funding for a car park at the Royal Adelaide Hospital and, ultimately, at the women's and children's hospital on the Adelaide Children's site.

Union agreement, overall, is important to us. However, the Deputy Chairman has been involved in fairly direct negotiations and has his hand on this. It might be wise for me to ask him to give us a complete update. I am accutely aware of the problems of parking at Flinders. I get more cards and letters about difficulties of parking at Flinders from constituents, patients and staff, and particularly from electorate offices, than on any other six subjects put together. I am anxious to resolve it as quickly as possible, if only to get the member for Fisher, among others, off my back.

Mr Sayers: It has been a frustrating exercise. It goes back to the days when the original proposal was rejected by the Public Works Standing Committee when funds were provided and it has a long history. In relation to the current proposal, consultants had been engaged by the Flinders Medical Centre Board to develop a self-funding proposal for the car park and one of the key elements of that was to introduce a charge recommended by the consultants on the existing open space car parks which are already provided to employees free of charge. That was important because, with a large number of open spaces available free of charge, it affected the commercial viability of the multistorey car park. That has been negotiated over the past few months with the unions, not to the total satisfaction of the Flinders Medical Centre Board, but certainly the unions have come some way in relation to that.

The Flinders Medical Centre Board has now re-engaged the consultants to re-look at the self-funding aspect of the multistorey car park based on the latest agreement with the unions. It is now back with the board and within two or three weeks it will tell us whether it is a goer with the current union agreement or whether we have to go back to the unions and re-negotiate.

The Hon. D.C. WOTTON: Following the Minister's undertaking to provide information on final budget allocations to every deficit funded hospital and health unit in the State, will he agree to make available copies of the letters, however many there are, to ensure that Parliament has the information that has been provided to these health units?

The Hon. J.R. Cornwall: I did not give that undertaking—it is too clever by half to try to put words in my mouth. We gave an undertaking that we would provide in summary

form the 200 letters or thereabouts that were sent out to all the health units.

The Hon. D.C. WOTTON: Supplementary to that, will the Minister provide copies of those letters?

The Hon. J.R. Cornwall: I think that to do so would be putting people about a lot. If the honourable member wants to see what the budget was for last year for each of the 200 health units, they appear in the published annual reports, and in the blue book. I will give the honourable member a copy of the blue book, if the Opposition spokesperson on health has not already given him one.

The Hon. D.C. WOTTON: I have the blue book, but I understand that that is not the same, so I would like the letters to be provided. I cannot see that being any major problem. Surely I am entitled to know that information?

The Hon. J.R. Cornwall: I cannot understand why the honourable member is making such a fuss about this. Each member has a hospital or health unit in their electorate and all they have to do is ask them. There are no secrets in the hospital system. If the honourable member wants to know the budget allocation to the Mount Barker Hospital, for example, he should ask those people, because they are absolutely at liberty to tell him. There is more freedom of information in the health system and in individual health units than anywhere else in this country.

The only reason why I am reticent is that I believe that I have senior staff with a whole lot of things to do and whether they should be fossicking around delivering 233 letters is really a matter of some concern to me in terms of setting a precedent. Let me give the honourable member an undertaking—and I am prepared to do this absolutely—that any member may approach their local hospital or any publicly funded health unit in their electorate and ask for the details, and they have my full authorisation, and I would expect the authorisation of the commission, to give that figure.

The Hon. D.C. WOTTON: The purpose of this Committee is to seek information regarding the health budget. I am not interested in going to the hospitals in my electorate. I want to look at the situation State-wide. That is why I have asked for this information specifically, and I cannot see that there will be a lot of work. I have asked specifically for copies of the letters.

Members interjecting:

The CHAIRMAN: Order! Let us conduct this Committee as it should be conducted. There will be no crossfire across the benches. The honourable member is entitled to ask the Minister a question, and we will then see what the answer is.

The Hon. J.R. Cornwall: I have told the honourable member not only that he can go to his local hospital, community health centre, CAFHS centre, or whatever, and ask for that information but that I am happy for them to give it to him. I will not undertake to tie up people in the commission who are paid a large amount of taxpayers' money to get on with the important business of administering a $927 million budget by sending out swags of copies of letters to members of the Opposition, or to anyone else. I cannot be more open than to say that they are completely at liberty to go to their local health unit and ask what was the final amount negotiated with the Health Commission. That is called freedom of information. I do not think that one could get that sort of detail from any Government department—it is only in flexible, open organisations like the Health Commission where we are able to make that sort of generous offer.

The Hon. D.C. WOTTON: I reiterate that I believe that it is an important part of the responsibility of this Committee. A lot of other information has been denied the Committee, and it is important that this information be provided, so I repeat that we are looking for about 230 letters, and that is all.

Members interjecting:

The Hon. D.C. WOTTON: If he wants to send them out with his Christmas cards, that is all right by me.

The CHAIRMAN: Order! We are not discussing Christmas cards.

The Hon. J.R. Cornwall: May I make two responses: first, I have made perfectly clear that any member can approach any health unit—and I will say it again, for about the sixth time, and I will say it slowly—and ask the health unit for the details of its final budget allocation. I deny absolutely that the Committee has been denied, as the member for Heysen puts it, 'a lot of information'. The Committee has been denied no information all day. There was one request only that I refused, and that was to table the entire file relating to Kalyra Hospital so that the Opposition could go on some stupid, destructive, witch-hunt. I am not about to do that. However, in terms of statistics, figures and tables in *Hansard*, we have made information available without precedent.

I am now saying that any member of Parliament can approach any public health unit in the State and ask for the final allocation of their 1987-88 budget, and that health unit is fully authorised to give that information to them. I do not know what more I can do. If the member for Heysen is having trouble finding his local health units, then we would certainly be happy, if he does not know his electorate well enough, to provide him with the addresses.

The CHAIRMAN: The honourable member for Flinders.

The Hon. D.C. WOTTON: I have asked only one question.

The CHAIRMAN: I am sorry, but according to my score the honourable member has now asked seven questions. The member for Flinders.

Members interjecting:

The CHAIRMAN: Order! I will chair this meeting—the member for Flinders has the call.

Mr BLACKER: Thank you, Mr Chairman. My questions relate to country health services and more specifically to the future of country hospitals, particularly those on Eyre Peninsula. At the annual general meeting of the United Farmers and Stockowners Association a board member of the Cowell Hospital stood and said, quite categorically, 'We have been told we will amalgamate with Cleve.' That statement created much concern for the people present. During the same week a similar comment appeared in the Eyre Peninsula *Tribune*; it reported Dr McCoy as saying in a private conversation that Cowell Hospital would amalgamate with the Cleve Hospital. This created much concern. I seek an assurance that the medical services in the Cowell/Cleve and Cummins/Tumby Bay areas will be assured of their medical services and continuation of their hospitals, if at all possible.

The Hon. J.R. Cornwall: The question asked relates to a fundamental and extremely important issue for a large number of people in the State. I am grateful that the member for Flinders has raised it. I am anxious that we try to keep politics out of this Committee to the greatest extent possible. I keep a pretty good eye on the West Coast press and I have noted that someone is on record as saying that 'Cornwall and the commission better look out, because they will perform better than Jeff Fenech,' or words to that effect. I do not think that any of us get anywhere with that sort of silly rhetoric. I am anxious that we do not politicise this matter in the same way that the Opposition did when we

were reviewing obstetric services in South Australia. A major review of obstetric services has been completed in a very positive way in this State involving a lot of players ranging from the College of Obstetrics and Gynaecology through to input from local people.

As a result of that, I will soon be taking to Cabinet for endorsement a policy that will result in an already good service being further upgraded and in women and their babies in non-metropolitan South Australia having access to one of the best obstetric services in the world. That was the outcome but, unfortunately, it was initially painted as some sort of dark plot to close country hospitals in order to effect cost savings. However, that was never the case.

The same applies to what we are about to embark on in rural South Australia generally. We are developing, for widespread discussion and consultation, a background paper that we may well put out as a green paper. That is, there will be no Government commitment to the form in which it goes out. That paper will be for widespread discussion as to how, within existing resources, we can upgrade health and hospital services throughout the State. It must be seen against that background.

Last year, during the Estimates Committee's proceedings, I gave the member for Flinders an undertaking that no country hospital in this State would be closed on the grounds of pure economics, and I repeat that undertaking today. We will put out a discussion paper that will canvass ways in which, facing the reality that resources are likely to be static over the next five years, areas can best be consolidated and further development of health services achieved, especially as to how we might direct additional specialist services into rural areas as part of that plan.

However, at this stage it would be most appropriate for me to ask the Chairman of the Health Commission to outline specifically the program that we contemplate: not the program that may end up in practice, but the program of consultation and discussion into which we may enter in developing strategies for each of the areas around the State. The Chairman may also wish to take the opportunity to comment on the secondhand allegations made by a board member concerning the Cowell hospital, but I shall leave that entirely to the Chairman's well known discretion.

Dr McCoy: As is well known, the commission has consolidated all country services into one division so that there could be a uniform approach to country hospitals and country health services. Ray Blight is the Executive Director of the Country Health Services Division. The commission has simple and clear objectives: to further improve the quality and the range of services available to country people and, in particular, to develop specialist centres so that country people will not always have to travel to Adelaide when they require specialist services.

The commission, through Ray Blight and his division, is developing a general strategy. Certain regions have been identified and Ray Blight has a strategy paper that is nearing completion. Indeed, at the end of next week he will commence an extensive period of consultation with country hospital administrators, board chairmen, and directors of nursing from hospitals and other community health services. Ray Sayers and I will make every effort to attend those seminars, at which Mr Blight will outline the need for country people to consider various ways of providing services that could result in the better provision of services to regional groups.

The commission has no fixed plan. The whole process is based on a full consultation with country people. Options will be put to each group, as has been done in the regional planning studies already completed. However, in those areas where plans have not been put, Ray Blight is developing what he calls options for management plans in order to achieve improvements locally for country people without the need for additional resources, at the same time ensuring that all South Australian country people have available the best and highest quality of care that we can provide.

I do not want to talk very much about Cowell. I have a transcript of what I said at the Elliston meeting and in general terms my statement there referred to what I have just said concerning the need for closer working arrangements between hospitals. After the Elliston meeting, I met Mr Kaden, who said, 'What does that mean for Cowell?' I said that I thought that there was a need to look carefully at the region and the relationship between Cowell and Cleve in order to work out a sensible arrangement. I said no more than that. I did not say that the Cowell hospital would be closed and I did not intend to make such a statement, although such was subsequently published.

That is the plan. We are embarking on an exhaustive period of consultation in country areas in order to allow country people to understand the need to consider different methods of providing services so that improvements for their constituents can be achieved.

Mr BLACKER: I have one quick question, but I am not sure whether it is in the province of this Committee. Can the Minister advise on the progress of redevelopment and extension plans for the Port Lincoln hospital?

The Hon. J.R. Cornwall: Mr Chairman, can we canvass capital works?

The CHAIRMAN: Yes, we are looking at the lot and finishing off everything by 6 o'clock.

Mr McCullough: Work on the Port Lincoln redevelopment has been scheduled to commence in 1990-91, which generally implies that specifications, detailed plans, and so on, would be done in the year before that, in 1989-90. The estimated cost of the redevelopment in today's values is $6.86 million.

Additional Departmental Adviser:

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

Mr Blight: A consultancy has been let at the moment with Resource Development Partnership to look at the functional arrangements within the hospital so that when it is time to engage architects for the construction work we will have the functional relationship and the work flows properly sorted out within the hospital.

Mr BECKER: Is the Minister furnished with funds from the Commonwealth to provide accident and emergency services at all Government hospitals and have there recently been heated discussions between the Minister and his Commonwealth counterpart about funding of after hours services at major country hospitals following a meeting between Dr Blewett and country doctors at Port Pirie? I understand that the State is funded for all after hours accident and emergency services by the Commonwealth and yet the State has been telling doctors to use accident and emergency services as an extension of their surgeries and hence ensure that patients claim for such services under Medicare in the normal way through the practitioner. If this is correct, is not the Government guilty of double dipping and cheating on the Commonwealth?

The Hon. J.R. Cornwall: I am the longest serving health Minister in this country and my close friend and colleague Dr Blewett is the second longest serving health Minister in this country—and some would argue (although I would never make this claim myself) that we were the two most successful. We never have cross words. I am dumbfounded

and astonished that such an allegation should be made. However, reverting to the serious part of the question, I will ask Mr Sayers to address the Committee on negotiations with country doctors in our major regional hospitals.

Mr Sayers: The claim had been made that the State had funds included at the commencement of the Medicare agreement in February 1984 to provide after-hours casualty services in country hospitals—but that was not the case. In fact, in February 1984 a small number of services or attendances at country hospitals were provided by the State and were allowed for in Commonwealth funding. The actual percentage is not known but it is very much less than 10 per cent of the total. So it was on that basis that a statement was made by the Federal Minister because he had been advised that funds had been included in the State allocation for 1984 for this purpose.

They had been included to fund the services that existed at that time. However, the vast majority of casualty services provided in South Australian country hospitals in 1984 came from medical practitioners funded under Commonwealth funding arrangements. As a consequence, Dr Blewett made a public statement which was true in part, but the emphasis was not, in our view, appropriate and the matter is now being discussed between the State and Commonwealth Governments.

The Hon. J.R. Cornwall: I might correct that and say that it was 'accurate in part'. I know that there was never any intention on the part of my Federal colleague to do other than state the facts as supplied to him by his senior advisers, one of whom was a senior officer of the South Australian Health Commission until fairly recently. As to the facts, some of them were contested but at this stage negotiations are proceeding amicably and I believe that this can be resolved within the reasonably near future. We are anxious to resolve it as soon as possible.

The CHAIRMAN: I declare the examination of the votes completed.

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

Community Welfare, $123 022 000

Chairman:
Mr D.M. Ferguson

Members:
The Hon. H. Allison
The Hon. Jennifer Cashmore
Mr T.R. Groom
Ms S.M. Lenehan
Mr K.H. Plunkett
The Hon. D.C. Wotton

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

Departmental Advisers:
Ms S. Vardon, Chief Executive Officer.
Ms L. Mann, Deputy Chief Executive Officer.
Mr G. Boxhall, Director, Administration and Finance.
Mr R. Squires, Director, Northern Metropolitan Region.
Mr R. Boss, Manager, Financial Services.
Ms D. Reiter, Senior Finance Officer.

The CHAIRMAN: I declare this line of expenditure open for examination. Will the member for Coles lead off?

The Hon. JENNIFER CASHMORE: Has the Minister an introductory statement that he would like to make? I am happy for him to give that statement.

The Hon. J.R. Cornwall: Yes, I do have a prepared statement. As I have no intention of reading it to the Committee, I will have it inserted in *Hansard*. It is as follows:

Department of Community Welfare Reflections 1986-87

- Over the past year, the department has continued to strive for excellence in its work, and to rigorous examination of its performance; it has started to consolidate its work in some key areas, such as child protection, and it has laid the groundwork for further improvement in its programs and service delivery over the coming year.

Theme 1: Accountability

- It is the department's belief that its integrity, rigour, skills and professionalism must be of the highest order and the processes we employ must operate to enhance and not inhibit the quality of our services.
- This commitment to a continuing and rigorous process of open appraisal of its performance was evident through the completion or initiation of a number of reviews, including that of:
  - Adoption Services
  - Budget Advice Service
  - Community Residential Care
  - Adolescents at Risk
  - In Need of Care (Bidmeade Review)
  - Substitute Care.
- The department's openness to scrutiny has been exemplified over the years by its invitation to key agencies such as Treasury to participate in its program reviews. This will continue, and the area of program reviews will be reassessed to ensure that the process is both thorough and accountable, and links with key decision-making stages and processes in the organisation.

Theme 2: Quality Control

- The department has also focused on directly increasing its excellence in intervention in some aspects of its primary work. Positions at the regional level in specialist services, child protection and substitute care were developed to increase competence in case management, staff development, expertise in advice, and general upgrading of practice.

Theme 3: Consistency

- It is the department's goal to ensure consistency of standards State-wide, in terms of quality, level and range. Consumers must have equality of access to services and programs, and this requires guaranteed standards. Standard procedures for staff responding to clients in the key areas of child protection and substitute care have been closely reviewed, and are being rewritten to ensure departmental intervention is of a consistently high quality across the State.

Theme 4: Protection

- The department, as a first priority, must direct its services towards the most disadvantaged and least powerful members of the community. Within this priority, the protection of children from specifically identifiable harm is of paramount importance.
- Over the past year, the department has started to consolidate its work in the child protection area, with the expansion of staffing to manage the increased workload, development of quality control including training, establishment of a joint Health/Welfare Child Protection Unit, and further strengthening of policy and practice guidelines.
- In the coming year, the department will focus further resources into community education, and preventive strategies in order to address the sources of violence and abuse within families.

Theme 5: Cooperation

- The department recognises that it is but one part of a network of Government and non-government human services, and clients are best served by the capacity of agencies to work in cooperation with others in the planning, development and delivery of services.
- The past year has seen a significant escalation of work between agencies, particularly health and welfare services, with emphasis on local planning and coordination of service delivery.
- In its reviews of key services, such as that of Substitute Care and Adolescents at Risk, the Department has both sought comment from its non-government partners in community welfare services, and has worked with them in developing agreed solutions.

Theme 6: Consumer Focus

- As the department's primary purpose is to meet the needs of its consumers, it aims to be consumer-centred and influenced. A position of consumer advocate has been established to ensure that clients have access to information and services, the opportunity to participate effectively in departmental decision-making processes, including the development and implementation of policies and programs.

Theme 7: Advocacy

- It is the department's responsibility to undertake an advocacy and community education role on behalf of the disadvantaged sections of the community.
- Over the past year, the department has reinforced its role in this by:
  - strengthening its and the community's capacity to protect children;
  - improving its capacity to respond to and educate the community about domestic violence;
  - reviewed its Budget Advice Service, in order to lay the groundwork for a more effective program;
  - developing the framework of a comprehensive social justice strategy, to the stage where it could be established as a Government-wide commitment.

Theme 8: Service Delivery Issues

- During the year, the Department of Aboriginal Affairs suddenly and unexpectedly withdrew financial support for the department's Aboriginal Welfare Program, placing at risk about 30 positions held by Aboriginal staff. The department has acted to ensure it will continue to upgrade its own services for Aboriginal people to reduce their over-representation in so many of its programs.
- Demand for departmental services continued to increase, and has required the department to keep a broad perspective, balanced with the need to focus its services in quite specific areas.

The themes described above will continue to be reflected in the department's service delivery over the next year. It is clear, though, that consolidation has occurred in some key areas, notably child protection. The actions taken both by the Government (in, for example,establishing the State Council on Child Protection, and increasing departmental staffing) and by the department, together with an increasing acknowledgment by the community of the need for action, have ensured that the level of protection for children has been markedly improved.

This work, and additional policy work undertaken in the department in areas such as services to families, intervention with families and permanency planning, also has laid the foundations for the work to come.

In particular, the department will be focusing on further upgrading the quality of care for these children who are not able to remain in their home, and are required to live in substitute care.

The department will continue to use, as its central themes, excellence, compassion and accountability.

The Hon. JENNIFER CASHMORE: I would like to start with a multi-part question relating to community participation in welfare. What proportion of staff time does the department's workload measurement system stipulate should be allocated to community development activities? Does the workload measurement system herald a decision to reassess and possibly get rid of the current 14 point priority rating system which classifies clients according to their social problems, recognising that community development does not necessarily occur in these linear associations that relate to the department's priority rating list?

Are certain community development activities given higher priority than others as a guide to staff in allocating their time? Does the implementation of this requirement in the past year, that is, the workload measurement system for community development activities, represent an acknowledgment by the Minister that for some years—and in particular since 1985—the department has failed to provide traditional services focusing on reducing or overcoming a broad range of social problems in the community but, rather, has adopted a narrower policy of crisis intervention and rehabilitation?

The Hon. J.R. Cornwall: I thank the member for Coles for that question, which is a very good one indeed and which is one that I was hoping would come up. I will respond very briefly; suffice to say that when I inherited the department in December 1985 it had been placed under great pressure in terms of budget cuts over a period since the late 1970s. I am not at this stage wishing to canvass in political terms who did what in what year, and so forth, but it had moved per force, because of successive budget constraints, from its role of doing many things, including community development, especially community support.

I do not believe it can ever have a total role of community development, but certainly it can have an enormously important role as a community support agency. That had been forgone virtually by default because the allocation to the department as a percentage of the total State Government budget, with a couple of notable and identifiable exceptions, had been contracting for almost a decade. On top of that one had the burgeoning notification of child abuse. Let me make it clear: I do not confine that to just child sexual abuse but to child abuse generally which has been and which now continues to increase exponentially, although I am happy to say it is moving, we think, towards a plateau. Indeed, based on the experience in the United States and other Australian States we can probably anticipate that we will reach that plateau in the next one or two years.

However, against that background there were both real and perceived stresses on the staff. At the same time, I am happy to say, the new Director-General as she was then and the Chief Executive Officer as she is now, instituted with her senior management a program of workload management. Also, through two successive budgets—1986-87 and now this year—we have been able to finance somewhere between an additional 60 to 70 positions *in toto*, apart from funding resources for the voluntary sector, so that I believe at the halfway point in my first term as Minister of Community Welfare we have reached an important turnaround point.

I hope that during the course of the next two years we will not only begin to see the fruits of our labour in terms of getting it right with child protection, and in a sophisticated and professional way, but we will also move back, as we are currently doing, to a significant role as a community support agency. In terms of workload management and outcomes, and so forth, I would ask my Chief Executive Officer to respond.

Ms Vardon: The question was in a number of parts, and I will respond to those various parts. As to what percentage of staff time was stipulated to be for community development, there is a rule of thumb that has been around for a number of years that we would like field staff in community welfare offices to work about 10 per cent of their time in community development. In fact, a recent analysis of the actual work time as effected by workload measurement was that, in the two items that we call 'welfare development in community' 'volunteers and community aides' and others, there was a total of about 9 per cent of all the time of the field staff allocated now that we can include community development. That is separate from general community development work, which I would like to talk about in a minute.

When one looks at the whole of the department it is not just the field services. A significant amount of funding of the department goes to supporting the non-government sector and about 35 per cent of the whole of our budget goes to what one might call a community development arm, which is support of the non-government sector in development of neighbourhood houses, youth development projects, and so on.

Taken as a whole, that is a very important community support and community development initiative. In relation to another program, adolescents at risk, which has about 24 staff attached to it, we have stipulated that 40 per cent of their work must be in community development type of activities. We realise the value of community development in that particular target group. In the questions relating to workload, it is often misunderstood that our priorities do not in fact imply case work, but our priorities are certainly targeted to groups that we consider to be most at risk. In fact, we do not direct our staff to any particular form of intervention. We expect them to take a community development approach as well as a group work approach and a case work approach in looking at the problems in their local communities.

It is not, I repeat, a way of forcing people into case work. Inevitably, however, the demand by individual clients coming to our counters is increasing, which puts on pressure for the case work response. We are challenging that inside our own organisation all the time. The workload measurement will not remove the priority listing. The workload measurement actually measures the work of the staff. From time to time we do review the priority listing. We would like to get rid of it, but it is a very sensible management tool when dealing with staff who are feeling overwhelmed by work. As tempting as it is to remove it, it is one of the most successful ways of reducing stress on our staff. Is there a part of the question we have not yet answered?

The Hon. JENNIFER CASHMORE: I think the part of the question which has not been addressed is whether the implementation of this requirement in the past year represents an acknowledgement by the Minister that for some years, particularly since 1985, the department has, instead of providing traditional services, focused on a rather narrower policy of crisis intervention and rehabilitation.

Ms Vardon: I cannot actually say that that has happened. When we look again at the work that is actually measured, there is a feeling in the community that all we do is child protection. In fact, on measurement, that is not so. If I went through all the work done in our field office, we would find that, for example, child protection work is only 20 per cent of the field work time. That includes everyone's time. We are doing quite a broad range of work, but not in every office. Some offices are more limited than others. I do not think that we can ever get back to a broad range of services.

What we have done is to say that the department can no longer do everything; that there is a real role for local government in human services, the non-government sector and other Government departments, and that we have to focus our workers as well as we can, given the resources that we have, but we can no longer be a general agency for every problem that the department used to take on in, say, the 1970s.

The Hon. J.R. Cornwall: As against that, there is a deliberate Government policy of coordination of human services generally, hence the coalescence movement with health involvement.

The Hon. JENNIFER CASHMORE: Can the Minister explain how the workload management system is enforced?

The Hon. J.R. Cornwall: I am sure that the Chief Executive Officer can do that far more competently and efficiently than I, and I will ask her to respond.

Ms Vardon: The workload measurement was designed by field staff, our internal auditor and the Public Service Association. Its purpose was to work out a way of controlling the work in each office. It is not actually a tool of management; at the central office level it is a tool for the local management, and once a week or once a fortnight, depending on the office, the work is allocated in time frames so that each particular item of work is estimated to an amount of time it will take over the next week or two weeks. The office is then able to assess how much time that officer has spare, and cases are then allocated in terms of the priorities as they present.

Some of the work is, therefore, not able to be done. This is recorded on a sheet which is collated, and the manager should know at any one time how much work is outstanding and how much work is being done. Some officers use it more rigorously than others.

The Hon. JENNIFER CASHMORE: My second subject is child sexual abuse, reference to which appears in the yellow book at page 303. In a recent press statement SACOSS, speaking on the subject of child sexual abuse, stated:

> No matter how much we would like the department and its staff to get its intervention right immediately, the reality is that some mistakes may be made on the way.

Does the Minister condone or accept an approach by the DCW to child sexual abuse which assumes that 'some mistakes along the way' is an acceptable practice?

The Hon. J.R. Cornwall: I accept an approach which says that the interests of the child are paramount: that is the overriding consideration. Quite clearly, this is an enormously difficult area. It is an area which society previously has chosen not to address, although it has been with us for a very long time—certainly generations, and possibly for hundreds of years. We have now chosen to address it in South Australia, as they have done in New South Wales, as they are beginning to do in other States, and as they have done or are beginning to do with various levels of sophistication around the world. The United States is certainly ahead of the UK, for example. I think that, on balance, in South Australia we are doing this very well. I can claim to have had some foresight in the matter when, as Minister of Health (although it was not my primary responsibility) in 1984, I convinced my Cabinet colleagues that we should set up a very high level task force with representation, as I recall, from 40 individuals and a significant number of groups.

By and large, I am very proud of the work that has been done in enormously difficult circumstances. If one wants to be critical of the performance of the social worker grade 1 who has been in a district office and who feels overwhelmed by the case work in this area which comes across his or her desk, I suppose that is always possible. If one wants to say that, on occasions, allegations have been made which subsequently proved to be unsubstantiated and, therefore, caused distress then, on a number of occasions, that has happened.

People have been accused of rape on occasions, too, but that has not caused us as a society to back away and say that we must not have rape laws because, just occasionally, someone might be wrongly accused. I have followed this matter with great diligence. I have tried to be, in a sense, the umpire. I have been at pains, as Minister, within the limits of my legitimate role as Minister, to see that we took as balanced a view as possible.

I believe very strongly—indeed, quite passionately—that we have been able to achieve that situation, and a lot of things have happened and a lot of things are continuing to happen which will ensure, I believe, that within this term of Government we will have the best child protection laws and the best child protection procedures and protocols in the country. We will have the best legislation as it relates to child sexual abuse, in particular, and the best protection of children in the community.

The aim—and I assure this Committee that I will follow it with singular dedication—is to ensure that by 1990 every child in this State will have not only a right but also an

expectation that they will be safe in their home environment, whatever and wherever that environment might be. That is the statement of the philosophy and the principle that underlies our approach to child protection in general and to child sexual abuse in particular.

As to the protocols that are being developed, the procedures that are followed, the practical administration and the operation of the professionals in the area—and we are talking about something that is very much multidisciplinary; it is certainly not the exclusive prerogative, nor should it be, of the department or the department's professional staff—I will call on Rod Squires (who is the Director of the Northern Metropolitan Region, who was a senior member of the Child Sexual Abuse Task Force, and who is one of the senior members of the department charged with the responsibility of child protection) to comment on some of the particular matters that I think deserve a response.

Mr Squires: I will mention a number of initiatives that have been taken to spearhead the need for upgrading child protection services both within the Department for Community Welfare and across other areas of the human services agencies. I am referring primarily to the Health Commission, the Education Department and the Police Department, as well as initiatives that are currently being taken with the Crown Solicitor's office and the Family Court. The significant event was the culmination of the Child Sexual Abuse Task Force Report which was distributed in November last year. Early this year there was the establishment of the joint Child Protection Unit, and this was an initiative by the Health Commission and the Department for Community Welfare to put together a policy and planning unit to upgrade policies, procedures, practices and protocols within this complex area of work.

A number of staffing appointments have been made, with Mr Kym Dwyer as the coordinator. A project officer has been appointed to work on policy and procedural developments, two staff were recently appointed to focus on the development of preventive strategies in child abuse and neglect, and Dr Di Hetzel has been seconded from the Health Commission to work on some of the medical aspects of child abuse and neglect. The Child Protection Unit has been involved in the upgrading of the departmental standard procedures. There have been some tangible outcomes. The revised standard procedures have been distributed within the department and to a number of other key Government departments for comments.

A manual of practice (which sets standards of practice, decision-making models and establishes standards of supervision) emanated from the United States of America and has been field tested for some eight months by Dr Barbara Meddin, who has a Ph.D. and who is situated in Perth. We are waiting to receive it, because we felt that there was no need for us to invent the wheel; we needed to capture the work that has been done in Western Australia and America.

The other initiatives involve the development of a case conferencing manual so that there can be proper interagency involvement. In addition, guidelines have been developed for interagency case management, so there are very clear roles and responsibilities of the other agencies that need to be involved in this complex area of child abuse and neglect. There have been many developments in tightening up the definitions of child abuse and neglect and the systems that we need to implement throughout the department to simplify things and to be able to cope with the volume of work that has been the result of additional notifications.

They are some of the initiatives that have been taken in the department by the Child Protection Unit. Other things that have occurred include the production of a medical protocol for child victims of sexual abuse. This was one of the recommendations of the Child Sexual Abuse Task Force and a group of doctors have been working on this protocol which is in the process of being distributed to a wide range of professional associations in the medical arena, as well as the Police Department, Crown Law and the Crown Prosecutor's office.

A number of working parties have been established. One is looking at the assessment and treatment of both adolescent and adult offenders. Another is looking at a protocol for specialist assessment of children. This is to take account of both the forensic requirements as well as the treatment and therapeutic requirements for children who have been abused. A working party has also been looking at the standards and the types of therapy services for child victims. Another working party has been looking at community based self-help groups. This has occurred because we need to expand the range of services for the child victims of abuse and the non-offending parent as well as the treatment services for the perpetrator.

The other initiative has been the establishment of a DCW/police working party to look at ways in which the police and community welfare staff can cooperate in an improved way and do joint interviewing, as well as ways in which evidence needs to be collected. Those are some of the detailed arrangements that have been implemented since the establishment of the Child Protection Unit. There has also been a review of the regional child protection panels which have been in operation for some 10 years, and a number of changes need to be made to them.

The Hon. JENNIFER CASHMORE: Does the Chief Executive Officer intend complying with a memorandum from Mrs Rosalie MacDonald, a senior member of the Premier's staff, issued in the past fortnight, and asking that the department review grievances compiled by Mr Tony Bushell regarding the department's management of the case involving his daughter? I understand that this review is a course of action also supported by senior officers of the Salvation Army, among others.

The Hon. J.R. Cornwall: The answer is, 'No.'

Ms LENEHAN: At page 303 of the Program Estimates, in relation to the 1987-88 specific targets and objectives, there is a statement that there will be an increase in community education regarding child abuse, and that to do this a senior community education officer and a community education officer have been appointed. I noted in the reflections that the Minister circulated that this is one of the aspects on page 3 that he highlighted. I completely support this community education program. Will the Minister or one of his officers outline for the Committee the way in which it is envisaged this community education program will be implemented by the officers who have been appointed?

The Hon. J.R. Cornwall: I defer to the Director, Northern Metropolitan, Mr Rod Squires, and ask him to respond to the question. Before he does I point out that there was some difficulty this afternoon and earlier today. There were 40 questions asked, and we are looking at a combined budget in excess of $1 billion. I understand that the Opposition health spokesman issued a statement late this afternoon that somehow or other I have attempted to obstruct the progress of this Committee. This is not really to be compared with some of the departments with budgets of $10 million to $20 million. I would like an indication from the members of the Committee about how much detail they want. If they want 'Yes' or 'No' answers, that is okay with me and we can provide them; however, if they want us to enter into significant detail and put on the record, as we

attempted to do all day today and as we are quite obviously attempting to do tonight, significant facts and figures then I believe that that is what the Committees are supposed to be about.

If, at the end of the day, for the troubles of all my senior officers all we get outside this Chamber is abuse, then I would like some indication at this point. We are very happy to respond in great detail, but I note that we have had only two full questions, albeit that the first question tonight was in three parts. I simply draw that to the attention of the Committee. From where I sit, we were happy with the way proceedings went earlier today and I am happy with the way proceedings are going tonight. I think that when people read the *Hansard* record they will see that there is an enormous volume of information, but I do not believe that I should cop a situation where the Estimates Committee process is abused when we do our very best to provide as much information as possible. The member for Heysen can smirk as much as he likes, but, nevertheless, the fact is—

The Hon. D.C. WOTTON interjecting:

The Hon. J.R. Cornwall: Never mind 'Come on!'; the fact is that the Opposition spokesman on health issued a silly statement at the end of today's proceedings that somehow or other, because we were providing all the information asked for, we were conducting an obfuscation process. I seek guidance in this matter.

The CHAIRMAN: This is a matter about which I cannot give the Minister guidance. If the Committee members preface their remarks by saying that they want full explanations or a short explanation, I would be happy to accept that. I accept that in some Committees the matter of whether a sign post goes here or there is not as important as a life and death matter dealing with hospitals, and the like, so there will be a variance from Committee to Committee on what the answers are, depending on the importance of the question. I must leave this matter up to the Committee—I cannot direct that the Minister shorten or lengthen his answers, as that is a matter for the Committee itself.

Ms LENEHAN: As I am the person who asked the question, perhaps I can explain briefly. The question I have asked relates to violence and abuse of children in families and I believe that this is an extremely important area. While I do not want to take up too much of the Committee's time, I would be grateful for an answer which encompasses the community education program that it is envisaged will be implemented and any other preventative strategies that the Minister feels are appropriate. As a member I have an enormous number of people coming to see me with these problems, as I am sure other members of the Parliament do. It seems to me that this is an area where a 'Yes' or 'No' answer is not appropriate, but I do not wish an answer that takes half an hour.

The Hon. J.R. Cornwall: I ask Mr Squires to respond on my behalf.

Mr Squires: The initiatives that we have on the drawing board for community education focus on the importance of the family and on the prevention of violence within the family. We need to increase the initiatives for educational opportunities for parents to understand child development and to develop parenting skills. The protective behaviours training in the Education Department needs to be expanded, not only within that department but also within the independent and Catholic schools, which need to be encouraged to establish similar protective programs. The important community education initiatives at local levels, with displays about the need for a child to be safe within its own home, need to be encouraged. There is already quite a lot of literature from both overseas and other States. I illustrate this with a document titled 'Child sexual assaults: No excuses, never ever', a community education initiative that was undertaken by the New South Wales Government. It refers to a lot of facts and myths about sexual abuse.

The Hon. J.R. Cornwall: When we have finished using this booklet, we will seek leave to table it.

Mr Squires: Other initiatives really relate to increasing community awareness, developing supports within local neighbourhoods, strengthening those supports, helping networks which need to be developed, and developing homemaker programs so that parents can be provided with assistance in caring for their children more adequately as well as developing child development skills. That is the broad outline. There will be broad community education programs on radio and television as well.

Ms LENEHAN: At page 305 of the Program Estimates there is reference to adolescents at risk. Earlier today, under the health line, I raised the matter of adolescents at risk in relation to the kinds of educational programs that could be offered in terms of AIDS. However, I note at page 305 of the yellow book that one of the specific targets and objectives for the coming year is the establishment of joint coordination and planning mechanisms for adolescents at risk in each region. I am aware that adolescents are at risk in a whole range of areas, not the least of which is alcohol and drug abuse, exploitation and other things. I apologise if I am being parochial, but I would like to know whether there are proposals to establish these joint coordination and planning mechanisms for the southern region of Adelaide, given that it has probably the fastest growing population and in some areas the largest proportion of population in the adolescent age group in South Australia.

The Hon. J.R. Cornwall: At the moment we are specifically developing what I think is an enormously positive and quite major program for adolescents at risk. I hope that by the end of this year, or early in the next calendar year, we will be able to release full and specific details of the program. An allocation has been made for that program in the 1987-88 budget. I ask the Chief Executive Officer to outline how we are bringing all the strands together and where we anticipate we will be in the development of the program by the end of the year and in broad terms—although at this stage we cannot be totally specific—where we are going with it. Having been briefed on it fairly recently, I think it is a very positive and exciting program indeed. I ask the Chief Executive Officer to outline what we mean both in specific and general terms by 'adolescents at risk'.

Ms Vardon: We have been concerned for some time that our departmental staff had a number of skills with adolescents at risk but that they tended to be a staff locked into the young offenders program. We have separated some of those staff from that program without putting it at risk in any way and we have melded it with our neighbourhood youth work program. We have considered how we can provide a better service for young people from 10 to 18 years of age whom we could characterise as being at risk from one or more of the following physical, emotional or sexual harms: some form of physical, emotional or sexual abuse; severely self-damaging behaviour; young people considering committing suicide; those where the family has broken down and they are about to be homeless; those continuing a substance of abuse and unable to be checked by their family; those at risk of exploitation and prostitution; teenage single parents; those who are homeless at a very early age and whom we are unable to get to school; those who are repeat runaways; and those seriously offending at an early age.

We considered that this group of young people needed special attention because they often fell through a number of programs and no-one was there to work with them. The department itself will develop adolescent support teams. Staff has been dedicated to those teams and hopefully they will be set up in each metropolitan region by December this year. There will be group workers and neighbourhood youth workers. One task of those teams will be to develop forums with other Government departments and work on this has already been done in the southern country region, most successfully, from Berri through to Mount Gambier. Those forums will include representatives of education, police, occasionally (and certainly in the metropolitan area) the Drug and Alcohol Services Council, our department, and other health facilities.

The purpose of that is for all those agencies to accept common responsibility for this group of children. There will be a team in all regions and a series of forums would certainly be established by these agencies in the southern region of Adelaide. I hope that this plan will be off the ground as soon as possible.

The Hon. J.R. Cornwall: I am sure, Mr Chairman, that the Chief Executive Officer was indicating that there would be a team in your area, as well as in that of the member for Mawson.

The CHAIRMAN: From the impartial position of the Chair, I say 'Hooray.'

Ms LENEHAN: One point in the reply related to the whole question of homelessness. Under program 6 on page 98 of the Estimates of Payments, reference is made to the supported accommodation and assistance program, which has had a significant increase in its budgetary allocation for the coming year to $7 469 000. If the Committee could not be given a break-down of that amount now, perhaps we could be told later where that money goes in terms of the various areas that receive assistance under this program. I am especially interested in the sums channelled to the provision of accommodation and the kinds of supported accommodation for young people. In the southern community, we have a youth accommodation service that has been running effectively and efficiently for some years, but those responsible for it always seem to be struggling for extra funds. Will they benefit from some of this extra resource allocation?

Additional Departmental Adviser:

Mr P. Bicknell, Manager, Non-government Welfare Unit.

The Hon. J.R. Cornwall: Rather than answer that myself, I think it would be desirable to call on Mr Peter Bicknell (Manager of the Non-government Welfare Unit), who is, among other things specifically concerned with the administration, on behalf of the State, of the sheltered accommodation assistance program, which is a joint Commonwealth-State program.

Mr Bicknell: Perhaps I could outline the budget as it presently stands in respect of the supported accommodation assistance program for this year. The Department for Community Welfare budget includes an allocation which, with Commonwealth matching, becomes $7 469 000. That sum is based on a matching arrangement between the Commonwealth and the State whereby the Commonwealth contributes 100 per cent for the State's 90 per cent. Since the State budget was formulated, the Minister has transferred another $100 000 from the Health portfolio and that will attract another $110 000 of Commonwealth funds.

The Minister has also been negotiating with the Commonwealth Government to increase the effort recognised by the Commonwealth Government as State Government effort in 'sap-like' programs. This is known as non-programmatic matching money. By having the Commonwealth Government acknowledge the extra effort of the Government and the department in the various areas in allocating money to the non-government sector in various places, the sum available this year for the supported accommodation program will be over $8 million. The department has discussed with the non-government sector the priorities that it should have in allocating this money and, in doing so, it has consulted widely, but at this stage decisions have not been taken as to the specific allocation of funds.

The Hon. D.C. WOTTON: I refer to the child protection program at page 303 of the yellow book. Are all notifications of alleged child abuse retained on file even though the evidence may not be sufficient to proceed to prosecution or even though the charge may be dismissed? If so, for how long is the entry of alleged abuse maintained on the file and does the maintenance of the entry of the notification conflict with the sentiments expressed by the Attorney-General that the expunging of certain criminal records after a certain time has merit? Will allegations of abuse that are not substantiated be incorporated into the Justice Information System?

The Hon. J.R. Cornwall: That question is a mixed bag: it is rather good in one part and rather terrible in another. A notification is not a criminal record. That is an extraordinary confusion. In 1986-87 there were 3 000 notifications of child abuse, but that is not to be confused with child sexual abuse. I would like a break-down as to what percentage of those 3 000 notifications, which incidentally involve 4 000 children, involved physical abuse, psychological abuse, sexual abuse or any other form. Of course, some of those notifications would still be proceeding.

I would also like a break-down of what estimate we might give the Committee, in replying to the member for Heysen's question, of what percentage of those notifications are likely to be proceeded with, validated or in fact are worthy of follow up. Obviously there are different categories. In one category initial investigation would prove that it was vexatious, spurious or not worth proceeding with.

The Hon. H. ALLISON: It should be expunged.

The Hon. J.R. Cornwall: I will ask Mr Squires to respond to that, also. What is the fate of that notification and does it remain on file forever? Does a suspected case of child abuse remain on file and, if so, for how long, and so on? It is a good question and I hope that the Committee will bear with us while we respond to it in some detail.

The Hon. D.C. WOTTON: Before an answer is provided, I go to the second part of my question: how does it relate to the Justice Information System?

The Hon. J.R. Cornwall: We will note that, but first we will address the issues that I have expanded on. However, it certainly does involve the Justice Information System, and I hope that Mr Squires will respond to that query in his usual competent way. If the honourable member is not satisfied with the response, I ask him to pursue it.

The Hon. H. ALLISON: More importantly, how does it relate to the ID card?

The Hon. J.R. Cornwall: I refuse to be sidetracked on that matter.

Mr Squires: It is a contentious issue which is receiving attention within the department. I mentioned earlier the upgrading of our standard procedures. Basically, we must establish, as laid down in our draft standard procedures, a notification register and then, after notifications have been received, and if they are in accordance with the definitions of physical, sexual or emotional abuse or neglect, we decide whether there is a legitimate notification of child abuse.

The next stage is to intervene and conduct an assessment. Following the assessment we make a decision about whether or not there will be a registration. In determining whether to register we acknowledge that we have been able to identify that abuse has been validated, either by our own intervention, by referring it to a doctor to obtain medical validation or by referring it to another specialist, such as a psychiatrist or a psychologist.

Currently we must determine how long the names of children will remain on this notification index and the registration index. We have not yet firmed up the time period. We need to address those issues and finalise the time period by about the end of November this year. These decisions are critical when we are incorporated into the Justice Information System. We are very conscious of the need to tidy up our register and the notification index.

The Hon. D.C. WOTTON: I refer to the program 'Substitute family care for children' on page 298 of the yellow book. In respect to the objective this year that DCW, in conjunction with the Substitute Care Advisory Committee, make recommendations regarding the range of services and funding levels needed to meet the needs of children separated, or at risk of separation from their families, will the Minister advise what services and funding levels are available to programs aimed at maintaining children within their families? Does the Minister concede that, without such a focus and without sufficient funding to carry out necessary remedial and preventative work to help a child's natural parents gain the necessary parenting skills, the removal of children becomes an expedient option and the reality is that it is very difficult, if not impossible, to reunite the child with the family?

The Hon. J.R. Cornwall: As a general comment, we are experiencing a significant expansion in the family support program in terms of parenting skills, supporting families, early intervention, and so on. All those matters are being given high priority as we move the department into the community support role to which I referred at the beginning of our discussion this evening. As to the specifics of the question, I will ask the Chief Executive Officer to respond.

Ms Vardon: The department does fund the non-government sector with a significant amount of money for foster care, children's payments and residential care. As the Minister said, the family support services program is significant and we do a number of things: for example, there are four types of foster placement. We believe that foster placement is extremely important for families where children are at risk of being separated from their parents. It is our great desire to return every child to their home. Sometimes families need practical help in the home and some respite care.

The first type of foster care that we support is short-term respite foster care whereby children under a range of families might go away for a weekend every now and then to give families a break. We support that program. We also support the early placement program, particularly by the Catholic Welfare Bureau and others where much work is done with a family where a child is at risk of placement. A lot of support, help and parental guidance is provided to make sure that these children can remain at home. There is also temporary foster care, where we might remove a child from a home for three or four months to give a family a break, and we then provide parenting support, financial assistance, financial counselling, and so on. In fact, a whole range of our programs meld together when children are separating from their parents: it might be the budget advice service from the department, the financial counselling service or counselling by our own staff, and so on. Our aim is always to keep a child at home at all costs, but sometimes that cannot happen.

Another type of foster care is what we call short-term foster care provided by the non-government sector, and we fund that type of program, which might last up to 18 months. There is also the long-term foster care program where children must leave their families for long periods. We will be allocating about $660 000 to non-government agencies for those foster care programs, and that is quite a significant amount of money which goes to the Catholic Welfare Bureau, Anglican Child Care, the Adelaide Central Mission, the Lutheran foster care program, the recently set up South-East emergency foster care program, and so on.

The Hon. J.R. Cornwall: I interpose here, Mr Chairman, to point out that I have a statistical table detailing the grants to non-government agencies for foster care. An amount of $660 000 is proposed for new initiatives funding as well as an inflation allowance and advances to non-government agencies for residential care. I ask that the table be included in *Hansard.*

SUBSTITUTE FAMILY CARE FOR CHILDREN
PROPOSED 1987-88

Grants—Non Government Agencies—Foster Care	$
Provisional Allocation Before Inflation:	
Catholic Welfare Bureau—Foster care	32 000
—Family care team	26 000
Anglican Child Care—Foster care	32 000
—Home support program	48 000
Adelaide Central Mission—Placement prevention	62 500
Lutheran—Foster care	32 000
S.E. Emergency Foster care/Teenage care	57 000
Teenage Care Program	73 000
Emergency Foster Care	125 000
Society of Sponsors	11 500
Aboriginal Child-Care (Intensive foster care)	50 000
C.N. Region—Foster Home	2 000
	$551 000
+Inflation Provision 7 per cent on $551 000	39 000
+Funds for New Initiatives 87/88 ($140 000 in full year)	70 000
	$660 000

Grants—Non-Government Agencies—Residential Care	$
Provisional Allocation Before Inflation:	
Catholic Family Welfare Bureau—Cottages	239 000
—St. Joseph's Centre	54 000
Anglican Child Care—Cottage	207 000
Adelaide Central Mission—Cottage	32 000
	$532 000
+Inflation Provision 7 per cent	37 000
	$569 000

The Hon. D.C. WOTTON: While I appreciate what the Minister and the Executive Director have had to say, that is not really what I was getting at. I am particularly concerned about finding out what you are doing to try to keep children in the home on a preventative basis. You have talked about the fostering schemes that you have, but what work and what funding are you providing for work that can be carried out to try to keep a child in a family situation?

The Hon. J.R. Cornwall: This year the family support program, which is a joint Commonwealth/State effort, is receiving funding of the order of $1.8 million. As to how that will be allocated, it is certainly not about domestic support in the home but about a whole range of activities that enhance parenting, particularly in the support of families with little children, young children. I will ask the Chief Executive Officer to clarify something and also to talk in some detail, without taking up too much time, about the sorts of targets that we have literally for family support and for early intervention and prevention, because there is a

great thrust starting to occur in the department. Indeed, I have a great commitment to prevention and early intervention, which is one reason why I have been fighting so hard (and I might add so successfully) for additional funding for the department.

Ms Vardon: I would like to clarify that foster care programs are often family support programs themselves. I am not talking about the long-term foster care because that is obviously when a child is taken away, but all those short-term foster programs that I spoke of do give relief to families. While the children are with respite care or short-term care, and so forth, we are often working with the families to get them strong enough to have the children back. That is an important form of prevention of family breakdown. I do not want foster care to be seen as a way of breaking families up—it keeps them together, particularly emergency foster care.

I suppose that the family support program is the most significant of all our programs: it is geared to supporting families with the financial counselling service. The main thrust of the family support program has been to develop homemaker programs and parenting skills programs. We know that many parents do not know how to be good parents, and we want them to be. We think that parenting education is important, as are parenting courses, and tied in with our child protection program in the next year we will put much more into the parenting programs, and Rod Squires talked about that earlier. Much of the family support money goes into that.

Other sorts of programs involve visiting. There was the program at Coober Pedy being funded where Aboriginal children were taken to school. The school worked with the families significantly so that their kids went to school and the families became part of the school community. The children had head lice reduced and became more accepted at the school. They felt better, and so on. I have a large list of family support programs. I will not go through them all, but they are all about early intervention and supporting families that might be vulnerable and at another time might have lost their children.

Ms LENEHAN: It seems in my experience, working in an area where there is a large degree of poverty and a relatively high degree of child abuse, that the whole question of a social justice strategy and the training of people, in terms of being able to manage their own budgets and having some feeling of competency about managing their funds and having adequate funds, cannot be separated from this whole question of family breakdown.

I realise that I am not telling the Committee anything it does not already know, because there is an enormous amount of research on that. Therefore, my question relates to the budget advice service. I am interested in hearing what are the proposals for the coming year concerning that service, and how successful does the Minister believe it is in meeting a range of objectives that are much broader than just providing straight budget advice to people?

The Hon. J.R. Cornwall: Clearly, that is not a dorothy dixer. The member for Mawson is trying to blow a perfectly good story that I had hoped to announce at a general press conference in two or three weeks. It is one of the first major initiatives of the social justice strategy. However, she has raised some very good and valid points. The department has had a budget advice service for many years, and currently we employ 41 casual part-time budget advisers who work on a sessional basis. They range from retired bank managers to people who have some skills in the area of advising heads of households (whatever a head of a household might be these days) on how they can manage on a limited amount of money. That amounts to 8.6 full-time staff and they are distributed through 41 locations around the suburbs and the State. One of the difficulties in 1987 is that that budget advice in many cases comes too late. For example, some credit practices are, to say the least, dubious. For a variety of reasons people are becoming overcommitted. The explosion of the plastic credit card has certainly contributed and is a well documented contributor to people becoming overcommitted.

By the time that they get to the budget advice service on many occasions the water level has risen above their nose and they are starting to drown in their commitments. All the budget advice in the world is not much good if one has a weekly commitment of $180 and an income of $120. A number of things need to be done. First, we need to restrucutre and upgrade our own service. A major review was done of the service in late 1985 and early 1986, I think, and we have since been devising means and looking at resources and waiting on some additional resources allocated in the 1987-88 budget to be able to upgrade our budget advice service to a genuine financial counselling service.

In addition, we know that it is necessary to involve the voluntary sector in financial counselling and advocacy. That is an important role for the Department of Consumer Affairs and we would not want in any way to usurp that. It is also an important role for the voluntary sector, for agencies like the Mission, which has traditionally provided financial counselling but which needs to take on a role of financial advocacy. As a matter of deliberate policy we believe that that advocacy should be taken on by the voluntary sector in an independent way.

It is rather more difficult for a Government agency, for example, to knock on the door of a credit provider and say that it believes that the company is involved in undesirable practices while the Department of State Development or one of the central agencies of Government is negotiating with the same company to try to get some sort of major financial deal going that would result in desirable development for the State. It is much more desirable that that advocacy role be taken on by the voluntary sector.

Without going into detail, money has been set aside for funding the voluntary sector for an enhanced financial counselling role as well as an independent financial advocacy role. Arrangements are well advanced to restructure and enhance our own role as a department, not just in budget advice but in financial counselling. All of those things are nearing fruition, and I anticipate that I will be able to make a major announcement concerning that as part of the social justice strategy reasonably early in October.

Ms LENEHAN: I would not want to pre-empt the Minister's announcement in that regard, so I will not pursue the matter. I would like to refer the Committee to page 306 of the yellow book referring to the domestic violence services. I am very aware of a number of issues going on at the moment with regard to domestic violence, and I know that the Domestic Violence Council has produced a report. In the answer to a question last week, the Premier announced that it would be made public, and I think he put a figure of six weeks on it, so I am not asking any question relating to the report which has not yet been released.

One of the specific targets and objectives for 1987-88 is the development of an integrated domestic violence data collection system. It seems to me that this is extremely important if we are going to get a comprehensive and accurate picture of how widespread domestic violence is in terms of it being reported. Can the Minister or his advisers tell the Committee how this is to be collated and what

benefits he believes will accrue from such an integrated system of the collection of data?

The Hon. J.R. Cornwall: The Committee members are no doubt aware that Sue Vardon was and is the Chairperson of the Domestic Violence Task Force. It is my recollection that there were something like 80 people on that task force and, in fact, I remember some of my male colleagues being somewhat sceptical about that being such an enormous number of people that it would never work, and that the task force would never produce a report. It is well known, of course, that as a practising quasi feminist I have far more confidence. In the event, I think that it was a very successful operation.

It took a long time, understandably, because many points of view had to be heard and investigated, but the task force has now produced a final report. It has been with the Premier for a few short weeks and a number of further consultations have taken place and, I understand, the recommendations arising from the report and the report itself should be going to Cabinet for consideration in the near future, certainly within weeks. I know what is in it: I am not about to share that with you publicly, but I think that it contains some very practical recommendations. As to your specific question, I think it is appropriate that I should ask the Chief Executive Officer—in this case Sue Vardon, Chairperson of the Domestic Violence Council—to respond.

Ms Vardon: One of the problems we had in writing the domestic violence report and doing the preliminary work-up for it was that we were unable to really capture the extent of violence. We had a few indicators: we had police reports, we had calls from Crisis Care, and we had numbers of women who were going to shelters, but we believed that domestic violence was a substantially bigger problem than actually showed up on any of the existing public records. For example, in our department we can tell you about child protection, but often if there is a family where the children are being abused it can be likely that the spouse is being abused as well, but we do not record that properly and it sometimes looks as though we do not do any work in our department on domestic violence. In fact, we are significantly involved with them as the families present to us.

Domestic violence as an issue is not well recorded. For example, there are a number of admissions into hospital casualty departments of women who are victims of violence, and the hospital casualty does not recognise, does not report or record on the intake sheet that a person was a victim of violence, and will probably talk about bruising or something, so it gets put under those categories and nothing else. We have been keen within our own department to make the connection between violence in the home, child protection and spouse abuse, as well as involving the Domestic Violence Council itself in trying to get better records; so Rod Squires and others have been negotiating with the police to get better reporting by all Government agencies of this particular social issue.

The advantages are that, once the raw data is available, we can probably do better with our intervention. The domestic violence report recommends a large number of ways of doing better, but sometimes one needs to have a more solid base on which to develop services, and we hope that we can develop an integrated data base with all Government agencies—particularly using JIS. which will be a very exciting tool for social policy development in this State. Using JIS, we will be able to have a much better understanding of this major social issue.

Ms LENEHAN: My next question to the Minister also relates to the same page and, in fact, to the next target and objective for this year, namely, the examination of the special needs of the disabled and the aged for domestic violence services. This is something about which I have long been concerned. Without asking the Minister to preempt anything which may be contained in the Domestic Violence Council's report, is it possible to share with the Committee the way in which such an examination can be undertaken? Evidence has been presented to me that this is one area which is really very hidden. Old people who are the victims of domestic violence are very reluctant to admit that this is happening to them, because of a sense of shame and a sense of failure, and people who have a disability often cannot report such domestic violence.

If one is confined, for example, as in one case I have heard of where someone was in a wheelchair, it is very difficult to report such instances of domestic violence when one physically cannot remove onself from the scene of such violence. Can the Committee have some information about how such an examination of these special needs (which I think everyone will acknowledge are very special) is proposed to be undertaken?

The Hon. J.R. Cornwall: It is true to say that there is a dearth of information in three areas: the aged—and the frail aged, in particular—the physically disabled, and the intellectually disabled. The problem of domestic violence in those groups has been raised variously by the Royal District Nursing Service, by Regency Park and by the Intellectually Disabled Services Council. The question of domestic violence in the aged is currently receiving some attention from the Commissioner for the Ageing (Adam Graycar). I have not had a specific proposal as to a major project or major research in the area, but it is certainly under attention and I anticipate that something will come to me in the foreseeable future.

The matters were addressed by the Domestic Violence Task Force. Basically, their recommendations are much as I have outlined the subject to the Committee—that the areas need further investigation. We simply do not know enough—nor does anyone else. We are not able to draw on some well documented work that has been done in other States, as I understand it, but it is a very good point which certainly needs to be addressed.

The Hon. H. ALLISON: I believe that the Minister has decided to close down three community-based or non-secure residential care units, and that he has also decided to declare 15 residential care staff to be redundant. It has been suggested that morale within that area is seriously under pressure. Will the Minister identify the units and say whether he has notified which staff are earmarked for dismissal?

The Hon. J.R. Cornwall: I have decided nothing; I know nothing. However, I have enormous faith and confidence in my Deputy CEO in these matters, and I will ask her to respond at once. If we do not obtain a satisfactory answer, we will jointly pursue the matter further.

Ms Mann: There has been a review this year of the community residential care facilities, and included in the review was consideration of alternative ways of operating those centres. One of the terms of reference was to look at whether the non-government sector could take responsibility for some of those centres. The review reported to the Minister and a number of further initiatives need to be undertaken. The issues were not as simple as they first appeared. The Minister initiated the review at the request of the non-government sector. It is also true to say that no decisions have been taken. One of the difficulties has been that the non-government sector initially was very interested in operating the facilities and argued, what appeared to be convincingly, that it could do so at minimal cost.

When it went back and did its homework in terms of the operations it would have to provide and the staffing for the nature of the young people that we serve in our own facilities, it got cold feet and determined that it could not do it at the kind of cost it had hoped (they were talking about, I think, 50 per cent of the cost that it costs us to operate them). Initially, while it was a willing partner to take over our facilities in a number of instances, the interest is no longer there. That explains, perhaps, how there might have been some consideration of the transfer of three centres, but there is not any plan, and there certainly was no discussion of redundant staff.

The Hon. J.R. Cornwall: May I immediately place on record the fact that I might have quite inadvertently misled this Committee. In fact, the review was established at my specific request. I did not immediately connect it up with the questions from the member for Mount Gambier. What happened is that the voluntary sector, as represented by three different agencies, came to me fairly early in my stewardship in community welfare and claimed that they could provide this community residential care—non-custodial care—very much more effectively and efficiently, and certainly more cheaply, than some of the services that we were providing.

The reality, when the matter was examined, was that in a sense it was taking the low tariff end and we were taking the tough end departmentally. We have not stopped talking with a whole range of people. This review is at present being circulated among all interested parties. It is not a public document in the sense that it has been released with a fanfare of trumpets and a suitable press conference, but it is in widespread circulation, and is presently a matter for ongoing consultation. If somebody comes up with a proposal which shows that the voluntary sector (in some areas at least) can do it better and cheaper without compromising the quality of care or the level of service, then we would certainly be prepared to look at it from a number of points of view, including the economic.

Until such time as I get all the responses in in November, there will be no propositions at all. Certainly, there is not going to be the sort of revolution which one or two of the people who came to see me initially would have suggested. If in fact they could have provided all these services at half-price without compromising the quality of care, I would have been extremely interested. In any case, the staff involved for us in community residential care are mostly permanent staff and their ongoing employment would have been assured in any case.

The Hon. H. ALLISON: Page 305 of the yellow book refers to adolescents at risk and the Norwood Project Centre. The broad objective is:

> ... to assist youth to overcome their developmental and situational difficulties so that they can lead safe and purposeful lives. The program attempts to prevent the need for statutory intervention at a later date.

Earlier this month DCW informed the Norwood Project Centre that its share of funding would not continue beyond 31 December 1987. The rationale for this action, according to a letter to the Editor of the *Advertiser* on 19 September from the Chief Executive Officer of DCW was that resources must go to the most disadvantaged—the most at risk children.

It has been alleged that this is a case of DCW focusing on crisis intervention rather than prevention of problems before they arise or are compounded. The decision appears at odds with the broad objectives of the department's 'Adolescents at Risk' program, let alone the Government's recently announced social justice strategy. The facts presented in a September newsletter of the centre are as follows:

Of the 150 students who have attended the centre from 59 different schools in three years—

45.6 per cent Victims of child abuse (sexual, physical and emotional abuse).
83 per cent Behaviour problems in community.
78 per cent Before the Children's Aid Panel.
48 per cent Physically violent [half of them almost].
75 per cent Major management problems for parents.
91 per cent Behaviour problem in yard.
87 per cent Behaviour problem in class.
26 per cent Substance abuse.
33 per cent Live in foster homes, units or care.

Considering these facts, was the Minister really denying that the Norwood Project Centre still had an important role to play both as an education program and in meeting DCW's own objectives under the 'Adolescents at Risk' program, because his Chief Executive Officer has not denied the value of the centre in helping adolescents at risk?

Does the Minister believe that it is acceptable for DCW to withdraw funding without first confirming whether the Education Department has resources to meet what is obviously, if these statistics presented by the centre are accurate, a really desperate shortfall?

The Hon. J.R. Cornwall: I do not want to get locked in any demarcation disputes, and as Chairman of the Human Services Committee of Cabinet I am all about coordination of services right across the board. Education fits in very well with health and welfare, and our relations by and large are very good. However, we have to look at how we allocate our resources even when we are allocated an extra $3 million in successive budgets, because the demands are very great. Basically, we have to look at value for money.

I thought that the letter from the Chief Executive Officer, which appeared in the *Advertiser*, was splendid and put our case very well. However, the decision regarding the Norwood Project Centre, how it was reached, why it was reached, and the pre-budget climate in which it was reached are matters which can be best addressed by the Deputy Chief Executive Officer, Ms Mann.

Ms Mann: It is true that the Norwood Project Centre has undertaken some very good work over the years and our withdrawal from the funding of staff in that project is in no way to demean the work that it has undertaken. We need to put into perspective the figures just cited to us. The Norwood Project Centre deals with about 50 children a year, 25 at any one time. The figures are for children in substitute care, abused children, and children who have been before the courts. The department deals with 6 000 children who go before children's aid panels each year, 4 000 who go before the courts, 4 000 subject of child protection notices, and so on. Therefore, if one matches the 50 children we are considering at the Norwood Project Centre against the 14 000 to 20 000 (because we have other children through wider adolescents at risk programs) one gets a picture that it is in fact a small program focusing on a small and specifically targeted educational component.

I do not want to demean the excellent work of the project but in terms of directing our resources to those most in need of them we had to take that hard decision and redirect from that small number at the Norwood Project Centre to those areas where we were still unable to deal adequately with the more pressing needs. That also includes the adolescents at risk program; the Chief Executive Officer earlier talked about the community development component. We are not withdrawing from the area but merely redirecting our resources to where we feel they can have a greater impact.

The Hon. H. ALLISON: My third question relates to the general field of administration and resource support and specifically to the appeal system contained within almost every decision arrived at by the Department for Community

Welfare. My question relates to the appeal mechanisms available for the investigation of complaints arising from DCW practices in the management and/or review of individual cases. Does the Minister consider that the department's consumer advocate has sufficient powers, status, and particularly independence from departmental pressures, to act as an impartial advocate?

Does he, at the same time, support his predecessor's belief that a community welfare Ombudsman is required as a foil or balance to the very considerable powers at the disposal of DCW to intervene in family relationships? If so, is he aware that the officer assigned the role in the Ombudsman's office to scrutinise complaints about DCW has been transferred back to the Crown Law office and that the position has not since been filled, a transfer I add that was not acknowledged by the Ombudsman's office for some six weeks despite repeated requests from a number of quarters, including the Premier's office, about the whereabouts of that officer.

The Hon. J.R. Cornwall: I am not about to interfere in the affairs of the Ombudsman. There is a general misconception in some ways as to where the department fits in the scheme of things. With regard to the areas in which we have undoubtedly received the most complaints—that is, the 'in need of care' applications and the child protection area generally—it ought to be remembered (and I cannot say this too often) that 'the welfare' does not go in and decide unilaterally that it will remove a child from a family or will declare that child to be in need of care, or that it will place that child in a foster home, or anything else.

The majority of those decisions go to the Children's Court and it is on a court order that a child is declared to be in need of care, not because some well meaning social worker has decided unilaterally that that is the decision that ought to be taken. A very large number of those decisions are taken after a case has been before the court, a case has been made out before the court, and the judge or magistrate in the Children's Court has made a proper decision under the system and independently that it is in the child's best interests that it be put into guardianship, or orders whatever other mechanism is considered desirable and suitable under the legislation.

That very often puts us in an extremely difficult position in defending those decisions. They are put up by the protagonists as being decisions taken unilaterally by the department when in fact we have had a judgment of the Children's Court. We are not allowed—in fact, we are quite expressly forbidden under existing legislation—to discuss Children's Court judgments even using non-identifying information. As a matter of interest, it has always seemed to me that that places us in a position of boxing with one hand tied behind our back and with a blindfold on. I discussed this matter only a few days ago with the Attorney-General and the Crown Solicitor. I believe a number of amendments are desirable which would at least enable the Minister or the Chief Executive Officer, under defined circumstances, to discuss decisions provided that quite clearly there was non-identifying information in order to totally protect the child.

It is enormously frustrating to know that a judgment has been taken regarding a particular case where the judge in the Children's Court has considered all of the evidence and decided that the child in the child's interest, should be declared to be in need of care, should be placed under the guardianship of the Minister until attaining a certain age, or until such time as the case is reviewed, and so forth, yet the parent of the child, with no regard to that at all, can claim that the department collectively or individuals of the department have acted improperly.

As Minister I find myself unable to adequately or properly defend officers who I know have acted most properly and who the court has found independently to have acted most properly. This is a matter that, although sensitive, must be addressed and will be addressed during the period that I am Minister. The other thing which we have done and which was announced recently (an initiative that was directly driven by me as Minister because I have some strong views about it) is to obtain funding in the 1987-88 budget to finance the appointment of independent child advocates to the Children's Interest Bureau.

Those advocates will be involved in pre-court conferences. They will act quite independently in the child's interests; they will act independently of the departmental officer or officers bringing forward a particular case; they will not have a legal or paralegal status, but will certainly be available in some way or other yet to be accurately defined to give expert evidence in the Children's Court if required or, in that sense, although not in the legal advocate sense, to intervene on behalf of the child. Therefore, we will have child advocates, we have the Children's Court which is quite independent and within the judicial system and cannot or must not ever be compromised, and we also have the Ombudsman. I can assure members that some of the active members of PIAC in particular have been to the Ombudsman and had him pursue their particular point of view with great vigour. I cannot recall one case to date where the Ombudsman has done other than find in favour of the officer or officers of the Department for Community Welfare. As I understand, although I have not been directly approached, at the moment the idea of a role for the Ombudsman specifically for children is being pursued.

My own notion is that it may be desirable to develop the Children's Interest Bureau a step further past the child advocacy and child advocate position to become literally a children's ombudsman. That is a personal view, not a Government view, and I have not taken it to Cabinet at this point. However, I strongly believe that it is a logical progression. It goes further than the recommendations in the Bidmeade review. It is well worth investigating. It is done in Scandinavian countries and has much to recommend it.

The consumer advocate role is concurrently being developed. It is not at a point where frankly I can comment in the sense of saying that it is either a wonderful success or a dismal failure. It is early days and we will continue to watch the position develop and be much better able to comment on the efficacy or otherwise of that role in six months or 12 months.

The Hon. H. ALLISON: I do not envy the Minister in what is really a difficult situation in family cases, whether it is family law or whatever. One factor that may lead to substantial abuse of departmental officers is involved in the delay between a child's leaving home, reporting for whatever cause to Community Welfare officers, being removed from home, being kept away from parents and family, and then for the case to be heard in court. What is the average length of time between reporting and having the matter judged in court, when one would assume that parents would be more amenable to accepting a truly impartial decision?

The Hon. J.R. Cornwall: The honourable member is now speaking of actually getting it into the courts?

The Hon. H. ALLISON: Yes. I am referring to the delay between the reporting of the case and its coming before a judge in court for an impartial hearing away from the Ombudsman or the department.

The Hon. J.R. Cornwall: The short answer is 'Too long.' Indeed, one might say 'Far too long.' However, the time is coming down.

The Hon. H. ALLISON: It is the period when officers are subject to the greatest abuse and when fall-outs occur between family, parents and children.

The Hon. J.R. Cornwall: I could not agree more. We are working on it. To a significant extent it is a resource problem. An additional acting magistrate has been appointed and recently reappointed, but I still concede the point that the time is unacceptably long. We will continue to advocate to try to have it reduced. However, that matter is not within my jurisdiction.

Ms LENEHAN: My first question relates to '1987-88 specific targets/objectives' on page 297 of the yellow book where it states that one objective is to prepare plans for relocation and decentralisation of Crisis Care. As the Noarlunga Community Services Forum and the southern community has raised this matter with the Department for Community Welfare for some years, are there any plans to provide a decentralised Crisis Care service in the southern community of Adelaide?

The Hon. J.R. Cornwall: That amount is to establish a Crisis Care service in the Iron Triangle, where it is most desperately needed. Over recent years a number of submissions and proposals have been put to us to decentralise Crisis Care in metropolitan Adelaide. A number of proposals have been put to us which would involve multi-disciplinary Crisis Care teams whereby our own people, for example, would work with the police in domestic violence cases—and that is just one example which comes readily to mind. The simple position this year is that we do not have the resources to do it. No initiatives are planned to decentralise Crisis Care in metropolitan Adelaide in 1987-88.

Ms LENEHAN: When funds do become available for the decentralisation of Crisis Care, I ask that the southern community be given some priority. Crisis Care provides an excellent service but the travelling time for people coming from the southern area is a great disadvantage to both the family and the individual in crisis, and I believe it is also frustrating for the workers. I want to frame my question in a positive and supportive way in terms of the services provided by Crisis Care and I would like it recorded that its services are desperately needed in the southern area.

Before asking my second question I seek some clarification. Under program 6 at page 98 of the Estimates of Payments, three figures are given in relation to welfare activities and the proposed amount for 1987-88 is $2.058 million. This does not accord with the figure provided on page 291 of the yellow book under 'Community welfare grants scheme', where the proposed amount for 1987-88 is $2.365 million, which is well over $200 000 more than the figure provided in the Estimates of Payments. Why is there a discrepancy between the figure provided in the yellow book and the figure in the Estimates of Payments?

The CHAIRMAN: This is not a supplementary question but a point of clarification.

Ms LENEHAN: Yes, I need clarification about which figure is correct for the community welfare grants before I can ask my question.

The Hon. J.R. Cornwall: It is a very good question which shows that the honourable member has been doing some homework. As is usually the case there is a quite logical explanation. I do not think that I should try and battle through this; I think it might be much better if either the Deputy CEO or the Director of Administration and Finance respond. It is clearly a bookkeeping matter. I point out that there has been a significant increase and not a decrease.

Ms LENEHAN: Could I just have the figure for community welfare grants for 1987-88.

Ms Mann: The discrepancy in the yellow book is that we have salaries used to administer the program from the department included in the total grants, which explains the difference.

Ms LENEHAN: So that the figure we should be working from is $2 058 000 in the white book. I note that there is a reduction in actual payments for 1986-87. Can the Minister give the Committee an assurance that the small grants for seniors program, which I believe has operated incredibly successfully, will not be reduced in this coming year?

The Hon. J.R. Cornwall: Yes, I can. I am concerned that the Committee may be left with the impression that community welfare grants and grants from the department to the voluntary sector may in some way have been reduced. If members were to read *Hansard*, it is important that we pursue the matter as to how much has been allocated. From the figures in front of me, it is important to look at the range of grants for home and community care, welfare activities, family support, supplementary accommodation assistance plan, non-government agencies—foster care and residential care—funds for seniors, youth development projects, United Way underwriting and capital subsidies to non-government agencies. Last year the total was $13.82 million and this year it is $15.65 million. Put in a nutshell, some of the money previously identified as being in community welfare grants has been transferred to the new family support program, where it attracts matching funds from the Commonwealth, and there has been a significant net increase.

Ms LENEHAN: If that is the case, can the Minister give the Committee an assurance that small grants for seniors—and I think he touched on that—will not be reduced this year?

The Hon. J.R. Cornwall: The 1987-88 budget provided $160 000 for the small grants for seniors fund. This was an increase of $10 000 over the allocation for 1986-87.

Ms LENEHAN: I am delighted with that answer. Can the Minister say what proportion of funds allocated to the voluntary sector actually go to church or religious organisations, so that we get some idea of the distribution of that money to the voluntary sector?

The Hon. J.R. Cornwall: I will ask one of my officers to give specific amounts on that in a moment. There was a suggestion that, because one particular agency was considered to be located in an area that was not especially suitable for youth accommodation, there was some unresolved question about the quality of the programs and support offered—that somehow or other we as a department and a Government did not support church agencies. Nothing could be further from the truth. In fact, 31 per cent of all funds allocated to community organisations through the non-government welfare unit go to church based groups.

I can give a further breakdown: of community welfare grants, 12 per cent goes to church based groups; 37 per cent of our family support program goes to church based groups; and in the support and accommodation assistance program, 23 per cent of the women's funding goes to church based groups.

Further, 31 per cent of youth based funding and 67 per cent of the general sheltered accommodation program go to church groups; and of the small grants for seniors, even, 15 per cent—including, one has to presume, the odd piano—finds its way to church based groups. So, we rely very heavily on the churches and, indeed, in the non-government sector see ourselves as being in partnership in the social welfare area with the churches.

The Hon. JENNIFER CASHMORE: My question is a multiple one relating to the Christies Beach women's shelter, identified on page 300 of the yellow book. Did the Christies

Beach women's shelter conform with instructions given by the Department for Community Welfare on financial accountability prior to the Minister's decision to close the shelter? Does the report by the Corporate Affairs Commission relating to the shelter (which I understand has been presented to the Government) substantiate the allegations of maladministration? In relation to the report *Shelters in the Storm*, does the Minister intend to take any action on the report's damning criticism of senior management of DCW for 'failing over five years to act on complaints and allegations frequently brought to their attention', and does the Minister accept the implied conclusion that the withdrawal of funding would not have been necessary if senior management and responsible Ministers—Federal and State—had acted earlier and more positively with respect to deficiencies in financial management and allegations of professional misbehaviour?

The Hon. J.R. Cornwall: The first question was in regard to whether the Christies Beach shelter signed or was prepared to sign the original undertaking which was required not just by the State Government and the Department for Community Welfare but also by the Commonwealth: the answer to that is 'No'. As to whether the Corporate Affairs Commission inquiry found that there were irregularities, serious or otherwise, the answer is 'Yes'. These are straight questions to which I can give straight answers. As to the allegation rather than question concerning the competence of the Department for Community Welfare over what was described as the previous five years, I have already answered that in the Legislative Council. I do not think for one minute that we could suggest that the department was always entirely competent or that it was blameless.

The reality, however, was that every time an attempt was made to get better financial accountability the bully girls used to use political muscle. I confine that appellation to one or two people at the Christies Beach shelter, and certainly not to the women who are associated with the other shelters in this State, the vast majority of whom, of course, emerged very well from the report *Shelters in the Storm*. They provide an excellent service and I take this opportunity, yet again, to commend them for the role they play as a significant, although certainly not exclusive, part of the network of support for women who have been victims of domestic violence. However, eventually, as Minister I had to say, 'The game's up: these are public funds and there is going to be accountability, and there is an end to it.'

I would have thought that the Opposition would applaud that position. I do not know whether you are suggesting seriously that I should have allowed to persist any longer a position in which there was no accountability for public funds. I have seen the report of the Corporate Affairs Commission and I know that there were various bank accounts which were never declared, for example, by the Christies Beach shelter. I could not allow that to go on. I do not point the finger at the department for not immediately resisting political pressure.

I commend those officers who have been involved and been placed under enormous stress because of the actions that we had to take. I particularly commend the officers in the non-government welfare unit, two or three of whom I know at this moment are very close to breakdown and burnout because of the trauma that has been inflicted on them in the actions that have had to be taken to straighten out Christies Beach. Nevertheless, they have done it with courage and integrity, and I commend them for it.

The Hon. JENNIFER CASHMORE: I refer to page 289 of the yellow book. The ALP's community welfare policy 1982 issued by the then Leader (John Bannon) noted that the Tonkin Government budget for 1982-83 proposed 1 243 full-time equivalent staff for the Department for Community Welfare. In relation to this level of staff the document noted:

> . . . the staffing reductions are callous. They can lead only to intensifying the deprivation experienced by a rising number of families in South Australia.

The staffing level proposed for DCW this year is 1 195.5 full-time equivalents. This number is a reduction of 11.5 over last year and a fall of 47.5 compared to the number proposed by the Tonkin Government for 1982-83.

Considering the verdict by SACOSS, SACOTA, CAN, YACCSA and DPI in the report 'A Caring State Strategy' that today deprivation experienced by families is greater on every indicator they selected than it was when the Bannon Government was elected, would the Minister describe the staffing reductions in DCW under his stewardship as 'callous' or 'scandalous'?

The Hon. J.R. Cornwall: I certainly would, if they had occurred. The honourable member is talking about my stewardship?

The Hon. JENNIFER CASHMORE: Yes, and the numbers of staff currently in the department compared to 1982.

The Hon. J.R. Cornwall: Let me make two points at once: part of that 1 243 were clearly Commonwealth funded positions. I think that 32 positions were funded under the Aboriginal Advancement Program which was swung over and hung over from the mid-1970s. I have been the Minister through two budgets. Last year I was able to obtain a full year's funding equivalent to about $800 000, and I think from memory 26 additional positions, although I would not be held to that on pain of losing my job. This year I know specifically that I have been able to achieve additional funding of $2.1 million and directly in welfare something like 28 positions when the rest of the Government has to accept some savings. If one includes child advocates and a number of other positions, it would be something of the order of 40 additional positions. I am very proud of what I have been able to achieve in a relatively short time. I will ask Ms Mann to attend to staff movements, where they might have gone and accounting.

Ms Mann: The earlier figures include the Magill Home staff who were transferred from Community Welfare to the South Australian Health Commission in February 1985; and in July 1986 when the Children's Services Office opened, the family day care functions and all the family day care and associated staff were transferred from Community Welfare, approximately another 100 staff. They could be the only staff changes that have occurred because there have been no staff reductions. In fact, there have been staff increases.

The Hon. J.R. Cornwall: In fact, we are about 200 staff better off than we were when we described the Tonkin Government's performance as appalling, which means that we were accurate then as we are now.

The Hon. JENNIFER CASHMORE: Do staffing levels for this year take account of one of the principal grievances of DCW field staff and clerical workers earlier this year that provision be made for replacement staff when long service leave is taken?

The Hon. J.R. Cornwall: Yes, that has been done.

The Hon. D.C. WOTTON: I received an answer to a question I asked previously on child abuse and we were talking particularly about family support programs. Ms Vardon indicated that there were a number of such programs. Is it possible to have information provided about how many family support programs there are?

During the Estimates Committees last year the Minister stated emphatically that it was never intended that there be

a formal merger and said that it had always been considered in terms of coalescence; there had never been any suggestion of formal amalgamation in any way, shape or form. This year at page 307 an issue is identified as a proposed co-location with the Health Commission in 1988-89 and a subsequent amalgamation of the department and the commission into one organisation. It is apparent that the Minister has changed direction yet again, and amalgamation now seems to be the flavour of the month.

Will the Minister confirm or deny whether amalgamation of the DCW and the Health Commission is now his objective? Will he advise whether it is correct that both the Department of Community Welfare and the Health Commission are to move location to the building being constructed on the corner of Pulteney Street and Rundle Mall? In July 1986, in order to pursue the concept of coalescence, a ministerial steering committee was established supported by a secretariat and two working parties. A joint bulletin was produced to ensure that staff of both organisations were kept up to date with developments. Are those structures still in place? Is the bulletin still being produced and, if so, will the Minister provide back copies and future copies to members who are interested in moves to amalgamate health and community welfare, in particular the shadow Ministers of Health and Community Welfare?

The Hon. J.R. Cornwall: I think the document to which the honourable member refers is circulated to about 1 200 people. I would not consider that to be a confidential document. I return to the matter of coalescence and amalgamation and the quotation taken somewhat out of context from last year.

The Hon. D.C. WOTTON: I do not think it was taken out of context, but was exactly as stated.

The Hon. J.R. Cornwall: It was taken out of context. What I said when I first became Minister for both health and welfare was that we would have an active program of coalescence. That proceeded for 18 months at all levels between executive officers of the department and the Health Commission through to the field. It was widely canvassed. Everywhere I went as Minister I endeavoured to continue to foster the idea that we would grow together. Many positive things came out of that. We have far greater cooperation now between the DCW and agencies such as CAFHS, CAMHS, the IDSC and the Drug and Alcohol Services Council, to name but four. That is an ongoing process.

At this point last year, no policy had been adopted that coalescence should move to amalgamation—that was perfectly true at that point. In about the middle of this year, or a little earlier (and remember that we had received a formal Cabinet imprimatur on coalescence in, I think November last year) it became obvious in ongoing negotiations that the next logical step from many points of view, and particularly from the efficiency point of view and being able to put more resources in the field while not duplicating a number of important areas of administration, was to amalgamate.

It was important to approach this sensibly and sensitively because it has not been achieved successfully in many parts of the world. As I discovered on my recent oversea trip, it is common to have a Minister or a chief executive officer at the top with welfare running down one stream and health down another. However, amalgamation has been achieved successfully in few countries or states in the world, so we moved towards it carefully in a planned way.

One catalyst ultimately was that the new building being erected on Town Acre 86 became available for lease with an option to purchase. On all the advice that I have received, it is eminently suitable for co-location of the department and the commission and we are currently negotiating with the consortium that is building on that site, at the corner of Pulteney Street and Rundle Mall, about a lease with an option to purchase. If those negotiations succeed (and I am optomistic at this stage that they will), we will co-locate in that building perhaps as early as the middle of next year, certainly no later than the end of 1988.

At this point, we are developing active proposals for amalgamation, having gathered momentum through a successful coalescence. We have proved that at many levels our services in primary health care, community health, community welfare, CAFHS, CAMHS, IDSC, and so on, are working together better as they have grown together through coalescence. I will recommend formally that we amalgamate and I would hope to take the submission and the timetable for amalgamation to Cabinet before Christmas.

The CHAIRMAN: We have time for one quick question and one quick answer.

The Hon. JENNIFER CASHMORE: Regarding adoptions, the commentary on major resource variations between 1986-87 and 1987-88 highlights the cost of additional staff to process intercountry adoptions. Why has this additional cost arisen when the Minister stated, on introducing the $1 200 fee for intercountry adoptions, that the exercise was a cost recovery one?

The Hon. J.R. Cornwall: I will ask Mr Boxall, our Administration and Finance Officer, to respond.

Mr Boxall: The short answer is that these costs are for additional staff, and receipts from the fees are reported elsewhere to offset the costs.

The Hon. J.R. Cornwall: In fact, I have a table detailing the family support program which I will incorporate in *Hansard.*

FAMILY SUPPORT PROGRAM
ESTIMATES OF PAYMENTS 1987-88

	$
Adelaide Central Mission	27 950
Anglican Child Care Services	329 731
Anglican Social Welfare Committee	16 125
Aroona Community Council	9 000
Australian Birthright Movement	24 188
Baptist Community Services	7 000
Bowden/Brompton Mission	
— Parent/Child Education Program	29 955
— Parent/Adolescent	8 869
— Parenting in Australia for Greek Italian Familes	8 223
Catholic Family Welfare Bureau	
— Family Care Resource Team	73 845
— Schools Intervention Program	8 462
Community and Neighbourhood Houses Association (Teenage Mothers Project)	12 938
Far West Aboriginal Progress Asociation	15 929
Goodwood Community Services	26 812
Holy Cross Lutheran Church	12 407
Indo-Chinese Australia Women's Association	53 762
Junction Community Centre	9 000
Lower Murray Nungas Club	22 325
Noarlunga Council	21 000
O.A.R.S.	8 063
Oodnadatta Aboriginal Housing Society	24 522
Port Adelaide Central Mission	48 287
Port Lincoln Children's Grants	10 583
Port Pirie Central Mission	55 850
Salisbury Council	57 212
Salisbury District Community Work Project	12 094
S.P.A.R.K.	81 325
South Australian Birth Association	6 988
Tea Tree Gully Council	54 956
Umoona Community Council	26 777
Y.W.C.A. Whyalla	12 900

Equipment	2 000
Administration	35 500
Grants awaiting approval	19 213
	$1 173 791
+ 3-4 Neighbourhood Houses	468 000
+ Inflation	88 209
+ New Money	100 000
− 1987-88 Payment in advance	32 000
	$1 798 000

The CHAIRMAN: Because of the effluxion of time, I declare the examination completed.

ADJOURNMENT

At 10 p.m. the Committee adjourned until Thursday 24 September at 11 a.m.