HOUSE OF ASSEMBLY

Wednesday 13 September 1989

ESTIMATES COMMITTEE A

Chairman:
The Hon. G.F. Keneally

Members:
Mr H. Becker
The Hon. Jennifer Cashmore
Mr M.R. De Laine
Mr T.R. Groom
Mr K.C. Hamilton
Mr J.K.G. Oswald

The Committee met at 11 a.m.

The CHAIRMAN: Before declaring any of the Estimates open for examination, there are one or two housekeeping and procedural matters that I should like to draw to the attention of the Committee so that there is consistency in the manner in which the Estimates Committees are managed. The first is a housekeeping item that might not seem so important now but it will be by the time the day proceeds. The afternoon and evening tea breaks will be around 3.30 and 9 p.m. That may vary 10 or 15 minutes, because we will arrange with the other Committee so that we do not all descend on the refreshment room at the same time. The 3.30 and 9 p.m. will be approximate times for breaks of about 15 minutes to have a cup of tea or whatever.

The Committee will be managed in a relatively informal manner. There is no need to stand to ask or to answer questions. The Committee will determine approximate timetabling for consideration of proposed payments to facilitate changeover of departmental advisers. I ask the Opposition, if possible, to indicate how long it will concentrate on particular proposed payments so that the Minister can advise his officers accordingly. Changes to the composition of the Committee will be notified as they occur. There will be some changes, and I will notify the Committee of them.

If the Minister undertakes to supply information at a later date, it must be in a form suitable for insertion in *Hansard* and two copies submitted no later than Friday 29 September. That is important because there have been occasions in the past when that information has not been made available to the Clerk, to *Hansard* and to Parliament in the time required.

I propose to allow the lead speaker for the Opposition and the Minister to make an opening statement, if they so desire, of about 10 minutes, but no longer than 15 minutes if that can be managed. There will be a flexible approach to giving the call for asking questions based on about three questions per member on alternating sides. Members may also be allowed to ask a brief supplementary question to conclude a line of questioning before switching to the next member. That procedure seemed to work very well yesterday. I hope to use the same method and I may be more or less generous as I judge the questioning to be, but members can be assured that they will get a fair crack of the whip.

Subject to the convenience of the Committee, a member who is outside the Committee and desires to ask a question will be permitted once the line of questioning on an item has been exhausted by the Committee. Indications in advance to the Chairman are necessary to allow that person to ask questions. Questions must be based on lines of expenditure as revealed in the Estimates of Payments, page 9. However, reference may be made to other documents, such as the Program Estimates, the Auditor-General's Report, etc. Ministers will be asked to introduce their advisers prior to commencement and at any changeovers. Questions are to be directed to the Minister, not to the advisers, but the Minister, at his discretion, may refer questions to his advisers for a response. For the benefit of departmental officers, a diagram showing the facilities which are available to them is available from the attendant at the back of the Chamber.

South Australian Health Commission, $923 571 000

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

Departmental Advisers:
Dr W.T. McCoy, Chairman, South Australian Health Commission.
Mr R. Sayers, Deputy Chairman, South Australian Health Commission.
Ms C. Gaston, Director, Nursing.
Dr R. Aust, Director, Information Services.
Mr R. Exelby, Director, Finance and Accounting.
Dr D. Filby, Executive Director, Planning and Policy Development.
Dr D. Blaikie, Executive Director, Metropolitan Health Services.
Mr R. Blight, Executive Director, Country Health Services.
Dr K. Kirke, Executive Director, Public and Environment Health Services.
Mr J. Dadds, Acting Director, Environmental Health Services.
Mr P. Davidge, Executive Director, Administration Services.
Ms C. Johnson, Executive Director, Statewide Health Services.

The CHAIRMAN: I declare the proposed payments open for examination, and refer members to pages 32 to 37 in the Estimates of Payments and pages 39 to 60 in the Program Estimates. Does the Opposition wish to make a statement?

Mr BECKER: I prefer that we deal with the Health Commission as a whole and not line by line. I think it makes it much easier that way because it is the total budget we are looking at. We do not prefer to make an introductory statement although the first question will follow somewhere along that line.

As of today there are still 56 beds closed at the Royal Adelaide Hospital—eight of them high dependency beds—as a direct consequence of the funding crisis at that hospital which came to prominence more than five months ago. Is the Minister aware that since April the number of closed beds at South Australia's premier hospital has until this week averaged between 60 and 84? This is despite these comments by the Premier on 14 June 1989 and reported in the *Advertiser* the following day when announcing a supposed rescue package:

> The new package would allow hospitals to restore services, upgrade equipment, meet increased demand, and give all hospitals a very good chance to stick to their budgets in this coming (financial) year, and to plan ahead in future years. There has not been a crisis, and there certainly will not be after this.

Let me describe the situation of the bowel cancer ward, Q6, at the Royal Adelaide. Half of this ward was closed without any notice to the head of the unit, with the result that some bowel cancer surgery had to be cancelled without notice. The half ward remained closed throughout July and August, and was reopened recently not for bowel cancer patients but for use by other disciplines. The bowel cancer unit at the RAH until very recently was the only recognised training unit for that specialty in Australia and New Zealand, and in order to retain that status it needs to function with 32 available beds.

Young surgeons, who are with the surgical unit for six months during their training, have now lost a sizeable part of their training. January is normally closed off for surgery, and thus training, and since April there have been continued closures limiting their training. In other words, they have lost four of their six months training period. As a result concern is now being expressed by the College of Surgeons.

As there has to be an ongoing intake of new trainees this is not a simple matter to say well those surgeons who have missed out on training this year can just repeat it next year. Let me quote a letter from Dr Des Hoffmann of ward Q6. The letter, addressed to Dr Brendon Kearney of the Royal Adelaide Hospital and dated 5 September 1989, states:

I would be extremely grateful if you would be able to inform me when the closed beds in my ward Q6 will be reopened. As you are no doubt aware, this has been extremely disruptive to patient care and has interfered greatly with surgical training and in some sense quite destructive to the Colo-rectal Unit which has proved itself in the eyes of the College of Surgeons as one of the places of excellence in this field in the whole of Australia and New Zealand.

Where as I have had a letter from the Minister of Health implying a return to normality I see no obvious signs of this occurring. Before responding further to the Minister I would appreciate greatly your urgent advice on this matter.

Kind Regards, Yours sincerely,

D. Hoffman, Head of Unit Colo-Rectal Q6

A copy was forwarded to Mr John Jose, Chairman, Division of Surgery at the Royal Adelaide Hospital. This letter has made absolutely plain the disastrous and continuing impact on training hospitals of the Government's decision to ration health in the latter half of 1988-89. Does the Minister now admit that the Government's decision to withhold extra funding to hospitals was irresponsible and has caused deep and long-term problems at the Royal Adelaide Hospital? Does the Minister now admit that the Government's so-called rescue package has not worked? Has any decision been made on whether the Royal Adelaide will be penalised for its $750 000 budget overrun last financial year and, if not, when is a decision likely?

The CHAIRMAN: The Minister may make a statement if he so wishes. He may also address himself to the comments of the honourable member and the questions asked.

The Hon. D.J. Hopgood: I will make a brief opening statement, if only to support some figures which I will seek to table at the appropriate time so that members can have a better appreciation of the important outlines of the health budget. I will then proceed to address the non-polemical components of the honourable member's question. I do not believe that the purpose of my being before this Committee is to give long, rambling policy statements and I will endeavour to be as specific as I can in response to specific questions.

However, it is important to correct a number of misconceptions that may still exist in respect of the Health Commission budget. Such misconceptions have appeared in the press from time to time. I partly addressed this matter in answer to a question in the House a week or so ago. It may be that members on this Committee still have misconceptions because one or two have been so bold as to use the forms of the House to suggest that I have misrepresented the content of the Health Commission budget. It is important for the proper running of the Committee that I make clear where the Health Commission and its units stand in relation to the budget.

The Government has allocated $1.061 billion as the gross expenditure budget of the Health Commission. This is made up of $1.049 billion as the standstill based on 1988-89 expenditure; additional moneys for the hospital funding package (new initiatives, and so on); and savings from general insurance and central office rationalisation. This represents a 4.6 per cent increase on the 1988-89 actual expenditure of $1.0145 billion. However, the figure of $1.06 billion for 1989-90 is not the final figure for the financial year. In fact, the final figure is likely to be of the order of $70 million more to take account of salary and wage increases as they occur during the year.

I can only assume that honourable members in some cases have simply not picked up that point. Secondly, in the various documents available to the Committee there are preliminary estimates of the budgets for individual health units. In some cases these estimates are not a true reflection of the likely end of year position not just because of the salary increases referred to earlier but because at this early stage of the year it has not been possible to allocate out all the funding; for example, funds are held back to meet costs associated with such items as emergency repairs and maintenance, motor vehicle replacement, and replacement of persons on long service leave in small units. All of these funds will be allocated and spent before the end of the year.

For both of these reasons then the details of proposed expenditure in 1989-90 should not be taken as representing the likely actual end of year position. Additional funding will be provided to the Health Commission to meet any additional salary and wages costs this year. This, Mr Chairman, will ensure that the total funding available to the commission this year will represent a real increase on last year's funding, continuing the trend of the past five years at least. I would like to table for the Committee's information details on the actual level of funding provided to the Health Commission and the real (that is, greater than inflation) increases this represents.

	1985-86	1986-87	1987-88	1988-89	1989-90 (est.)
Recurrent funding	761.5	837.5	941.0	1014.5	1134.5
Increase over previous year	72.5	76.0	103.5	73.5	120.0
%	10.5	10.0	12.4	7.8	12.0
Increase above inflation	2.2	0.8	5.7	0.5	5.0

No matter what one does with the figures, that is how the situation finishes up. That is the best indication we can get of the funding position of the Health Commission and all of its units for this financial year.

Finally, I would be remiss if I did not bring to the Committee's attention the very significant capital works program envisaged for the Health Commission this year. At this stage I am probably not in a position to speak to it in any detail, but I will address the global figure. Compared to $49.2 million, which was spent in 1988-89, $74 million is allocated for 1989-90. While details of specific proposals are in the papers, I do not wish to discuss them. It indicates how important the Government sees health issues and how important it is that our hospitals and other units be properly equipped.

As to the gravamen of the honourable member's question, in general terms—before I ask Dr Blaikie to address himself to this matter—it is true that, despite the fact that the Government provided a very early indication to all health

units of the funding position that they would occupy for this financial year, an above expected rate of sickness—or absenteeism on the grounds of ill-health—amongst the nursing staff at the Royal Adelaide Hospital and also a more difficult task than had been envisaged in recruiting has meant that some beds have had to remain closed. However, it is also true to say that, despite that fact, in the last month for which we have figures—that is, July—the number of people on the booking lists for elective surgery came down marginally. In addition, it is true to say that, where people have needed emergency surgery, they have been able to get it. I will now ask Dr Blaikie to provide the more specific details.

Dr Blaikie: Ward Q6 at the Royal Adelaide Hospital is now open. The problems experienced at the Royal Adelaide Hospital are not funding related at all, but are due to difficulties in recruiting sufficient nurses to staff all the beds at the hospital. The primary reason has been high levels of sick leave and general difficulties in recruiting. At the moment, 56 beds at the Royal Adelaide Hospital are closed: 16 beds in ward R7; 16 in ward R3; 16 in ward S6 and eight in ward S4. I should point out that ward S6 is undergoing renovation and while it is, I am grateful that those 16 beds are closed, because I am sure the patients would not wish to be in there while the ward is being renovated. That means that, in effect, 40 beds at the Royal Adelaide Hospital are closed at present purely and simply due to an inability to recruit nurses.

However, there are some positive signs, and I am pleased to advise the Committee that in August there was a net gain of 10 nurses to the Royal Adelaide Hospital, and in September thus far there has been a net gain of 18. So, the signs are very hopeful, and the hospital anticipates that it will be able to open an additional 16 beds next week.

The second part of the honourable member's question related to the hospital funding package, and the third part of the question, to the penalty. I will address the third part first. Yes, a penalty was applied to the Royal Adelaide Hospital in the light of its budget overrun last year. That is normal practice; the South Australian Health Commission advises all hospitals that that practice will be followed. However, during negotiations with the hospital this year, we were able to provide additional funds to assist the hospital, and I will come to that later. In view of the latest results of the funding allocation model—and members may know that the funding allocation model allocates budgets on the basis of workload rather than on just historical expenditure—the Royal Adelaide Hospital is overfunded to the tune of $700 000 relative to the Flinders Medical Centre. During negotiations with the hospital administration, $318 000 was therefore removed from the Royal Adelaide Hospital's funding base.

The net result of all of this is that the Royal Adelaide Hospital did suffer a penalty in 1989-90 of around $346 000. However, in considering that penalty, it is important to realise that the hospital received significant additional funds this year. In particular, the hospital received the significant sum of $3.78 million under the metropolitan hospitals funding package, which was announced by the Premier on 14 June. This was additional money provided to the Royal Adelaide Hospital this year, and breaks down as follows: $700 000 to replace items of equipment; $748 000 to reinstate some of the closures of last year; $850 000 for elective booking lists; and $1.5 million as a continuation of the increase in activity last year.

In addition to those funds, $579 000 was allocated to the Royal Adelaide Hospital this year under the Medicare incentive program, and $175 000 under the hospital enhancement program. I point out that the allocations under those latter two programs represent 45 per cent of all allocations to metropolitan hospitals.

Mr BECKER: Supplementary to that: the situation as I know it, is that, whilst Q6 is open, it is closed to colo-rectal surgery. I hope that we are not being misinformed this morning and that there is no confusion over the issue. I want to know exactly what the situation is in relation to Q6 and, in particular, colo-rectal surgery. I consider this to be extremely important. I would hate to be one of those people who have a problem and are on the waiting list, if the explanation we have been given this morning is correct. It seems to me that the big problem at the Royal Adelaide Hospital relates to the large number of nurses absent through illness. That is probably through stress, because it is obvious that they are overworked. There seems to be something amiss there as well. What is the real position with regard to Q6?

The Hon. D.J. Hopgood: The information we have given to the Committee is the same information which has been given to the Health Commission. Perhaps in order to absolutely satisfy the honourable member we will take the question on notice and provide an absolutely authoritative answer later in the morning as to exactly what is happening in Q6 right now.

Mr BECKER: I would appreciate that. In the *Advertiser* of 26 August 1989 the Minister of Health was reported as saying:

> For 1989-90, because of the substantial new funds being put into health expenditure, our current expectation is that actual payments are likely to be 12 per cent more than for 1988-89. With inflation in 1989-90 estimated at 7 per cent, we would have real growth of about 5 per cent on the previous year.

The Minister has now provided the Committee with the figures he used, I assume, to arrive at the 12 per cent increase from the previous year's expenditure. Will the Minister separate those figures into recurrent and capital expenditure?

The Hon. D.J. Hopgood: They are all recurrent. Capital is a separate one, which runs at $74 million.

Mr BECKER: Well, we have a problem. Will the Minister explain why his figures differ from those referred to by a Health Commission spokesman on 15 June, who was quoted in the *Advertiser* as saying:

> The 1989-90 budget would be the same as this year's hospital budget, but would be increased by the rate of inflation to ensure that it stayed the same in real terms.

Does this mean that hospitals will not get the 5 per cent clear increase that the Minister has stated? Does the figure of $74.9 million for capital works in 1989-90, as supplied on 24 August in a reply to a question on notice, include $11 million being provided by private sources for the Noarlunga Hospital project? If the above is correct, will the Minister confirm that the revised figure for capital expenditure on health for 1989-90 is $63 million, compared with $49.2 million for last year, that another $11 million was held over unspent, and so that therefore there has only been an actual increase of $3 million in capital expenditure this year? I have referred to the figures that the Minister has given us, because across the top, from 1985-86 through to 1989-90 it is recurrent funding, except when we come to 1989-90. In answer to a question on notice, figures were provided to the Opposition which indicated that the recurrent figure was $1 061.5 million, while today the Minister has quoted the figure of $1 134.5 million. I can only assume that the difference relates to capital expenditure.

The CHAIRMAN: I will make a generous ruling here: recurrent and capital expenditure are two different items, but as we will inevitably be discussing both lines in relation

to some of the questions that are asked, I will allow such questions to proceed, as is the case in this instance.

The Hon. D.J. Hopgood: First, in relation to the loan program, I reassure the honourable member that the $74 million capital is all from Government sources: no private money is involved in it. As to recurrent expenditure, I will be charitable and assume that the honourable member has not yet had the opportunity to absorb the statement I read at the beginning of this Committee.

The $1.1345 billion estimated total expenditure through the Health Commission and its units for this financial year is all-up. That is to say, it is what is appropriated in this budget to my lines, plus what we expect to spend from the round sum allowances for wage and salary increases. What the honourable member betrays in his question is something that has also come out in statements the members of the Opposition have made from time to time about this budget.

If you want to compare like with like, if you want to compare what we spent last financial year, you cannot simply compare that with what is in the budget this year. You have to compare the estimate with what we will spend in the next financial year. If you want to compare apples with apples or pears with pears, you have to make some estimate of what the wage and salary increases are likely to be. As I said in my original statement, the figure of $1.06 billion for 1989-90 is not the final figure.

The final figure is likely to be about $70 million more to take account of wage and salary increases as they occur during the year. The honourable member's figures do not compute because he is ignoring that particular factor. That factor also has to be taken into account when one looks at the actual figures given to each of the hospitals, along with some of the other funds that will still be flowing to them for the reason that I indicated in my opening statement.

Mr GROOM: First, I congratulate the Minister on the skilful and sensitive way in which he handles his portfolios. Consequently, my questions will not be of a probing nature, but more information seeking. I do not have prepared questions, but I will give an assurance that they are not Dorothy Dixers. What plans does the Health Commission have for the position of health services in country areas?

The Hon. D.J. Hopgood: It would be reasonable for me to ask Mr Blight to join us, because he would obviously have greater detail. I am sure he will not want to give us a long statement, but a brief summary of the initiatives in the ongoing program for country health services would be illuminating to the Committee.

Mr Blight: The general plan for country health services is based on improvements in two key areas. With respect to hospital services, we propose to continue to expand the range of medical and surgical services that are available in our country regions, but on a regional basis. We cannot hope to provide these expensive services in every one of our 60 or so country hospitals. As that portion of our plan unfolds, it is likely that we will see the expansion of services on a regional basis.

The present situation is that about 25 per cent of hospital services for country people are provided in the metropolitan area, with two exceptions. In Whyalla the figure is about 8 per cent only, because it is a large regional hospital with a good range of specialist residents in the town. The other exception is Mount Gambier where the figure is about 10 per cent. We believe that such figures could be achieved in other country regions, therefore improving the accessibility to those hospital services for country people.

The other part of the improvement of services is in primary care services, in particular community mental health services; women's health services; child and adolescent mental health services; health promotion; and illness prevention services. Our rationale for that is that the development of those services is lagging somewhat in the country. Whereas country people are prepared to travel to the metropolitan area for hospital services, they are not doing that for the primary health care services.

That is why we want to improve primary health care services in country centres. The organisation of those centres will not be on a regional base. Those services generally are highly mobile and can therefore be provided on a visiting basis to each of our country towns. That has been the position in the past. As we expand those services, we expect that it will be done in those areas.

The funding of those services is probably worth some comment. We have promoted a strategy in the country based on the principle of ensuring that every health dollar is spent to the best effect and therefore of looking for opportunities to reallocate funds between areas of low priority or low need into these new areas of need. We are encouraging boards of management in the country to work together to take a regional view of their needs and to cooperate in management initiatives to free resources so that those funds can be put back into expanded specialist hospital services and expanded primary health care services.

The challenge in all of that is to secure commitment to and local involvement in the redistribution of resources as is required in our 14 health planning regions. Over the past two years or so, there have been some innovative responses on how funds might be saved without reducing services. Some examples have been the implementation of joint administrations between hospitals. That is a means of reducing the administrative overheads. It does not impact on the services being provided, but it allows funds to be redistributed to other needs.

Commercialisation is also an area where there are some promising projects in their early stages. We are looking at ways of reducing the demand on the public purse without reducing the services available to public patients, and again freeing funds for other approaches. There are two projects of note in that area. One is at the Barmera Hospital which the board is now finalising. There is also a strongly expressed interest at Mount Gambier where, with the building of a new hospital, we will look at the Noarlunga-type solution of including in the one facility a public and a private hospital. Initiatives like that have the potential to release substantial funds.

To summarise, the vision for health care delivery in non-metropolitan South Australia will be guided by four principles: the development of more comprehensive health services in the country for country people; the development of those services on a regional model; the implementation and maintenance of mechanisms to ensure high standards of patient care and high quality management practices in each of our country hospitals; and the achievement of major improvements in rural health services through the redistribution of existing resources.

Mr De LAINE: I understand that there has been increased pressure on services provided by the Royal District Nursing Society. Has the Government made any extra financial assistance available to the society this year?

The Hon. D.J. Hopgood: Yes. We have been aware for some time of the increased pressure on the RDNS for several reasons. First, there is an increase in high acuity patients due to more day surgery, early discharge, and the numbers of terminally ill patients wishing to die at home. That situation has created additional stress and pressure on the services provided by the RDNS.

Several strategies have been introduced to assist in resolving some of these problems. There has been the appointment of two additional rounds in the metropolitan area staffed by casuals; and the injection of $150 000 into the budget in August and a further $200 000 this month, making a total of $350 000, with a full year effect of $400 000. There is also to be an attempt on the validation of staff work loads by an activity sampling exercise.

It has been established that work loads are heavy and the existing staff cannot take on additional work, so we are confident that we have done the right thing by making these additional resources available. An analysis is being undertaken on the redeployment of staff to ascertain effective management of resources. I had a meeting in Parliament only last week with representatives of the RDNS. They were then given the information about these additional resources that are being made available to assist, and they also have my commitment that we will continue to monitor the situation as closely as we can.

Mr De LAINE: Will the Minister outline what expenditure has been made on hospital equipment in 1988-89, and what additional funds have been provided for the purchase of hospital equipment in 1989-90?

The Hon. D.J. Hopgood: Before 1988-89 the Commonwealth teaching hospital equipment program provided $4.2 million in each of the three years of the program—a total of $12.6 million—for the purchase of pieces of medical equipment valued at more than $50 000 each. With the cessation of the Commonwealth program, the State Government provided $4.8 million in 1988-89 from the capital works program for the purchase of medical equipment in both metropolitan and country hospitals. In addition, a total of $4.943 million from the operating budgets of the seven major metropolitan hospitals and the Institute of Medical and Veterinary Science was spent on equipment.

In 1988-89, further moneys were provided for equipment purchases for metropolitan hospitals: $825 000 million was allocated under the Hospital Enhancement Program, and $1.108 million was allocated under the Medicare Incentive Program. In 1989-90, the State Government will provide $4.3 million from the capital works program for the purchase of medical equipment in metropolitan and country hospitals.

The four-year $46.4 million metropolitan hospitals funding package also includes $2 million for the replacement of minor items of equipment in 1989-90; investment in computing equipment at a variety of country and metropolitan hospitals will total $4.136 million in 1989-90; and there are also a number of major capital works which I do not think I will delay the Committee with at this stage. I undertake to give to the honourable member the specific details of how these funds will be spent, in view of his interest, so we can proceed to the next question.

Mr BECKER: The Minister made a statement this morning that $70 million is included in the estimates for increases in wages and salaries. I noticed that last year there was an estimate of $41 million for increases in wages and salaries and related payments. However, on page 328 of his report the Auditor-General states that the cost of salaries and wages and related payments increased by $61 million (9 per cent) to $743 million. I take it that the $70 million mentioned by the Minister relates to a 9 per cent increase. What extraordinary items will cause the wages and salaries line to increase by $70 million, or does it mean that there will be a wage and salary increase in the vicinity of 9 per cent?

The Hon. D.J. Hopgood: The $70 million is more than just salaries. It is the total amount we expect to get from round sum allowances for all cost increases. However, it is important to indicate to the honourable member and to the Committee that we anticipate that professional salaries will exceed inflation in this coming financial year. The honourable member would know of the outcome of the negotiations with the visiting medical officers in our hospitals. That resulted in a quite hefty increase of $14.3 million in our salaries bill. The changes to the trainee medical officers award resulted in a $12 million increase. We are also into discussions at present with the representatives of SASMOA in anticipation that there will be some increases for resident medical officers, and I would not be at all surprised if before too long we are into fairly detailed discussions with the nurses so far as their salary rates are concerned.

All of these increases have to be negotiated within the overall wage guidelines but, of course, they can be and will be. However, that does not necessarily mean that we will be held to inflation in all of these areas. It may well be that it will turn out to be rather more than $70 million. This Government has always honoured industrial agreements, and therefore the 5 per cent increase in real terms may turn out to be somewhat more than that.

Mr BECKER: On Page 342 of the Auditor-General's Report the total payments for recognised hospitals and associated services are detailed as follows: 1987-88, $595.1 million and 1988-89, $636.3 million, an increase of $41.3 million or 7 per cent. However, there is one unanswered variation under superannuation or terminal leave payments, where there is a rise from $16.485 million to $24.494 million, a rise of $8 million. I understand that this represents a full year of the 3 per cent in respect of superannuation increases compared with five months in 1987-88. However, to get a proper year to year comparison, 1987-88 should be taken on a full year basis for the cycle. This would reduce the actual increase on expenditure to 5.9 per cent or 1.1 per cent less than inflation. Will the Minister confirm this figure?

Mr Sayers: The superannuation increase certainly included three components: the normal inflation component on superannuation contributions by the employer; for the first year the full impact of the 3 per cent; and the cost associated with some employees commencing superannuation for the first time. As far as the detail is concerned in relation to those percentages, I will have to check the figures and get back to the honourable member.

Mr BECKER: Will the Minister detail the items of extra expenditure that resulted in the $73 000 or 20 per cent increase in gross actual payments to the Office of the Minister of Health between the 1987-88 and 1988-89 financial years?

The Hon. D.J. Hopgood: We will have to take that one on notice. I refer back to the now famous ward, Q6, Royal Adelaide Hospital, and colo-rectal surgery. Ward Q6 is available for colo-rectal surgery, but not exclusively at this point. Once all beds are open, it is anticipated that all the beds in Q6 will be allocated to colo-rectal surgery.

Mr HAMILTON: As one who has lived in the western suburbs since 1968, I would like to express my appreciation of the Queen Elizabeth Hospital and its staff and administration for the work they have done. Some people unfortunately want to use that hospital as a political tool, particularly leading up to the State election. I refer to the shadow spokesperson and the Leader of the Opposition who recently levelled criticism at local members in the western suburbs and by inference, myself as to our involvement in that area. I refute that and, indeed, the hospital itself and members of the Queen Elizabeth Hospital Medical Staff Society in recent correspondence expressed their appreciation to me personally (and indeed to my colleagues) for my

involvement in that area. I have a very close affinity with the hospital and its board. As long as I am the member for Albert Park, I am certainly not going to sit back and take this sort of criticism of what I see as a very important facility in the western suburbs.

When will the new CT scanner be installed at the Queen Elizabeth Hospital, and also the digital subtraction angiogram equipment? In response to correspondence I have received from the Queen Elizabeth Hospital Medical Staff Society, I would also like to know from the Minister what the situation is in respect of the financial allocation for this hospital in relation to the socio-economic circumstances of

The Hon. D.J. Hopgood: I thank the honourable member for what he says about the Queen Elizabeth Hospital. As someone who had one near and dear to them discharged from the Queen Elizabeth Hospital yesterday following successful renal surgery, I endorse what he said about the services provided to not only the people of the western suburbs but also on a much broader basis. The CT scanner and associated back-up data processing equipment are important initiatives for that hospital. I went to the hospital recently and talked to the doctor in charge of radiology, and he is very excited about this departure. I ask Dr Blaikie to give specific details.

Dr Blaikie: As to when the two items of equipment mentioned will be installed, the best I can say is this financial year. An amount of $1.1 million has been made available for the digital subtraction angiography equipment—the first of its kind at the Queen Elizabeth Hospital. That equipment will be used in the general radiology and cardiology suite at the hospital. Ministerial approval has been given for the purchase of the equipment. The hospital is now going through the normal tendering process. The new CT scanner, at an estimated cost of $1.7 million, has also been approved and the hospital is currently going through the tendering procedures. I have spoken to members of the hospital and it is fair to say that they are thrilled with those two major capital items.

The second part of the honourable member's question related to the general allocation to the Queen Elizabeth Hospital and to claims that have been made. I am aware of them, and I have seen the press statements released by the Leader of the Opposition about the hospital not being treated fairly. I can assure the Committee that that is not the case. The Queen Elizabeth Hospital has an allocation of $102 889 600 for 1989-90. That allocation represents a standstill budget on last year's expenditure, a full funding award carry over from last year and 6.5 per cent indexation on goods and services. The allocation includes $1.579 million under the metropolitan hospitals funding package. That allocation was distributed to the hospitals after extensive negotiations with each of the hospitals, and the Queen Elizabeth Hospital is no exception.

I am pleased to point out that the allocation of $490 000 for equipment items is in addition to the capital items and represents 25 per cent of total funds available for equipment under that package. If we compare that with the fact that the Queen Elizabeth Hospital represents about 20 per cent of the budget for metropolitan hospitals, we can agree that the hospital has been treated well in recognition of the fact that it was in need of equipment replacement to a greater extent than, for example, its colleague hospital the Flinders Medical Centre. The allocation of $750 000 for elective surgical procedures also represents 25 per cent of overall funds available.

The hospital will concede that the allocation to it was done very equitably and fairly and the Health Commission did take into account the age of the hospital and the fact that it is a western suburbs hospital treating a lower socio-economic group. I have some affinity with that hospital as I was a member of the board of management for a while. If anything, I would have thought that I might have been accused of bias in favour of the hospital.

Mr HAMILTON: I now refer to the Ru Rua Nursing Home. It was a delightful day when that home was closed. On a number of occasions on which I visited I did not like the place at all, and I am not referring to the persons within it. One can reflect on reasons why people were put into that establishment, but I will not make a political speech. Now that Ru Rua Nursing Home has been closed, will the Minister advise whether the current living arrangements are satisfactory for the intellectually disabled persons who lived there? I have in my electorate a woman very much interested in this matter. She was at one time involved with the Ru Rua Nursing Home. She has been critical of that establishment and is very concerned about the current living arrangements for the intellectually disabled persons from there.

What arrangements have been made for those people, what level of staffing is there in the new accommodation and what training has been organised for the staff? What daytime activities have been planned for these people and what guaranteees can the Government give to my constituent that these people have the best of care, particularly in regard to hygiene? An allegation has been made that some of these people are not being looked after properly and are being fed tinned food. I found that surprising, but the allegation was made in the presence of witnesses. To quash that allegation, will the Minister give some assurances?

The Hon. D.J. Hopgood: I will ask Colleen Johnson, the Executive Director, Statewide Health Services, to respond.

Ms Johnson: Ru Rua Nursing Home was formally closed on 1 August 1989 and 98 former residents have been accommodated in the community in 21 group homes (19 are in the metropolitan area, there is one at Mount Gambier and one at Port Augusta). Each house has been modified to meet the needs of residents with wheelchairs and each house has its own transport with a modified seven seater van to enable residents to participate in community activities and move around as required. Four adults, all of Aboriginal background, have been repatriated to the Northern Territory, as was their wish, where a group home has been established at Katherine. Two residents have gone into long-term foster care and one has been adopted. One adult is boarding with a family and another has returned to her natural family. Both are receiving attendant care support. Four people have moved into group homes in existing accommodation services.

I turn to the staffing of the homes. The staffing model has changed at Ru Rua from one of nurses—enrolled nurses and nurse assistants—to developmental educators and developmental care workers. This is to ensure that residents receive education and are given the opportunity to develop skills to learn to be as independent as possible and to participate in the many community options and activities as are available to them. This change in the staffing model has occurred in conjunction with the implementation of new direct care staff structures across all of the IDSC residential services. Each community home, which now accommodates four people, has betwen 6.5 and 7.5 staff consisting of permanent full-time, part-time and casual staff to enable more flexibility to meet the needs of residents.

Each metropolitan region has a residential services manager and an assistant manager, and program and services coordinators have been employed in each regional office to provide case management support. Extensive staff training

has been undertaken, including in-service training of existing staff and pre-employment programs to attract new recruits. Specialised training has been undertaken in a number of areas, including drug administration, special feeding techniques and physical handling of residents. In accordance with this, a new staff appraisal system is being implemented to ensure ongoing monitoring and review of standards of care and staff training and development needs of residents.

The Royal District Nursing Society has agreed to provide nursing services, as required, to residents and it is also providing supervision of staff of houses to ensure that the care given to residents is adequate and appropriate. In relation to day activities, a large amount of additional funding went into that area at the time of devolution. Adult day services for residents of the group homes have been funded jointly by the South Australian Health Commission and the disability services program of the Commonwealth Department of Community Services and Health. The services are operated by Spastic Centres of South Australia and focus on personal skills development and recreation through participation in community activities.

Spastic Centres of South Australia is also providing school support services and attendant care and therapy to enable students who were formerly residents to attend special classes in four regional locations. Individual planning services have been introduced for each resident to ensure ongoing program planning and review of their requirements in all life areas. This includes health monitoring, which is of particular importance given the severity of disability of residents. A comprehensive evaluation of Ru Rua's devolution is being undertaken jointly with the South Australian Health Commission and the Commonwealth Department of Community Services and Health.

In summary, devolution of residents from Ru Rua is a process that has been undertaken with a great deal of planning, consultation with parents and parent involvement. In addition, there has been an injection of additional funds and development of new services. A very high priority has been placed on the process of involvement of residents in community services to ensure and to enhance quality of life. In particular, a high priority is placed on physical care, which includes hygiene, food and other aspects of their day-to-day living.

The Hon. JENNIFER CASHMORE: Will the Minister provide an estimate of the likely year ending budget allocation to his office in 1989-90? I note that the figures for the previous year could not be provided, but I imagine the Minister is aware of what is happening in the year to come, given that the Blue Book contains a preliminary figure of $482 000, which is more than $80 000—or 19 per cent—higher than the estimate for this time last year. What expenditure, if any, is proposed in addition to the preliminary estimates in the Blue Book?

The Hon. D.J. Hopgood: I will try to get that information for the honourable member. I can only guess at this stage that a higher expenditure may relate to a higher establishment in the office because, of course, the two departments—the Health Commission and the Department for Community Welfare—have been brought together under the one portfolio. In effect there is a greater throughput of correspondence, phone calls and that sort of thing to my office. In addition, there is the important portfolio responsibility of the aged, and the Commissioner also reports to me. I am advised that the effect of that change is the addition of two positions to my office establishment, and that may well account for the increase. My reason for seeking further information on the earlier question about last year is that, of course, it could only apply marginally. I did not occupy the portfolio for very long during that year. I will get more specific information for the honourable member.

The Hon. JENNIFER CASHMORE: Does the Minister have a car phone or a cellular phone that is rented and paid for at the taxpayer's expense? If so, when was it installed, what was the cost of the acquisition and installation, and what was the operating cost for 1988-89 and for 1989-90 to date? The Opposition would appreciate a breakdown of local, STD and ISD calls.

The Hon. D.J. Hopgood: On and off, I have been a Minister for nearly 13 years. Over that time there have been various overtures to me to have a car phone installed. I have consistently replied that that would happen 'over my dead body', and that remains my position.

The Hon. JENNIFER CASHMORE: I refer to the line 'Intra-Agency Support Items not Allocated to Programs': will the Minister provide an itemised rundown of spending in the last financial year and the budget spending for this financial year under 'Salaries, wages and related payments', and 'Administration expenses, minor equipment . . . and sundries'?

The Hon. D.J. Hopgood: The honourable member may prefer that we take that question on notice, and that will be done.

Mr HAMILTON: Referring again to the western suburbs, the Minister will be well aware of my particular interest in the Alfreda Rehabilitation Centre—a centre in which the Tonkin Government showed very little interest, particularly in relation to the hydrotherapy pool. What is happening in relation to the expansion of the services to be provided by the Alfreda Rehabilitation Centre under its commercialisation program? I refer to page 46 of the Program Estimates. How will that money be used—I understand it will be utilised through WorkCover and the rehabilitation of people who use that centre?

The Hon. D.J. Hopgood: With the introduction of the Workers Rehabilitation and Compensation Act 1986, Alfreda Rehabilitation has become a contracted provider with WorkCover. I understand that it is the only Government agency to be so contracted. Services provided by Alfreda Rehabilitation for 'non-compensable' patients continue to be at no charge. Alfreda gained a contract with Comcare in 1988-89 to provide rehabilitation services for Commonwealth Government employees. The increased revenue generated from the 'commercialisation' of Alfreda was used to appoint additional rehabilitation counsellors and allied health staff during 1988-89 and will be used this year to purchase additional equipment and to provide purpose designed facilities to accommodate assessment and fitness functions as well as upgraded reception and administration areas.

In 1988-89, the first full year of operation, Alfreda generated additional revenue of $450 000 bringing the total revenue collected to $780 000. It is estimated revenue collections will increase by a further $506 000 in 1989-90. Alfreda had a surplus of $151 000 in 1988-89 and anticipates a surplus of around $450 000 in 1989-90.

Mr OSWALD: Will the Minister detail the source from which the extra $1 million to fit out the CitiCentre building was obtained, following last December's revelation of a huge rise in fitting-out costs, and will the Minister detail what savings were achieved by the reduction of 16 staff in central office? Were these positions deleted entirely or shifted elsewhere in the health system? What positions were deleted and what were the applicable annual salaries? Was the reduction of 16 staff by the Health Commission intended to meet the $1 million extra required to fit out the CitiCentre? In the *Advertiser* of 9 December 1988, the former Health Minister, Mr Blevins, was quoted concerning a blow-

out in the cost of the fitting out of the Health Commission's CitiCentre premises in Hindmarsh Square, as follows:

Mr Blevins confirmed after the meeting that staff reductions would occur but said the number of staff and over what period of time were 'still being considered'.

That article also stated that the Government had told the Health Commission that it would not meet this $1 million in extra costs, which had been incurred in the commission's move to CitiCentre.

Dr McCoy: The honourable member has asked two questions; one is about CitiCentre and the other is about the central office of the Health Commission, and I will deal with them separately. The funds required for the refurbishment of the CitiCentre location were borrowed by the Health Commission, they have been included in the operating accounts of the Health Commission and will take 15 years to repay, after which there will be a benefit of $1.4 million. Following that fifteenth year, there will be a $1 million benefit per annum to the Health Commission or to its successor at the time. So, the funds were borrowed and have been included in the operating costs of the central office of the Health Commission, to be paid back over 15 years.

The actual amount borrowed was estimated to be $4.9 million. In fact, the capital budget was underspent and the final figure will be about $4.6 million, of which, $3.7 million was expended to 30 June 1989. There are a number of functional benefits in moving to that building. First, there was the colocation of the Commission, the Department of Community Welfare, the Office of the Commissioner for the Ageing, the Minister and now the Department of Recreation and Sport. They are now all in the one building, and that has brought great functional benefits to staff in those units. Health Commission buildings were consolidated from seven to two and DCW buildings, from two to one. There was a reduction in area from 13 725 square metres to 12 654 square metres. Staff and visitors to the new site have greater access and it has been possible to provide a more functional office layout.

The decision was made having regard to all the facts and a number of costs were avoided by going to the CitiCentre, and they are estimated in current figures to be about $2.4 million. I have mentioned the budget. The operating cost consequences are cost neutral to the Government and to the Health Commission, which obtained no additional funds as a result of the move to CitiCentre. The loan will be totally repaid after 15 years. The beneficiary of the move to CitiCentre is the Commissioners of Charitable Funds, the owner of the land on which CitiCentre was built. That organisation's Commissioners will receive $600 000 per annum, which will be used to support equipment and research, mainly at the Royal Adelaide Hospital, but at some other hospitals as well, and there may be an increase in that figure when final profit sharing is negotiated with the owner of the building.

The honourable member asked how these costs were to be paid, but no additional funds were provided by the Government. The cost will be absorbed within the central office budget, and over the past five years there has been a progressive reduction in the number of people working in central office. In 1986 the number was about 543; in 1987, 501; in 1988, 472; and in 1989, 456. The target figure for 1990 is 410. That is detailed in the Auditor-General's Report. Up to now, of all members of the central office of the Health Commission, 140 work in the Health Department and are involved in providing services to the whole South Australian community; in environmental health, occupational health and epidemiology. So, the true figure for the central office of the Health Commission is 270, making it a very lean organisation indeed. The reduction in numbers between last year and this year is a combination of the transfer of some functions outside the commission and a reduction in funded positions.

I would have to take this question on notice in order to give the precise detail of those two components of the reduction. In summary, the commission derives great benefit from the move to CitiCentre. It was cost neutral to the Government, the capital costs are being borrowed and paid back over a 15-year period and the increased rentals and loan payment charges are being funded by reductions in central office budget requirements.

Mr OSWALD: Part of my question may have been answered but could the Minister detail the recurrent costs to the Health Commission in 1988-89 in leasing two additional floors of the CitiCentre building to accommodate staff initially overlooked in the occupancy calculations? What is the estimated recurrent cost for 1989-90 and subsequent years? In giving his reply, could the Minister state what has been the annual saving since 1987-88 from staff reductions in head office, given that the former Health Minister, Dr Cornwall, stated in July 1986 that planned reductions would yield annual savings of $1.2 million?

Dr McCoy: I am not sure whether I have the detail to answer all of that question now and, therefore, I will take it on notice and provide a subsequent answer in detail.

Mr OSWALD: How many Health Commission staff are acccommodated in Heinz House, at 61 Hindmarsh Square, and what is the annual cost of providing accommodation to these employees separated from those housed at CitiCentre? Will the Minister say what arrangement has been made regarding accommodation of the 80 staff who were earlier this year located in the State Bank building on the corner of Rundle and Pulteney Streets, due to lack of space in the CitiCentre building; what is the status of the commisssion's long-term lease with the State Bank of office premises in the aforesaid building; and what would be the cost of terminating that lease? If it has not been terminated, what is the ongoing cost?

The Hon. D.J. Hopgood: We will take those questions on notice and get the information to the honourable member as soon as we can.

Mr BECKER: On 8 June 1989 the Chairman of the Health Commission, Dr McCoy, put out a press release, which stated, in part:

'A leaner and even more efficient central office of the Health Commission will result from a major reorganisation,' the Commission's Chairman, Dr W.T. McCoy, said today.

Dr McCoy was commenting on a report into the commission's corporate services division by outside consultants.

What was the cost of the Speakman Stillwell consultancy into the operations of the commission's central office?

The Hon. D.J. Hopgood: The cost was $48 200.

Mr BECKER: How many positions have been abolished or transferred, as forecast in Dr McCoy's press release? If this has not occurred, why not?

The Hon. D.J. Hopgood: I will ask the Chairman to provide the details.

Dr McCoy: The number of positions abolished is about 50 at this stage. I am undertaking an internal review of the organisation of the central office and the final figures are not yet known. They will not be finalised until early 1990. It is likely that that figure will be higher. There was some transfer of functions from the central office to non-incorporated health unit status. An example of that is the 20-plus people who work in the sexually transmitted diseases clinic on North Terrace to provide a clinical service. It is not a central office function and is no longer considered as such.

Mr BECKER: Will the Minister provide information on the Health Commission Chairman's salary as at 30 June 1988, 30 June 1989, and on any allowances that the Chairman receives in addition to salary? Further, how many officers within the Health Commission are currently employed at EO level and how many at AO level?

The Hon. D.J. Hopgood: Salaries are gazetted. We will take the question on notice, and I am sure we can get the information before the end of the day.

Mr De LAINE: What progress has been made in the integration of the Daw Park Repatriation General Hospital into the South Australian hospital system?

The Hon. D.J. Hopgood: I am sure that members of the Committee would be aware that the Federal Minister for Veterans' Affairs (Hon. Ben Humphreys) has indicated that the Commonwealth Government intends to achieve integration of the two hospital systems (Commonwealth and State) by 1 July 1995.

The rationalisation and eventual integration of the two systems is generally supported by this Government, provided that several conditions are met: that the veterans are given access to comprehensive health and hospital services at the same special level that they have always enjoyed; that the Commonwealth gives a guarantee that all funds will be transferred to the State and indexed for inflation; that the Commonwealth completes the comprehensive upgrading of physical facilities at Daw Park before the date of transfer; that the veterans' community, and particularly the RSL organisation, is satisfied with the arrangements, particularly those relating to priority of access and quality of health care; and that the staff of the Repatriation General Hospital, Daw Park, are satisfied that their interests are adequately safeguarded. Although this major integration is some years away and subject to the Commonwealth's satisfactory fulfilment of the State's conditions, as I have previously indicated, significant cooperation already exists between Flinders Medical Centre and the Repatriation General Hospital.

I shall briefly detail some examples of this cooperation, which include: shared responsibilities for specialist medical staff in the disciplines of geriatrics, vascular surgery, rheumatology, gastroenterology, rehabilitation medicine, urology and palliative care; the appointment of Professor Villis Marshall as Director of Surgical Services at both hospitals, which, of course, was a landmark occasion; the appointment of Professor Dennis Smith as Professor of Rehabilitation Medicine, located at the Repatriation General Hospital; and the establishment of a joint State-Commonwealth-funded hospice, located in Daw House, within the Repatriation General Hospital campus. Members of the Committee will recall the debate which led up to that matter, involving another health unit in another location.

The cooperation in this regard also includes: the appointment of Professor Ian Maddocks as head of Palliative Care Services at FMC and Director of the hospice at Daw Park; the rotation of trainee medical officers between both hospitals as part of a conjoint training program; inpatient treatment of 'community patients' at Daw Park, especially those requiring medical rehabilitation; and transfer of some FMC emergency patients to Daw Park, mainly in the medical disciplines. I think it is all going very well. For members who have not had a chance to do so, I suggest that they go down to the Daw Park Repatriation General Hospital and have a look at the services that are available there.

Mr De LAINE: A 1989-90 specific target/objective is to consider implementation of the recommendations from the Domiciliary Care Services Review (page 46 of the Program Estimates). Will the Minister provide details of those recommendations?

The Hon. D.J. Hopgood: No report is available to me. Once the report has been made available we will have to consider the recommendations and decisions will have to be made. I will be prepared to discuss with the honourable member these decisions and the implications of them once they have been made.

Mr De LAINE: A 1988-89 specific target/objective concerned the appropriate targeting of CAFHS services in schools (page 53 of the Program Estimates). Will the Minister provide details?

The Hon. D.J. Hopgood: The target refers to a decision which resulted from an extensive review of CAFHS conducted in 1986-87, with a view to providing universal health screening services for school children, as well as other improvements in aspects of CAFHS school services. The decision was to ensure that health screening services were truly available to all South Australian school children, and from now on health screening services will be offered to all children before or at the commencement of school. This will obviously ensure that all children with hitherto, for example, unrecognised vision, hearing, developmental, or other health problems, will be identified at about the age of four or five before they start their formal primary education. In the same manner, health screening for hearing, vision or curvature of the spine is offered to all students commencing their secondary education.

There have been various other ways in which services provided to schools by CAFHS have been improved. There is the establishment of a telephone information service for teachers and other professionals; promotion of comprehensive health education in all schools through CAFHS working in conjunction with the Education Department and other health agencies; and, of course, in keeping with the Government's social justice strategy, CAFHS has focused its remaining school health services in areas of apparent disadvantage because of the well-established links between socioeconomic disadvantage and poor health. I believe CAFHS thus provides a range of primary health care services, including health assessments in priority project schools—one is called, 'The Disadvantaged Schools Program'—special schools and language centres. We are excited about some of these initiatives.

The Hon. JENNIFER CASHMORE: In relation to the Health Commission's change in property and public risk policy insurance, I have a series of specific questions, some of which may have to be put on notice. In relation to public risk, what was the total value of insurance premiums paid to the AMP Society, and to the other insurers for each of the following years: 1986-87, 1987-88 and 1988-89? What public hospitals did the AMP provide with insurance cover, and what insurers were used for other public hospitals? Which of the hospitals or health units did each of these insurers cover?

The Hon. D.J. Hopgood: I will take that on notice and obtain a reply as soon as possible.

The Hon. JENNIFER CASHMORE: What is the total value of insurance claims paid out for claims within the public health system by its insurers for the years 1986, 1987 and 1988 from each separate insurer, hospital, and health unit?

The Hon. D.J. Hopgood: I will ask the Deputy Chairman Mr Sayers to comment before we take the question on notice.

Mr Sayers: The details would certainly have to be taken on notice. We do not have that information available, for example, whether or not the claims are paid out. The Health Commission would be unaware of the extent of some of these policies, because we insure and allow the claims pay-

ments to be made over a number of years. For instance, occurring in the year in which we were insured and, therefore, the detail quite often is not shared with the commission in many of those cases. However, we will provide as much information as we can in relation to the question.

The Hon. JENNIFER CASHMORE: Given that the Health Commission is now becoming a self-insurer—and I would appreciate a response from the Minister of Health why the commission has chosen to do this—what money has been set aside for this and subsequent financial years to provide for future insurance claims against public hospitals and health units? Where does this money show in the Program Estimates and in the Blue Book?

Mr Sayers: In relation to the public liability, medical malpractice funds have been reserved for the amounts of money we expect to pay out this year. In relation to those two items, the amount that has been reserved in the Health Commission budget is $4.5 million and a further amount of $2 million has been reserved within the Treasury to meet all future claims that will arise in this financial year. The money to be paid out for claims by the Health Commission this year in its own budget, a further $2 million, has been reserved in the Treasury line.

The Hon. JENNIFER CASHMORE: It seems to me—and certainly to many members of the public in the insurance profession—that it is an extremely high risk policy for the commission to change from insuring property and public liability with insurers where the risk is spread to carrying the total risk itself. What advice did the Government obtain before proceeding to this policy, and on what basis did it proceed? For example, if there were to be an earthquake which affected the Royal Adelaide Hospital, the liability of the State would be hundreds of millions of dollars, and not spread in the way normal insurance risks are spread.

The Hon. D.J. Hopgood: I am advised that, in June of last year, the Public Actuary requested that the Health Commission undertake a review of its insurance arrangements with a view to adopting a self-insurance program. So, the initiative initially came from the actuary. This was in consideration with insurance premiums totalling $7.4 million being paid for the 1988-89 year and the possibility of fund retention in future years achieved through self-insurance. In October of last year, the commission undertook an extensive review of its insurance policies which, since 1 July 1980, had been purchased through the insurance industry. In June of this year, the commission determined that it would adopt a self-insurance program as of 1 July this year—the beginning of the financial year. I will give the details: public liability; medical malpractice; industrial special risks; property; boiler explosions; machinery breakdown; inland transit, covering household furniture; the effect of staff changing locations; motor vehicle comprehensive insurance, including loss of no claim bonus including staff using private vehicles on official business; personal accident; voluntary workers and board members.

The only exception to this approach was the renewal with the present underwriter of a personal accident policy covering medical, nursing and other staff undertaking emergency medical retrieval activities. I believe the honourable member has already been given the other information that I have in front of me. The possibility of a disaster of that magnitude is something that cannot be set aside. However, the Government has a responsibility to continue to provide services in whatever set of circumstances arise. In those circumstances, given that they say an act of God would have virtually rewritten the book, I imagine the Government would have to rewrite the book as well.

The Hon. JENNIFER CASHMORE: I have a number of detailed questions on this page, which I will give to the Minister. Do they all have to be read into *Hansard* for them to be answered in the Estimates Committees, or should they be put on notice in the normal way? There are probably four or five additional questions that I did not read into the record.

The Hon. D.J. Hopgood: I will undertake to answer the questions in whatever form they are given to me.

The CHAIRMAN: Normally they are put in the record. If you undertake to answer these questions in that way, then I am sure it will be satisfactory.

Mr GROOM: I understand that the Government Health Commission is an exempt employer under the Worker's Rehabilitation and Compensation Act. Can the Minister outline how the commission has undertaken and coped with its responsibilities as an exempt employer?

The Hon. D.J. Hopgood: Each health unit participating in the South Australian Health Commission's workers' compensation scheme is an exempt employer in its own right, pursuant to the current legal opinions. SGIC Risk Management Services have been contracted by the Health Commission on behalf of the individual health units to provide a claims management service, including the expertise to allow individual health units to make appropriate determinations on workers' compensation claims submitted by their employees. By the provision of seminars and individual attention, the Health Commission has assisted individual health units in understanding and interpreting the current legislation.

An educational and promotional campaign has been implemented advising workers of their rights and responsibilities, and how to submit workers' compensation claims and receive rehabilitation. Practices and procedures have been established to enable line managers to accept responsibility for the rehabilitation of workers under their control, and for individual health units to receive financial recognition on satisfactory performance. The South Australian Health Commission and individual health units have developed a rehabilitation policy which commits the organisation to providing the best possible rehabilitation in the event of a worker being injured during the course of his/her employment. The policy adopted by the Health Commission has been discussed with both the WorkCover corporation and the appropriate union organisations.

Funding has been provided for proactive rehabilitation to rectify problems before they manifest as workers' compensation claims and for use by the Occupational Health and Safety Advisory Committee in the identification of hazards in the workplace and future prevention. Contracts will be renewed with WorkCover contracted providers to ensure that the high standard of rehabilitation within the Health Commission continues, and that professional intervention is available when in-house services are unable to cope or are found to be inadequate.

Mr HAMILTON: The Minister will recall that on 17 November 1983 I asked about Neighbourhood Watch in South Australia. I have heard that there is a hospital security program operating in the State called Hospital Watch. Can the Minister confirm the existence of such a program and whether it is suitable for adoption in South Australia? I understand that it has been on trial at the Queen Elizabeth Hospital, but that may be incorrect.

Dr McCoy: Security is of vital importance in hospitals. There are 25 000 staff in our hospitals and about 10 000 patients at any one time and probably about the same number of visitors, so security is important from two points of view. One relates to the buildings and contents—the

assets of the Health Commission—which are valued at $2 billion and upwards. The second relates to the security of patients, visitors and staff. Members know about Neighbourhood Watch, and I was delighted recently to learn about Hospital Watch. I have a placard on Hospital Watch that is being prepared for members to see. The placard has been developed by Hosplan and Government Insurance Office in New South Wales, with which we are negotiating. Mr Taylor of the commission is actively pursuing this matter with hospital administrations. I had a recent meeting with the metropolitan hospital coordinating group at which there was agreement in principle that all the metropolitan hospitals (and I hope in time all hospitals in the State) will agree to become members of Hospital Watch. Hospital Watch relies on the fact that staff in our hospitals are our most important asset in terms of security. If staff are made more security conscious, it is likely that problems relating to staff and property can be minimised.

Mr HAMILTON: I thank the Minister and his staff for that information. I am sure that everyone will be interested in saving money, particularly in that area. At Acacia Court in my electorate there is a program to help people who suffer from Alzheimer's disease or dementia. Can the Minister say what funding has been provided for these programs in South Australia and what additional assistance will be provided to the relatives of those who unfortunately suffer from this disease? In the western suburbs it is of particular importance, and it is to me because many aged people reside in my electorate.

Ms Johnson: The question will need to be referred to the Department for Community Welfare, which will be appearing this evening. There are dementia hostels funded in this State through the Commonwealth Government. We have 25 of these hostels. In addition, ADARDS, an organisation which takes an interest in and provides services for people suffering from dementia, receives an allocation through the Home and Community Care Program, which is part of the Department for Community Welfare. I believe that ADARDS receives about $200 000 a year.

Mr OSWALD: I refer to the previous question on Hospital Watch, which we applaud. Hospital Watch is probably intended to detect dishonest people from outside the hospital system. I have a question about theft within the hospital system, so I will ask it and it can be tied back into Hospital Watch or whatever area it is to be tackled in. What was the total value of goods and equipment lost or unaccounted for in each of Adelaide's seven major hospitals in the past financial year and the previous two financial years? What was the description of such goods and equipment lost or unaccounted for over that period? What was the individual value of the major items that were missing?

The Hon. D.J. Hopgood: We will get that information for the honourable member. I make the point that Hospital Watch is as much directed towards theft, particularly petty theft that may occur as a result of initiatives taken by people working in the hospital, as it is to theft that might occur as a result of the activities of visitors. Part of the Hospital Watch program is to make people who work in the hospital system understand that their positions are at risk from a very small minority of their workmates but these things occur from time to time. However, we will get that information.

Mr OSWALD: I refer to sick leave. What was the total number of sick days taken by Health Commission central office employees in 1988-89? How many were not covered by medical certificates and how many of those sick days not covered by certificates were taken on a Friday or Monday or a day immediately before or after public holidays?

The Hon. D.J. Hopgood: I note that the honourable member refers specifically to the central office and not to the health units in the field. I ask the Chairman to reply.

Dr McCoy: A survey completed in December 1988 estimated that 5.03 days were lost per central office employee for sick leave per annum. That compares with an average of 11 days of sick leave in the five metropolitan hospitals. The average in the catering staff was 11.82 days; in the clerical staff 9.24 days; in the domestic staff 12.33 days; in the nursing staff 10.82 days; and for porters and orderlies 10.6 days. The average for the five hospitals, as I said, is 11 days, and the average for Health Commission employees is less than half that figure. There has been a lot of discussion about sick leave and alleged abuses of sick leave. We have spent a great deal of time and effort addressing the problem. It is clearly an international problem.

We obtained information a few months ago about the sick leave experience in other countries: the average in Holland is 21 days; Sweden, 18 days; Czechoslovakia, 16 days; West Germany, 15 days; and the United Kingdom, 15 days. The only one significantly lower is the United States of America with seven days. Information suggested that the sick leave problem affected both public and private sectors at about the same level. Clearly sick leave is not the exclusive domain of blue collar workers as the sick leave experience in respect of a number of other categories of staff is roughly the same.

We have taken many actions. We have put in monitoring systems and commenced staff counselling and training sessions through the staff development council. We realise that, in part, sick leave may be due to boredom and the repetitious nature of a number of jobs in hospitals and in the health system generally. We are looking at job enrichment and restructuring programs and have spent money and effort in the cleaning department of the Royal Adelaide Hospital.

Mr OSWALD: The Minister mentioned that he was attempting to do something about the level of sick leave, and he attributed it to boredom and repitition. Are there any other reasons for the increase in sick leave, such as low morale or stress on staff generally in hospitals? What is the total estimated cost estimated of additional sick leave in each of the major metropolitan hospitals?

The Hon. D.J. Hopgood: On the whole question of stress, no doubt some aspects of nursing are stressful. I do not detect anything in the system to suggest that the stresses are significantly greater in 1989 than in 1985. In June this year a representative of the Opposition complained about closed beds and reduced activity in hospitals and had us believe that there was little stress in hospitals, that it was only boredom as people were standing around doing nothing. One cannot have it both ways: either there is a high level of activity in hospitals and people are under a good deal of pressure if not stress because of such activity, or there is a low level of activity in hospitals in which case they may be bored but are unlikely to be stressed. Boredom of itself is not a stressful condition, as the honourable member would know. I have visited a good number of hospitals lately, including the Queen Elizabeth Hospital yesterday.

Dr McCoy: A great number of issues are important in the sick leave debate. The award entitlement is very important, as is the need for medical certificates, and the question of stress and morale clearly has an impact on sick leave. When we have a computerised system we will be able to analyse the information more carefully, but sick leave is believed to be more prevalent adjacent to weekends and long weekends. We have an award entitlement of 12 days per year. In the metropolitan hospitals it is estimated that

each day of sick leave is worth about $600 000, so there are clearly great savings if that number can be reduced.

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

The CHAIRMAN: I understand that the Minister has a response to a question asked this morning.

Mr Sayers: The question related to the Auditor-General's Report and the figure of $595.1 million for recognised hospitals in the year ended 30 June 1988 increasing to $636.33 million in 1989. It was mentioned that that was an increase of $41 million or 7 per cent; but, when discounted for an increase in superannuation and terminal leave, it was reduced to a figure closer to 6 per cent.

The two figures cannot be compared in their raw state. There are a number of matters that need to be adjusted to compare like with like, including the number of pay periods. We have, of course, 27 pays in some years and 26 in others. There is, in that recognised hospital section, the impact of average weekly earnings which has a major impact as compared with the rest of the Health Commission budget. Average weekly earnings inflate hospital expenditure at a rate different to the CPI.

Another reason is the adjustment of major items of a one-off nature that occurs in the various years and you need to be able to adjust for those. Some of those are quite substantial; for example, there has been a major variation in workers compensation payments between those two years, and those figures need to be adjusted for that, also. The final one is the transfer of services between health units that take services from one section to another. For example, the removal of the head injury services from the Royal Adelaide Hospital to the Julia Farr Centre takes it from the recognised hospital expenditure area to another area in the expenditure accounts.

The only figure that really can be compared is the bottom line and, of course, in the figures presented earlier that showed an increase of 0.5 per cent above the inflation rate. Other figures, just to support the expenditure on recognised hospitals, show that the expenditure on recognised hospitals for both the years mentioned in the question have remained at 68.9 per cent of the Health Commission's budget and, of course, that increased to 69 per cent in the 1989-90 budget.

Mr HAMILTON: I was particularly taken by an article in this morning's *Advertiser* headed 'RAH gives hot breakfast the cold shoulder'. I am particularly intrigued by the article, but perhaps I could ask an impertinent question of the Minister: what did he have for breakfast this morning? Does he, as a Minister of Health, set an example? He will probably kill me for asking this question and it is certainly not a dorothy dixer: does the Minister agree with the decision of the Royal Adelaide Hospital, but, more importantly, what did he have for breakfast?

The Hon. D.J. Hopgood: I was interested in the article in this morning's *Advertiser*. I think it is important that we realise that a traditional hot breakfast can be a fairly dangerous sort of diet. For example, eggs, bacon and black coffee are all high in either cholesterol, salt or caffeine content and all are frowned upon by dietitians. So far as I am aware, the RAH decision mirrors the decision taken by the Queen Elizabeth Hospital some time ago to provide a high fibre diet wherever possible. I can probably say that, in turn my breakfast this morning mirrored what people were having in the RAH and QEH, because I had cornflakes, half a piece of toast and a cup of tea. The serious part of this is that the decision at the Royal Adelaide Hospital is not related to funding or anything like that at all; it is related to advice from dietitians. When you think about it, the catering staff must be on hand, anyway, because some people have very special diets and that is basically where your costs are. There may be some marginally lower costs where people have cereal rather than a fully cooked breakfast but it would be marginal indeed. The decision has been taken on dietary grounds; it has nothing to do with funding.

Mr De LAINE: I refer to 'specialist and general hospital and associated services', on page 54 of the Program Estimates. What is the situation in respect of the hyperbaric medical service at the Royal Adelaide Hospital since the collapse of the Victorian division of the National Safety Council of Australia in March this year?

The Hon. D.J. Hopgood: The Government has agreed that this service must continue and it has, in effect, picked up the tab. The total operating cost is $600 000 per annum, of which $200 000 was previously provided by the National Safety Council of Australia. A problem arose as a result of the unfortunate demise of the NSC. On 5 June this year Cabinet approved additional funding of $214 000 to compensate for the loss of this funding and to allow the hospital to continue to provide full hyperbaric medicine services for this financial year. We are dealing with perhaps 100 public sector and many more professional and recreational divers who live with the knowledge that they might have to have recourse to the use of this service. The service, which is recognised worldwide for what it provides, will continue.

Mr GROOM: I understand the Commonwealth provides funds for health services generally under the Medicare agreement. Will the Minister provide some details of any specific additional funding for health services provided under the Medicare agreement?

Dr Filby: As well as the general level of assistance that the Commonwealth provides, there are two specific programs which have operated over the past couple of years. They are the hospital enhancement program and the Medicare incentive program. The enhancement program is a joint program with both Commonwealth and State funds and it is primarily for the purchase of items of equipment and for the improvement of clinical services. Last year funding was about $2.4 million and this year it will be about $6.1 million. Projects funded under this program include the establishment of a six-bed psychiatric unit at the Adelaide Children's Hospital, the additional anaesthesia staff at Lyell McEwin, and an expansion of the diabetics program at the Queen Elizabeth Hospital.

Under the Medicare incentive program there were specific allocations of funds for palliative care services, for services to assist in the early discharge of patients from hospital, for the development of new practices for palliative care and early discharge arrangements and for additional day surgery services. Under this program, we funded a number of additional services including a joint replacement unit at the Royal Adelaide Hospital, the expansion of pain care services at the Royal Adelaide Hospital, additional funding for the Royal District Nursing Society to allow it to expand to a full 24-hour service and significant money for community-based palliative care teams to provide for terminally ill patients with palliative care in the community rather than in a hospital setting. There is also significant additional money for day surgery in both metropolitan and country hospitals.

Mr BECKER: Further to the previous question I asked in relation to the general review of what is known as the Speakman Stillwell review, has the Public Service Association agreed to the abolition of 46 positions in the South

Australian Health Commission office and what positions are to be abolished, or are these positions to be transferred to other areas of the health system? In a circular to all PSA members of the Health Commission Central Office—Corporate Services Review Update—by the Public Service Association stated:

> Future of the Speakman Stillwell report: In a letter that the association received on Friday of last week, the Chairman of the commission [I assume that is the Health Commission] stated that the Speakman Stillwell review 'cannot possibly be seen as a blueprint for the consideration of the wider issues now before the commission' and has assured us that the report will not be used as a basis for taskforce deliberations and that it will not be circulated further.

In the Public Service Review of August 1989, under the heading 'Using outside consultants—the risks', the General Secretary stated that the 'upshot has been that the report has effectively been withdrawn and an internal task force, which includes representation from the association, has been established to carry out the reorganisation.'

Dr McCoy: The member is correct, the report of Speakman Stillwell has not been accepted as a blueprint for the future of the central office of the commission. I have formed a task force, which is headed by Ray Blight, on which there are three representatives of the Public Service Association, in addition to Tony Milne, from the Government Management Board, and Gail Fraser, from the Department of Personnel and Industrial Relations. That group is studying the tasks, functions and the numbers in the central office, with the request that it report to me before Christmas on the implementation of the reorganisation.

The main thrust of that reorganisation will be to ensure that any changes may have one major objective, that is, to improve the administration of health services and hospital services in this State, and to improve the relationships between health units and the central office of the commission. In relation to the honourable member's question about numbers, in response to an earlier similar question, I said that I would provide details at a later date.

Mr BECKER: What are the respective approved levels of staffing at each of the seven major public hospitals in Adelaide as at 30 June 1987, 1988 and 1989? Will the Minister explain the shortfall of 178 staff at Adelaide's three largest hospitals, when the Auditor-General's Report of 1989 is compared to information provided at the last Estimates Committee? What was the breakdown of medical, nursing, and administrative numbers at each of the seven hospitals as at June 1989?

Dr McCoy: I refer the honourable member to the Health Commission's Gold Book, which is prepared each month and which states the number of staff by health units monitored by the central office of the commission about two months after the event. This is the report to end of June 1989. The approved target—referring to full-time equivalents—for the Royal Adelaide Hospital was 3 589, and at the end of the year the actual number was 74.9 above the approved target; at Flinders Medical Centre, the approved target was 2 334.7 and at the end of the year it was 15.8 below that target; at Queen Elizabeth Hospital, the approved target was 2 588 and at the end of the year the figure was 5.1 below that target; the approved target for the ACH campus of the Adelaide Medical Centre for Women and Children was 1 278.9; it was 34.4 above that target at the end of the year; at the Queen Victoria campus of that hospital, the approved target was 610.2 and it was 1.3 above the target at the end of the year. Therefore, the total approved target full time equivalent for those major metropolitan hospitals was 10 400.8 and they were 89.7 above the target. The honourable member asked for a breakdown of staff categories; I do not have that information with me but it can be provided later.

Mr BECKER: Can the Minister now provide information on the total number of beds to be available at the new Adelaide Medical Centre for Women and Children (AMCWC)? A letter from the Minister's predecessor, dated 6 April 1989, stated that no decision had yet been made. How many of these beds are to be gynaecological and where will they be located?

Dr Blaikie: Precise details have not yet been resolved because, whilst in principle decisions have been made, the development brief for the new hospital has not yet been completed and is some way off. The number of beds available at the Adelaide Children's Hospital component of the Adelaide Medical Centre for Women and Children will remain as it is—some 215 beds. The Queen Victoria component of the AMCWC is likely to consist of two by 26 post natal wards and a 34 bed ante natal ward and 18 bed high dependency delivery suite. The end result of that is that obstetric bed numbers at the new faciliting are likely to be the same as they now are at the Queen Victoria, that is a total of 86 obstetric beds.

The matter of some debate is the number of gynaecological beds that will be established at the centre. The brief from which the boards of directors of both hospitals agreed to dissolve and form the new centre, talked of 15 gynaecological beds being established at the new hospital. That is half the number now available at the Queen Elizabeth Hospital. The only other beds that might be involved are neo natal beds. The present plan is that the level two neonatal cots will be increased by two to 37, as part of the new facility, and that level 3 neo natal cots will be increased by one to 15. In summary, the same number of beds will be made available in all areas of obstetrics and children's care. There will be an increase in neo natal cots and there may be a halving of gynaecological beds, although that decision has not yet been made.

Mr BECKER: Can the Minister confirm that the revised estimate cost for the redevelopment of the Children's Hospital, to be known as AMCWC, is now in excess of $49 million; a 32 per cent increase on the figure in the Capital Works Program 1989-90?

The Hon. D.J. Hopgood: My information is that the estimated cost as at December 1989 was $37.5 million, and I know of no other revised estimate beyond that.

Dr McCoy: Dr Blaikie, John Milliken, and I are the commission's representatives on the steering committee that will oversee this new major hospital redevelopment to rehouse the Queen Victoria Hospital on the Adelaide Children's Hospital site. As the Minister has mentioned, the budget for the new hospital is $37.5 million. At the first meeting of that steering committee we were presented with a preliminary view containing a large number of items that are not included in the project, and the estimated total cost came to considerably more than the $37.5 million. We have made it clear to the hospital administration and board chairperson that it is necessary to identify only those projects that are part of the relocation project so that its exact cost can be determined. The present budget, which is included in our forward capital works program, is $37.5 million.

The Hon. JENNIFER CASHMORE: Whilst the decision has not yet been firmly taken to halve the number of specialist gynaecological beds at the new hospital, it is a fairly dramatic decision, and the cut of 15 beds is fairly significant. What is the reason for that; are those beds to be relocated, possibly at Mareeba? How are the women of South Australia to be served if the number of those beds is halved?

The Hon. D.J. Hopgood: I understand it was a recommendation from the feasibility study that this would be sufficient to be able to meet the demand, given the sort of demographic studies that have been undertaken.

Dr McCoy: This matter is still unresolved. It has always been intended that, in the new location, there would be a combined and coordinated gynaecology service between the Royal Adelaide Hospital and the Adelaide Medical Centre for Women and Children, and that the number of beds at the Royal Adelaide Hospital and those on site at the AMCWC would be of the combined unit. What has not yet been finally decided is what services will be provided at the Royal Adelaide Hospital and what will be provided at AMCWC but I can assure the member for Coles that the number provided will be appropriate to the needs of those two hospitals, and that there will be no cut in services.

The Hon. JENNIFER CASHMORE: What is the total number of beds now available at the Queen Victoria and Royal Adelaide gynaecological units? We assume from that total—

Dr Blaikie: Thirty beds.

The Hon. JENNIFER CASHMORE: That was confirmed at the Royal Adelaide?

Dr Blaikie: We do not know, but we can find that out.

Mr HAMILTON: Page 2 of the Program Estimates refers to the establishment of the pilot mammography screening program at Queen Elizabeth Hospital, Flinders Medical Centre and the Royal Adelaide Hospital and on the same page it also refers to the extension of the mammography screening programs. Given that the information provided indicates that one in 13 Australian women gets breast cancer at some time in her life and that, in 1987, 554 South Australian women were diagnosed as having breast cancer, can the Minister indicate the success of that program? In addition, given that it is set in the specific targets and objectives of the expansion of this screening program, would he give details about that expansion of the program? It is an important issue, particularly to country people, who are interested in these programs.

The Hon. D.J. Hopgood: The experience in South Australia of what are still pilot programs is not sufficiently lengthy to allow us to draw sound conclusions. What we can say is that, in experimental trials in the United States and Sweden, it has been shown that breast cancer mortality can be reduced by about 30 per cent in populations to which mammographic screening is offered. Even in those areas, not all women participated in the screening at prescribed intervals to get an idea of what was happening. It is possible that the effect was better than the 30 per cent reduction in mortality that was reported. For our screening, a pilot program is underway at the Queen Elizabeth Hospital, Flinders Medical Centre and the Royal Adelaide Hospital. It is important that there be very tight quality control over such testing, because it has been widely reported that, at certain times and places, there has been an unacceptably high level of wrong initial diagnosis, which leads to a great deal of needless anxiety on the part of the patient until it is eventually confirmed that the original diagnosis was wrong. Quality control is important.

I am not talking about the South Australian experience in particular, but about the general experience in this area. Because of this, the National Health and Medical Research Council has advised that broader screening should occur only through extension of this sort of program: the pilot programs where we can ensure that the quality control is held as tightly as possible. The total State Government's funds allocated in 1988-89 for the screening component of the program was $134 000 with an 1989-90 full year effect of $354 000. The central coordinating unit funded by the Commonwealth was allocated $218 000 in 1988-89, with a full year effect in 1989-90 of an additional $140 000, which includes the new initiatives money.

Mr HAMILTON: On page 51 of the estimates I note mention of the establishment of palliative care teams in different areas of metropolitan Adelaide and, the extension of the existing western palliative care program. Obviously, that being somewhat parochial, it involves me, the member for Price, and other colleagues in the western suburbs, and I would be particularly interested in the overall extension and establishment of these palliative care programs in South Australia, specifically in the western suburbs.

The Hon. D.J. Hopgood: I have answered a couple of questions in Parliament about this, in respect of the north and north-east so I will concentrate on the west, which is of interest to the honourable member. In 1989-90, $100 000 has been provided under the Medicare incentive program, to extend the membership of the western palliative care team, and the Health Commission has provided a grant of $243 900 to Southern Cross Homes in 1989-90, as a contribution towards a hospice unit at the Philip Kennedy Centre, which I have visited and I commend the work that is being done there. That grant includes $53 000 specifically for the treatment of AIDS patients. The other Government initiatives have been mentioned publicly in response to questions I have received in Parliament in relation to the Lyell McEwin Health Service and Modbury Hospital.

The CHAIRMAN: Does the honourable member intend to ask a supplementary question about Port Pirie, Port Augusta and Whyalla?

Mr HAMILTON: Why deny the Chairman! I was going to ask that question, and I ask the Minister to respond accordingly.

The Hon. D.J. Hopgood: I am tempted to say that we will take it on notice! The aim of palliative care in country South Australia is to enable persons with a terminal illness to remain at home in familiar and family surroundings, as they usually are, if they so desire. We try to provide improved education and support to the family of the patient, while providing existing community services and coordinating any additional services that may be required. Some Commonwealth Government funding has been allocated to rural palliative care services. I note, for example, that at Port Pirie the Mid North service effectively has a full year grant of $47 450 this financial year.

Mr HAMILTON: I have just had placed on my table a pamphlet which somewhat intrigues me. In no way am I reflecting on the company concerned, but I ask the Minister whether he and/or his colleagues would check the credentials relating to the company concerned, Niagara, which has an address in South Plympton. The pamphlet says 'Tick where you hurt'. It further states 'Niagara can help you: ease arthritic pain and increase mobility, ease sore, aching muscles, soothe rheumatic pains whenever they occur, increase circulation where applied, reduce high blood pressure . . . hip pain, ease high and low back pains . . . improve joint mobility.'

The Hon. JENNIFER CASHMORE interjecting:

Mr HAMILTON: I do not believe it is a waste of time. It does relate to the question.

The CHAIRMAN: The honourable member is required to refer to a line.

Mr HAMILTON: This matter does impact on aged people in the community and relates to palliative care as well. As to these claims, I ask that the credentials of this organisation be checked out. Various claims are made, such as this treatment is medically proven by worldwide research

in leading hospitals, without the use of drugs. Will the Minister investigate these claims, through the Health Commission and, indeed, through the NHMRC?

The CHAIRMAN: I believe that it would be normal practice for the Health Commission to check such matters that come to its attention and that it would have the resources available to do it.

The Hon. D.J. Hopgood: I always thought that Niagara related to a waterfall in North America or a steam locomotive with a 484 wheel arrangement. I am told that these people have been around for some time; but we will check out the specific claims in this pamphlet—which I understand was distributed today as an insert in the afternoon newspaper—and report back to the honourable member, the Committee and, if necessary, the community at large.

Mr BECKER: Supplementary to a question I asked earlier about the costs of building the AMCWC, to which an answer was given by the Health Commission, what figure did the hospital come up with to the Health Commission and how much higher was it beyond the original estimate?

Dr McCoy: From memory it was some $48 million; it was very much higher than the budget figure. It was a figure that was not accepted, I hasten to add, by the Committee, which recognised the imperative of the budget figure that had been set, and it was decided to undertake a major investigation to ensure that all the things that were not part of the relocation of the Queen Victoria Hospital were excluded from the project.

The Hon. JENNIFER CASHMORE: I refer to page 336 of the Auditor-General's Report and the reference to the Central Linen Service. Apart from the supply of linen to hospitals, in what areas is the Central Linen Service involved—or in what areas does it intend to become involved? I understand that it is offering maintenance contracts for hospitals in competition with the private sector and that it is also trying to establish a food consultancy and cleaning contract service. What is the Government's attitude to this extension of its role?

The Hon. D.J. Hopgood: I have no information about the Central Linen Service expanding into provision of foodstuffs and that sort of thing. The position of the Government in relation to the Central Linen Service is that we encourage it to do whatever it possibly can to maintain its productivity and profitability, given, of course, the limitations of industrial awards and the necessity to have proper financial accounting, and all those sorts of things.

The production process at the Central Linen Service has been re-equipped, and that has been very successful. I was down there on the day when the Central Linen Service got itself into the *Guinness Book of Records* due to the very high productivity achieved on that day. One would not expect that level of productivity to always be maintained, but I can say that in the past 12 months average direct labour productivity has been about 46 kilograms per operator hour. We understand that the best run private laundries regard 36 kilograms as being excellent. I will endeavour to get such further information for the honourable member as might be available, but it could be that no further information is available.

The Hon. JENNIFER CASHMORE: The profitability referred to by the Minister is obviously affected by the costs which the Central Linen Service may have waived, by comparison with its competitors in the private sector. Will the Minister advise the Committee what taxes and duties does the Central Linen Service pay—for example, rental duty under the Stamp Duties Act, FID, Federal bank debits tax, council rates, water rates, and an amount equivalent to Federal income tax? There is no record in the estimates of Central Linen Service income tax payments.

The Hon. D.J. Hopgood: We will obtain that information for the honourable member. I think the important thing here is the extent to which it can be established that the health system, particularly the hospital system, is advantaged by having the Central Linen Service. We want to measure the whole thing in terms of what it would cost us if the service were not there. In any event, I will certainly get that information.

The Hon. JENNIFER CASHMORE: I have a series of questions, some of which may need to be put on notice, but they are all related to the Auditor-General's Report. Can the Minister identify the factors which indicated that the Queensland company, with which the Central Linen Service is trading, should be selected? For what reasons was that chosen? Are there any other companies outside South Australia with which the CLS trades and, if yes, which companies are they? Are there any other organisations, other than hospitals and nursing homes within South Australia, with which the service trades and, if so, what are they?

The Hon. D.J. Hopgood: We will take those questions on notice.

The Hon. JENNIFER CASHMORE: What profit margins were applied to linen purchased in South Australia and sold to the Queensland company? Now that sales tax is payable, what has that done to the profit margins, as indicated in the Auditor-General's Report? What volume, in money terms, was supplied to the Queensland company up to 30 June 1989?

The Hon. D.J. Hopgood: I believe I should apologise to the Committee: it did not occur to me that perhaps Mr Arnold should have been here today. I take responsibility for the fact that he is not here.

The Hon. JENNIFER CASHMORE: It is impossible to foresee who will be needed.

The Hon. D.J. Hopgood: Yes, but I believe I should have taken steps to ensure that he was here. These questions will all be referred to him, and I will get the replies to the honourable member as soon as possible.

The Hon. JENNIFER CASHMORE: From whom did the Central Linen Service purchase the Queensland company's linen requirements? Was that done in South Australia or in other States? What links does the service have with major linen rental and laundering companies in other States? In what transactions has sales tax been avoided by the Central Linen Service?

The Hon. D.J. Hopgood: I will bring back replies to those questions.

The Hon. JENNIFER CASHMORE: What are the controls over the sale of linen with which the board has directed all sales must now comply?

The Hon. D.J. Hopgood: I will bring back a reply to that question.

Mr De LAINE: In the Program Estimates (page 50) under 'Services for Aborigines' reference is made to the establishment of substance abuse programs and sobering up services in Port Augusta and Ceduna. Does the department have any plans for similar services in Port Adelaide?

The Hon. D.J. Hopgood: I will ask Colleen Johnson to briefly indicate our approach to this.

Ms Johnson: As the honourable member has said, at present the commission is in the process of establishing two sobering up centres at Port Augusta and Ceduna. There are no immediate plans by the Health Commission to establish any more sobering up centres. However, the Drug and Alcohol Council certainly provides funding to several non-government agencies around town who provide sobering up

services. I believe the best we can do at present is to obtain from DAS a list of sobering up centres that it partially funds.

Mr De LAINE: On page 55 of the Program Estimates, under the South Australian Health Commission community-based primary health care services program, a specific target is the establishment of a Marion community services accommodation facility. Will the Minister present some details on this facility?

The Hon. D.J. Hopgood: The two-stage development of a health village on Department for Community Welfare land on Sturt Road at Marion is proposed. However, during the early stages of the conceptual development of this process, it became apparent that the Marion City Council was interested in developing new administrative premises within its area and negotiations were entered into. As a result of this, the Marion council acquired one hectare of land on the Sturt Road site to enable the construction of a new administrative centre. The Health Commission has purchased the existing Marion council administrative centre on Marion Road as a site for stage one of the Marion community services facility, all of which explains why the Marion council logo has been removed from its old administrative centre—I noticed that as I came in this morning.

Stage one of the facility will house the Southern Domiciliary Care and Rehabilitation Service, the Royal District Nursing Service, Southern Hospice Care and the Glenside Hospital psychogeriatric centre. Tenders for alterations, extensions and work on the Marion Road site closed on 29 August this year. The actual refurbishment work is scheduled to commence in mid-October following the council's shift to new premises on Sturt Road. The refurbishment is expected to cost approximately $1.5 million, with completion scheduled for May next year.

Mr De LAINE: In the Program Estimates (page 48) 'Services for mental health' it states:

> Services to intellectually and psychiatrically disabled residents in boarding houses have been initiated.

What type of services are provided and how are they delivered?

Ms Johnson: In the 1988-89 social justice budget, $239 000 was allocated to the mental health accommodation program—which has recently been renamed the community accommodation support service—to implement specific recommendations of the report on boarding houses. Several initiatives have been developed through the allocation of those funds. Two regional support teams have been established: one in the south which is presently concentrating in the Glenelg area; and one in the north-east area which is concentrating at present in the Norwood area. The community accommodation support service was renamed as from 14 August, and that is to more accurately reflect its review function. The allocation of funds has also enabled the appointment of occupational therapy and activity staff to the community support teams. They have commenced the delivery of services.

The establishment of a southern regional branch office for the community accommodation support service at Clovelly Park—where the southern regional support team will operate—includes occupational therapy and activity staff. Funding has also been made available to the isolated persons project at Norwood to employ a coordinator for its day centre.

Mr OSWALD: Page 46 of the Program Estimates, under the heading 'Issue/trends', states that the number of client contacts by domiciliary care services is estimated to rise by 16 210 to 330 000. However, page 40 indicates that recurrent expenditure for domiciliary care is estimated to decrease by $219 500 to $18.943 million, which is a cut of 1.6 per cent in money terms, and 8.6 per cent in real terms. As the outlook for persons in need of domiciliary care services appears bleak, what action is the Government taking to ensure that people in need of home care services receive the services they require to live at home? What is the Minister's view on the trend to move away from institutional care when vital home delivery services, such as domiciliary care, are being starved of funds to meet the basic needs of clients?

The Hon. D.J. Hopgood: I believe the outlook is promising; in particular, the home and community care program has enabled us to do many things in this area that would otherwise have not been possible. Obviously, the whole trend is for people subject to such programs to be integrated into the community to the extent that that is possible. I believe we have to be careful in overturning the zealotry of past days—when it was seen as appropriate that everybody be institutionalised—that we do not introduce a new form of zealotry which, as it were, ignores the particular problems that these people face. However, having said that in general, I will ask Dr Blaikie to respond in respect of the actual resources that we are currently able to put into these programs.

Dr Blaikie: Funds for domiciliary care services have increased dramatically in recent years—in fact, by 200 per cent since 1983-84—in recognition of the increasing need for home-based care with a fairly active acute hospital system and an ageing population. Last year, leading up to the 1988-89 budget, domiciliary care services were the only services not to have to find any productivity savings in last year's allocation. That was an indication of the Health Commission's concern for a vibrant and vital domiciliary care service.

The figures referred to by the honourable member are misleading. Again, as we have said on a number of occasions today, we are not comparing like with like. I cannot speak for the country domiciliary care services, but I can give an indication with respect to metropolitan domiciliary care services and explain the differences between the two years.

In 1988-89 the total funding to metropolitan domiciliary care services was $15.6 million. In 1988-89 it would appear that it totalled $15.5 million, but last year in domiciliary care there were a number of one-off expenditures. I shall not bore the Committee with all the details, but most notable was expenditure of $666 000 on motor vehicle replacement last year. That will not occur this year. Under Government policy, motor vehicles are replaced every second year, so we have an immediate reduction of $666 000 for motor vehicle replacement which will not occur this year. There has been a saving of about $256 000 in respect of workers compensation. Again, that is not in the budget. It does not mean any reduction in services—it is an efficiency saving.

There are award carry-overs of $144 000 that need to be taken into account, small amounts for terminal leave which are still being held centrally, some equipment that was purchased last year that does not need to be purchased this year totalling $90 000, and so on. There is no need to go through all of those. There has been a moderate increase in the HACC funds to domiciliary care services. In this current year those services will be as well treated as they were last year.

Mr OSWALD: Is the Minister aware that a proposal has been put to the commission by the Adelaide Children's Hospital to place an absolute ceiling on the number of

medical and surgical admissions to the hospital due to funding constraints which will prevent the use of the 60 surgical beds by medical patients and will necessitate the transfer of children requiring medical admission to other hospitals when the 48-bed allocation for medical uses is full? Will the Minister make funds available to reopen the 20-bed Joanna ward to offset the need for such transfers?

Dr Blaikie: I am not aware that a proposal has been put to the Health Commission. I have had discussions with Mr Gould, the Chief Executive Officer of that hospital. The Children's Hospital is by any objective yardstick very well funded. Indeed, in studies this year comparing it with similar hospitals interstate, the indications are that it could be as much as $6 million over-funded relative to its sister hospitals in other places. I do not accept that the Children's Hospital has a major funding crisis.

In the past two years the hospital has run into various difficulties. The new Chief Executive Officer is keen to ensure that the hospital is run as efficiently as possible and that bed management plans are adopted to enable the hospital to have more beds available in the winter months when greater numbers of admissions are expected and to have fewer beds available in the summer months. That is all at this stage. I am aware that the board of directors has received a document from the Chief Executive Officer relating to the management of the hospital. That is the responsibility of the board of directors, not the Health Commission. However, the Chairman of the Health Commission and I will be having discussions with the hospital later this week or early next week.

Mr OSWALD: I should like to refer back to the part of my question dealing with the reopening of the Joanna ward. Is that under consideration?

Dr Blaikie: I was unaware that the Children's Hospital had insufficient beds open. I do not know the specific details of Joanna ward, but I shall be only too pleased to get them. The number of beds available at the Children's Hospital currently is very much greater than it has been. In the past financial year the available beds increased from 171.5 to 181.9. 'Available beds' means beds over the whole of the year. Beds are often closed at weekends when there is no elective surgery. That is an increase of 10 beds over the past financial year. In addition, in earlier questions, there was mention of the psychiatric inpatient unit which has been established at the Children's Hospital. That has provided additional beds that were not available before. The post-acute care unit for cystic fibrosis has also been established in the last financial year. Those two units together provide an additional 16 beds. I take on notice the question with respect to Joanna ward, but my opinion is that there are no bed difficulties at the Children's Hospital at the moment.

Mr OSWALD: On how many occasions during the past financial year has the Adelaide Children's Hospital been full? On those occasions how many patients had surgery cancelled, how many patients were transferred to other hospitals and how many were sent home? Finally, what was the average length of time that intending patients had to wait for a bed to be allocated during periods of bed shortage?

Dr Blaikie: Six cases of elective surgery were cancelled at the Adelaide Children's Hospital in the period January to July this year. There was one case in June 1989 and five cases in July 1989. All of those six cases were cancelled because of the lack of beds. What was the next part of the question?

Mr OSWALD: On how many occasions in the past financial year was the hospital full? We can assume at least six times from your answer. The final part of the question was: what was the average length of time intending patients had to wait for a bed to be allocated during periods of bed shortage?

Dr Blaikie: I do not know the answer to the second part. From time to time people have to wait in accident emergency departments for beds, if that is what the honourable member is getting at. No patients were turned away from the Children's Hospital for emergency care in the past financial year. In the past six months of the past financial year six patients had their elective surgery cancelled. That is the best I can do. Otherwise I have to take the question on notice.

Mr OSWALD: How long would patients have to wait to come back in?

Dr Blaikie: I do not know, but generally it would not be very long. They are usually reappointed very quickly. However, in those six cases I do not know the answer. I will attempt to get it.

Mr HAMILTON: I am aware that the report of the Trauma Service Review Committee released last year made many recommendations on improving the care of patients who had suffered major trauma. What proportion of hospital emergency resources is consumed by patients experiencing major trauma and have there been any further developments in this area since the report was released? Specifically, how does it impact on the Queen Elizabeth Hospital?

Dr Blaikie: Late in 1987 the previous Minister commissioned Professor Gary Phillips from the Flinders Medical Centre to conduct a detailed review of trauma services in Adelaide and his report was released in September 1988. The report made 22 recommendations relating to the improvement of accident emergency and trauma care services in the Adelaide metropolitan area. The basis of those recommendations included first aid at the scene of the accident; rapid ambulance response where appropriate; rapid assessment and management by ambulance crews; and rapid transport to the appropriate hospital. It is interesting to dwell on a couple of highlights of the report, as follows:

> There are many aspects of our trauma system which are excellent, but there are other areas of deficiency. Elements of the system receiving specific praise in the report included:
>
> The commitment by individuals to high quality trauma care.
>
> Medical retrieval services provided by public hospital—
>
> No other State has as highly developed and comprehensive a retrieval service as South Australia.
>
> St John Ambulance Services—
>
> The integrated ambulance/hospital system existing in Adelaide is an excellent one from the point of view of patient care and outcome . . .
>
> Adelaide is fortunate in some respects, especially its geography and traffic flow patterns, which allow ready access to hospital and major trauma treatment facilities.

Phillips concluded that there were some deficiencies. The Health Commission reponse to the report was to establish a Metropolitan Hospitals Accident and Emergency Services Committee, consisting of representatives of major hospitals, St John Ambulance and the South Australian Health Commission. With the advent of the Commonwealth Government's hospital enhancement program referred to earlier, $300 000 was allocated to that committee for 1988-89 specifically for accident and emergency services. The committee chose to spend the money in the first year on the purchase of equipment to upgrade services, so $300 000 was spent on equipment.

In the case of the Queen Elizabeth Hospital, the honourable member mentioned $33 000 being allocated last year. This year the committee decided and recommended to the metropolitan hospitals coordinating group (which has accepted the recommendation) that funds be provided specifically for additional staff. A further allocation for 1989-

90 for staff in accident and emergency areas of major hospitals is in place. The Queen Elizabeth Hospital received $35 000 for a part-time registered nurse and a part-time visiting medical officer. The recommendations in the Phillips report have been taken seriously by the commission and are being implemented progressively.

Mr HAMILTON: Will the Minister provide information on the haematology services that operate within South Australia? How many people understand what haematology is all about, and how many are encouraged to deliver platelets within hospitals in South Australia? How is the public at large encouraged to assist hospitals with the provision of platelets?

Dr McCoy: I am not a haematology expert. The haematology departments are laboratory departments in all major hospitals in Adelaide—Lyell McEwin, Modbury, AMCWC, Royal Adelaide, Queen Elizabeth and Flinders Medical Centre. Those laboratory departments undertake blood tests by taking blood samples from patients and examining them either in computerised machines or through a microscope in order to diagnose blood diseases such as leukaemia. The Red Cross Blood Transfusion Service, funded jointly by the commission and the Commonwealth, is responsible for collecting blood and blood platelets as well as numerous other specific fractions of blood used, for example, in the treatment of people with haemophilia and similar diseases. The Red Cross Blood Transfusion Service undertakes an advertising campaign to ensure that it has an appropriate number of donors and keeps on computer file those people with unusual blood groups who might be called on from time to time to give blood donations for patients with blood disorders.

Whilst on the subject of the Red Cross Blood Transfusion Service, for a number of years it has been conducting tests upon entrance to ensure that no infected blood is used in the blood transfusion system. I refer particularly to the HIV virus. Since it instituted that test it has done hundreds of thousands of tests on blood donors and has not to my knowledge found one HIV positive case. So, the forms blood donors are required to sign are effective in screening out HIV positive people as potential blood donors. I am happy to obtain further information for the honourable member.

Mr HAMILTON: Page 54 of the Program Estimates refers to the upgrading of obstetrics, gynaecology and day surgery facilities at the Queen Elizabeth Hospital. I have an interest in this year. Will the Minister provide more details, which I can then impart to the constituents who come into my office?

Dr McCoy: The forward capital program for 1989-90 lists a number of items related to the Queen Elizabeth Hospital. We earlier referred to the digital subtraction angiography into the CAT scanner. There has been a major upgrade of gynaecology, obstetric and day surgery facilities at a project cost of $8.78 million. In 1989-90, $1.4 million is appropriated for this project, which is scheduled for commencement in October 1989. Also on the capital program there is $2.7 million for the Queen Elizabeth Hospital in order to upgrade its kitchen and to provide a central plating service throughout the hospital.

Mr BECKER: On how many occasions in the past fiscal year have the Royal Adelaide Hospital, Flinders Medical Centre, Queen Elizabeth Hospital, Lyell McEwin Hospital and Modbury Hospital been fully occupied? On those occasions how many patients have been transferred to other hospitals, and to which hospitals, how many patients were sent home and how many have had surgery cancelled?

Dr Blaikie: I referred earlier to the elective surgery cancellations at the Children's Hospital. I can give elective surgery cancellations for the calendar year 1989, January to July, for all hospitals and in most cases the reasons for those: Royal Adelaide Hospital some 421, Flinders Medical Centre 490, the Queen Elizabeth Hospital 782, Modbury Hospital 49, Lyell McEwin Hospital 82, and (as I said earlier) the Adelaide Children's Hospital six, making a total of 1 830 elective surgery cancellations in the six month period. Unfortunately, I have no figures for the Royal Adelaide Hospital because they were unable to supply them, but in most cases it was a lack of beds, in some cases it was theatre unavailability, and in other cases surgeon unavailability.

No emergency patients were transferred from the Royal Adelaide Hospital. Some emergency patients have been transferred from other hospitals and, indeed, as members are probably aware, the Flinders Medical Centre is part of what is colloquially known as the transfer-on policy; the Flinders Medical Centre, having had a large increase in activity last year, has once again transferred patients on. But when we talk about transferring patients we are not talking about transferring on, in most cases, emergency patients; in some cases we are, certainly, where services are not available at the hospital that is doing the referring. In most cases we are transferring to hospitals only because the services are not available at the particular hospital.

In 1988-89 there was a total of 422 transfers from the Flinders Medical Centre but the bulk of those transfers were with the Repatriation Hospital, and we heard in response to an earlier question that there is a very close working relationship between that hospital and Flinders Medical Centre. Of more consequence, I think, is the number of transfers from Flinders Medical Centre to the Royal Adelaide Hospital, in 1988-89 there were 99, and that compares with 138 in 1987-88. So, indeed, last year was a better year in terms of the need to transfer patients from Flinders Medical Centre to Royal Adelaide Hospital.

Mr BECKER: How many of those operations were cancelled in 1988-89 due to budgetary restrictions?

The Hon. D.J. Hopgood: I think it would be very difficult to dissect. There are a number of reasons why elective surgery is sometimes cancelled. One reason may well be that a bed is not available in the area of that particular specialty. It may be not that a bed is not available somewhere else in hospital but that a bed is not available in that specialty, and for the convenience of the hospital, the surgeons and indeed quite possibly the patient, it is deemed appropriate to wait until a bed is available in that specialty. It may also be that, having scheduled the surgery, the physician and possibly the surgeon reexamine the case and decide that it is in the interests of the patient that that surgery not proceed at that particular time. For example, I am aware that there is a school of thought among some surgeons and physicians which says that hip replacements should perhaps sometimes be postponed into later life rather than being undertaken at a particular time. So those considerations also have to be taken into account in determining exactly what the scheduling of these surgical procedures, dealing with non life threatening complaints, should be.

Mr BECKER: How many operations were cancelled from 1 July 1989 to 31 August 1989 at each of the major hospitals due to either budgetary restrictions or nursing staff shortages?

Dr Blaikie: Royal Adelaide Hospital, 268; Finders Medical Centre, 246; Queen Elizabeth Hospital, 265; Modbury Hospital, 26; for Lyell McEwin, 38; and Adelaide Children's Hospital, five. Again, I said earlier, that without the figures

for the Royal Adelaide Hospital it is difficult to make sense but in most cases, as I said, it is because of a lack of beds—because we are aware that there was a shortage of beds at the Royal Adelaide Hospital in particular at that time.

The Hon. D.J. Hopgood: Rather than the term 'cancellation' I much prefer 'postponement', since in some cases the surgical procedure is reinstituted within a week or a couple of weeks of the actual postponement taking place, but people persist in using this term; as long as it is used in the proper context, I guess.

Dr BECKER: So that makes it about 850 cancellations in two months?

Dr Blaikie: That is right, although I have not added those sums up.

Mr BECKER: That is most significant compared with the previous year. On what date were limitations on elective surgery, brought in due to budgetary restrictions or nursing staff shortages, finally lifted; and, if they have not been lifted, where are they still being applied and what specifically are those restrictions?

The Hon. D.J. Hopgood: There are no restrictions applying currently as a result of budgetary matters. The hospitals have been given their budgets; there is growth in those budgets, and they know there are growths in those budgets. They know they are able to plan with those growth funds in mind. We have explained earlier that there has been a slower than anticipated recruitment of nursing staff particularly at Royal Adelaide Hospital, although things seem to be improving and from time to time the hospital is able to reopen beds. I am not in a position to say exactly when the full complement of beds will be open but things are brightening so far as that is concerned. It is quite clear that from the time the hospitals were given their budgets, which I think was about one month after the Premier's announcement of the additional funds for the hospitals this financial year, there have been no financial constraints leading to bed closure and then, as as result of that, postponement of surgical procedure.

Where a surgical procedure has been postponed, that has either been for non-resource reasons, as I indicated earlier, where a decision is made between the patient and the doctor that it is not appropriate to proceed at that time, or because nursing staff has not been available.

Mr BECKER: What was the average length of time patients were waiting for bed allocations in Royal Adelaide Hospital's Accident and Emergency section, and in the A and E sections of the other major Adelaide hospitals in April, May and June 1989, as compared to the corresponding months in 1988?

The Hon. D.J. Hopgood: We will provide what information we can. However, it should be clearly understood that if a person is delivered in an ambulance to a hospital, that person will be taken into the casualty section immediately, an assessment is made and, in some cases, surgical procedures are carried out within a few hours of admission. On the famous occasion when I was in the Casualty Section on a Thursday evening, two operations were being carried out, one of which I witnessed. That procedure was being carried out on people who had been admitted earlier in the day. Indeed, they had been admitted from interstate—they had been brought from Alice Springs. So, the waiting time for some types of examination was virtually nil and in terms of surgical procedure, it was simply a matter of hours because of the urgency of that particular procedure. However, I am told that some figures are available and they will be provided to the honourable member within that context.

Mr HAMILTON: I refer to page 58 of the Program Estimate—'1989-90 Specific Targets/Objectives'—which refers to action taken to reduce injury hazards, particularly in playgrounds and swimming pools. Under the heading mention is made of the effect of injury surveillance and control for playgrounds, swimming pools, and cyclists. What action has been taken to reduce those hazards, particularly in playgrounds and swimming pools? I know that Sacon has been involved in this issue for some time, particularly as it relates to schools. I am interested in the impact that this may have on playgrounds, and in swimming pools. Of equal importance, is the surveillance of cyclists.

Dr Kirke: There is an injury surveillance and control unit within the Public Health Division that maintains a watching brief on the accident and emergency records of people attending those units in the major hospitals as a result of injuries, and that includes figures for the Adelaide Children's Hospital. Therefore, we have an ongoing surveillance of children injured in playground accidents. Two particular areas of concern—and areas that we are addressing through local government and the Playgrounds Association—are the surfaces of playgrounds and the quality of playground equipment. In relation to swimming pools, the same preamble applies. I suspect that members will all recall the dreadful case some years ago of the little girl who was disembowelled after sitting on a skimmer box. This is an ongoing issue. Recently, we were able to persuade the *Investigators* to look at the issue in this State. Skimmer boxes will be modified to prevent that happening again.

In regard to cyclists, the major area for remedial action relates to the wearing of helmets. When a cyclist dies as a result of injury, it is generally as a result of head injury, and most of those injuries could have been prevented by the wearing of helmets. A program is now in the pipeline to increase public awareness of that fact and, hopefully, subsidies will be provided to increase the availability of bicycle helmets.

Mr HAMILTON: I am aware that there is considerable concern in local government in relation to the question of public liability for playground equipment. Can the Minister elaborate on this issue? What action has been taken in conjunction with the Minister's department in relation to public liability, be it within school grounds and or in any other area?

The Hon. D.J. Hopgood: This is probably more a matter for the Attorney-General, but I undertake to talk to him about it and provide the honourable member with whatever information is available.

Mr HAMILTON: There is no question that this issue impacts on many people in South Australia. I look forward to receiving some statistical information in relation to that matter. I refer to page 59 of the Program Estimates—'Establish a project to measure nursing dependency levels and costs in four major metropolitan hospitals', and 'Assess future demands for specific nursing services.' Can the Minister elaborate on both of those issues?

Ms Gaston: In response to the first question, this is specifically related to a project to determine the cost of nursing care per patient in a number of health units. This project is funded jointly by the Commonwealth Government and the State Government. It is attempting to measure the nursing cost that will be derived by piloting a particular computer software program, which will provide a description of nursing care delivered and allocate a cost to that delivery according to a very important criterion: that is, predetermined nursing standards.

The system will run through a personal computer, which will be based in each of the 20 wards involved in the pilot program across four health units at the Royal Adelaide Hospital, the Lyell McEwin Health Service, Flinders Med-

ical Centre and one division at the AMCWC, that is, the Adelaide Children's Hospital. Linkage will occur with existing information systems, calculated and assembled in the Information Services Branch of the Health Commission, being used for the allocation of cost to all health services, as has been previously mentioned today. The project commenced in August of this year and will take place over about an 18-month period. The particular benefit to this State and the health services in this State is that it will provide Australian nurse weightings and costs, whereas the present current DIG system uses American weightings. It is expected that the outcomes of this project in South Australia will be extrapolated further and used in other States. What was the second part of the question?

Mr HAMILTON: Assess the future demands for specific nursing services.

Ms Gaston: That is to be determined through the use of the labour force model that has been adopted in the Nursing Branch of the Health Commission in association with the Information Services Branch. The labour force model is a computerised means of forecasting nursing requirements, and is based on a series of assumptions about health service requirements in future. There has been agreement on these assumptions, but we are now establishing more scientific, quantitative methods for determining what these requirements will be. The development of these systems is very much in its infancy, but we are finding that South Australia is in the vanguard of the development of these systems, and has to work very much from the infancy of these processes.

Mr HAMILTON: I notice that the preliminary allocation for the 'Second Story' in 1989-90 is $474 000. (Health Commission Annual Report page 6). Can the Minister indicate what activities are being provided for youth at the Second Story?

The Hon. D.J. Hopgood: The services provided include medical care, counselling services, fitness programs, personal development programs, living and social skills programs, drug and alcohol services, sexuality counselling, young women's groups, youth worker and police training. A number of roles in the city have been expanded of late, for example, administering the cautionary diversion pilot project to identify people under 18 at risk or in danger of exploitation and to direct them to the alternatives to the juvenile justice system; a joint program with the Hindley Street youth project and Family Planning Association to provide services to improve the sexual health of young people; and the joint Adelaide City Council and Save the Children project on child protection; and providing a health advocate to provide services to disadvantaged young people and the agencies they use in the south-west of the city.

Summin up, individual contacts with young people have risen from 1 427 in 1986-87 to 17 337 in 1988-89. About 2 500 of these contacts in 1988-89 were with a half time doctor and half time nurse, and up to 20 young people were referred to their local medical practitioners each week.

The Hon. JENNIFER CASHMORE: I ask a supplementary question on behalf of the member for Hanson about figures on cancellations of elective surgery in 1989, which were provided by Dr Blaikie. Can the Minister provide on notice the equivalent figures for each month and each hospital for 1988, including the reasons for cancellation, as outlined previously?

The Hon. D.J. Hopgood: Yes.

The Hon. JENNIFER CASHMORE: My own question relates to AIDS. Following the announcement at the weekend by the Victorian Minister of Health about the Victorian Government's policy of detention of HIV positive people who continue to have sexual relations despite the deadly nature of the disease, has the South Australian Government developed a policy for use in such circumstances and, if so, what is it?

The Hon. D.J. Hopgood: No decision has yet been taken by Cabinet in relation to the Victorian approach. We are interested in it and are looking at it very closely. I call upon Dr Kirke to supplement my answer in some detail.

Dr Kirke: We have watched with interest the Victorian process. People would know that the Commonwealth Department of Community Services and Health has just released its White Paper on the national strategy on control of AIDS. That has been available to us for rather less than a fortnight, but we will certainly be taking the recommendations of that report into account. The Health Act already includes a section on the control of infectious diseases, and we have powers under that Act. Also, in extreme circumstances, we will have power under the new Public and Environmental Health Act to detain people who pose a risk to the community. So, the case involving the lady in New South Wales could be duplicated here under existing legislation.

The Hon. JENNIFER CASHMORE: I have not read the AIDS report and so I am not familiar with its recommendations. Is any information on the HIV positive status of patients provided to medical staff at hospitals and, if not, does the Government have any plans to ensure that such information is available to the staff? If not, why not?

The Hon. D.J. Hopgood: We will be developing a policy as a result of the White Paper. At this stage I do not think we can argue that the screening that is involved when an individual is admitted to hospital will necessarily turn up the possibility of that person being HIV positive. That is something that is under consideration. Obviously, in many of the instances where cases are referred, medical staff would be aware of that problem.

The Hon. JENNIFER CASHMORE: Obviously, the Minister is considering a policy in the light of the report, but he did not actually refer to what happens at present. What is the policy—even if it is not an enunciated policy? What happens? Is that information made available to staff and, if not, why not?

The Hon. D.J. Hopgood: My understanding is that if the information is available it is made known to staff and that, in particular, where a person being admitted to hospital is clearly from one of the identified 'at risk' groups, efforts would be made to identify whether or not this problem was present. What I am saying to the honourable member is that at this stage I cannot guarantee that in every instance of every admission the information would be available or, indeed, could be made available under existing practices.

We are reviewing existing practices, of course, in the light of the Commonwealth's White Paper and other matters that are around the place. What bedevils this entire area, is the whole question of the impact of certain procedures on people's willingness to come forward and identify themselves as having possibly been subject to the problem. The last thing we want to do, and the last thing that Commonwealth Minister Blewett and his advisers want to do is to drive the problem underground.

The Hon. JENNIFER CASHMORE: In relation to the Lyell McEwin Health Service, how many vehicles were attached to that organisation last financial year? What is the figure for the previous two financial years? Further, will the Minister table the results of an investigation into the number of vehicles at the Lyell McEwin Health Service conducted by the Auditor-General?

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

Mr GROOM: I think the member for Hanson asked some questions about the postponement of elective surgery for patients over the past six months. What percentage of overall elective surgery does this represent?

The Hon. D.J. Hopgood: This is an important question in putting into context the figures that were given to the Committee by my officer. On the basis of the figures and the number of total elective surgical procedures that are carried out every six months, my understanding is that the figure in this regard is about 4 per cent. I simply draw to the attention of the Committee the fact that a figure can look reasonably impressive when seen on its own but in the context of the total number of procedures that are carried out by our metropolitan teaching hospitals it becomes fairly small. I understand that about 4 per cent of all total procedures would be subject to some postponement at some stage.

Mr GROOM: It is shown at page 46 of the Program Estimates that one of the last financial year's targets related to the redevelopment of Magill Home. What was involved in the completion of that redevelopment?

The Hon. D.J. Hopgood: In October 1988, both residents and staff were transferred to the Tregenza Avenue Aged Care Service at Elizabeth South. The new facilities consist of purpose-built, domestic-style accommodation, comprising a 30-bed nursing home, 40 hostel places, a day care centre, administrative and services areas, and a 'corner shop' which serves residents and the surrounding community. In addition, 40 community-based beds have been established in surrounding suburbs, using existing housing stock. That began with six beds in January this year.

This community-based accommodation is serviced by the Tregenza Avenue Aged Care Service and managed by the Elizabeth and Districts Aged Housing Association, which is a housing cooperative under the Housing Trust. I am pleased to announce to the Committee that the sale of the site at Magill for $4.8 million has meant that the entire project has been self-funding.

Mr De LAINE: Under the Services for Women program at page 52 of the Program Estimates there is a reference to mammographic screening programs: will the Minister elaborate on that program?

The Hon. D.J. Hopgood: Information has already been given to the Committee on that matter.

Mr OSWALD: Yesterday, the Minister of Recreation and Sport declined to answer a question about the Health Development Foundation on the grounds that it was the Minister of Health's responsibility. Is the Minister of Health able to provide an answer?

The Hon. D.J. Hopgood: Indeed.

Mr OSWALD: The Health Development Foundation is jointly funded by the Departments of Health, Education and Recreation and Sport. What is the total budget, and how much comes from the Department of Recreation and Sport and in what form? What is the Health Development Foundation doing in relation to fitness, and has its direction changed since it was first announced three years ago? What is its involvement with commercial gymnasiums, and how much has been allocated for this purpose?

The Hon. D.J. Hopgood: We are trying to obtain the details of the budget. My understanding is that negotiations were concluded in June of this year for the establishment of a joint venture arrangement between the Health Development Foundation and the State Government Insurance Commission. The joint venture—to be called 'Health Development Australia'—will manage the Health Development Foundation's existing adult preventative health program. This includes the health and fitness centre in Light Square previously managed by the Australian Health Foundation; the St Vincents recreation centre at Noarlunga; the health search project and the health assessment project conducted through leisure centres; rehabilitation programs; and work site health programs. Under the agreement, SGIC will make an initial cash $300 000 contribution and contribute $100 000 to the joint venture of HDF's school-based health promotion programs in the areas of cardiovascular disease and preventable cancers. Profits will be distributed to SGIC and HDF on the ratio of 51:49. It may be that Dr McCoy has more information on the budget.

Dr McCoy: The Health Commission contribution to the Health Development Foundation in 1989-90 is $283 500. The Education Department will make another contribution and, as I understand it, a contribution will be made by the Department of Recreation and Sport. However, I do not know the exact amount of those other contributions.

Mr OSWALD: In relation to the Health Development Foundation, what was the financial payment for Light Square, and what was the arrangement for the purchase of Titan fitness products? At what cost, and were these cash payments?

The Hon. D.J. Hopgood: We will take those questions on notice.

Mr OSWALD: Have there been any overseas trips since the setting up of the Health Development Foundation? If so, for what purpose and at what cost? What are the estimated conversion costs for the new gymnasium at the Station Arcade?

The Hon. D.J. Hopgood: I will take those questions on notice.

Mr OSWALD: In relation to the provision of after-hours casualty and outpatient schemes which are now operating in three out of four major regional centres, I have a letter from the Health Commission signed by Mr Ray Blight to the Ceduna medical practice. It states:

> The aim of the program is to make 'free at the point of service' casualty services available in the larger regional hospitals.

It points out that the after-hours service is now being provided in three out of four hospitals, but Mount Gambier was unwilling to participate. It appears there is some concern in the medical profession about the fact that it was operating only within the Iron Triangle. I have another letter here signed by the President of AMA, it states:

> The doctors in the Iron Triangle are quite happy, of course, I share your view—

this is the writer—

> this nonsense has provided that relatively small group with an appropriate fee and have relatively disadvantaged all other country doctors performing after-hours services.

Although the Commission regards this as a pilot scheme, will it extend this scheme to other country centres so that the medical profession and the public can benefit to the same extent as is happening in the Iron Triangle?

Mr Blight: By way of background, I explain that the structure of country hospital medical services in South Australia is quite different to that which prevails in the eastern States. In the larger provincial centres resident medical officers are available, and in the minor centres contracted doctors are available to provide free casualty and outpatient services. That has not been the case in South Australia where, traditionally, those services have been provided by local private medical practitioners on a private practice basis.

Prior to the August 1987 changes to the Commonwealth medical benefits schedule, South Australian GPs were able to charge an after-hours consult fee which had a loading over and above the normal in-hours consult fee. However,

with the August 1987 changes to the schedule, the after-hours consult fee was set at the same rate as the in-hours consult fee. General practitioners in the Iron Triangle towns in particular reacted strongly against that Commonwealth induced change because the pattern of services contained substantial numbers after-hours patients in the Casualty Department. It was less of a problem in the smaller hospitals, because the August 1987 changes included the so-called 'Item 70 fee' which enabled the first patient seen after hours to be charged at a substantially higher rate. So, in a small country town where one or two patients come in during the evening there would not be the same financial disadvantage created. However it was a problem in the Iron Triangle towns where there is a busy after-hours workload in the casualty department.

Many representations were made by the South Australian Health Commission to the Commonwealth to reintroduce the after-hours consult fee. We were supported in that by representative doctors from the Iron Triangle and also by the Australian Medical Association. However, the Commonwealth did hold firm to its position, but it took the line that South Australia—as with other eastern States—should be providing free casualty services in the major provincial centres. It was that position that set the scene for further Commonwealth/South Australian negotiations on limited free outpatient casualty services in the major provincial centres. The Health Commission's position was that it needed to be limited because of the additional financial burden imposed on the system by moving to a free service.

After discussions with the South Australian branch of the AMA, the pilot scheme was introduced in February/March 1989, whereby the local private medical practitioners in Port Augusta, Whyalla and Port Pirie agreed to provide an after-hours emergency service in their respective hospitals. Those three hospitals, plus the Mount Gambier hospital, are the four major regional health units in rural South Australia. Negotiations with the Commonwealth are on the basis of those four sites only, in the first instance. Unfortunately, the medical practitioners in Mount Gambier have chosen not to participate in the agreement at this stage. The agreement requires that medical practitioners bill the hospital—rather than the patients—for this after-hours service, thus it is seen to be free at the point of service.

The Commonwealth Government has agreed to provide additional funding equivalent to the benefits it would have paid for the 1988-89 and 1989-90 financial years, an equivalent to 50 per cent of what it would have paid for the 1990-91 financial year to initiate the scheme. I believe the experience to date has been quite interesting. The actual cost of providing a service at the three participating hospitals in the period February to June was $278 000. That was considerably less than was originally estimated, partly because Mount Gambier did not participate, but also because there was not the increase in after-hours utilisation of the hospitals that had been expected.

Of course, that was one of the fears of the general practitioners. They were concerned that, prior to this scheme, they would not be seeing as many patients in their rooms during normal hours, and that the after-hours free service would be overloaded. That has not been the case. The actual number presenting after hours has remained relatively constant, except for a small increase on Sunday evenings for some reason or another.

The South Australian branch of the AMA and the Health Commission will examine the functioning of the scheme after it has been operating for 12 months. Subsequent to that review, the scheme may be extended to other regional hospitals. That can only be done with the further injection of funds.

The Ceduna hospital is in a somewhat difficult position. It is on the main feeder road west, and traffic volumes through Ceduna have increased continually over the past few years. Ceduna has seen a large increase in the demand for outpatient services. Most of that demand is by non-residents of the Ceduna township, and that places the hospital and the medical practice at Ceduna in a difficult position. When we review this scheme with the Commonwealth, we might look at the problems of hospitals on main arterial roads to consider their future inclusion in the scheme.

Mr HAMILTON: On page 54 of the Program Estimates there is a reference, 'Commence Port Pirie hospital and complete Berri hospital redevelopment'. Has the commencement of such redevelopment started? What will the redevelopment at those respective hospitals mean? What are the costs involved?

Mr Blight: Perhaps I can start with the Riverland Regional Hospital at Berri. It will be recalled from my earlier comments that we have a strategy of trying to relocate specialist services from the metropolitan area into our country centres. The Riverland is a good example of that strategy being worked through. The leakage rate of hospital services for Riverland residents to the metropolitan area is about 25 per cent—one of the highest leakage rates in country South Australia. The Riverland has a catchment population of about 34 000 people, which is certainly an adequate population to justify specialist medical and surgical services. That reasoning led to a proposal to redevelop the Berri hospital as a Riverland regional specialist hospital.

The Berri hospital, prior to redevelopment, was a 30-bed level 1 hospital. This new proposal will provide 56 beds on the site, and about half of those beds will be for specialist medical and surgical services. The construction of the hospital is well advanced and we expect it to be completed before the end of this financial year. The total value of the project is about $8.6 million.

An important part of the services at Berri will be the attraction of resident specialists into the region. At present there is only one specialist—a much overworked general surgeon. In recent months the hospital has been attempting to attract further specialist staff, and I understand it has been successful in obtaining an orthopaedic surgeon and a gynaecologist, and it is in the final stages of negotiating for an anaesthetist. If that set of medical staff can be attracted into the area, with the new regional hospital commissioned next year, I think that the Riverland will be very well placed for improved services.

The Port Pirie hospital in its present condition is very expensive to maintain, mainly because of the poor fabric of the building. It is also a difficult hospital to staff because of the layout. In strategic terms, Port Pirie is seen to be a sensible base for the further development of specialist medical and surgical services for the township and also for the hinterland to the east of the ranges. We would see the population catchment area for the Port Pirie hospital being about 17 000 residents.

The redevelopment of the Port Pirie hospital will include upgrades to the diagnostic and treatment departments. It will provide a substantial augmentation to the ward capacity. One existing modern ward at Port Pirie will be retained. There will be upgrades providing a new casualty outpatient department and main theatre blocks including a day surgery facility. The upgrade will include the mid-north community care centre which is on site at Port Pirie, plus other minor projects such as the improvement of fire protection and the provision of a pyrolytic incinerator. The project has recently

been through the Public Works Standing Committee procedure, and the public hearing on the proposal was held in Port Pirie about three weeks ago. We expect approvals on the project within the next three weeks. The total cost of the project is estimated at $8.8 million, and we expect construction to start early in 1990.

Mr HAMILTON: I am not sure whether this question will come under the auspices of the Minister of Health or the Minister of Community Welfare—probably both. I will ask the question and be guided by your decision, Mr Chairman. From time to time ageing parent constituents have approached me because of their concern about their intellectually handicapped children, many of whom are adults. The parents are naturally worried, when they die, about the provision that will be made for looking after those intellectually handicapped adults. I recall one woman in particular, who used to reside in my electorate, who rang me some time ago and expressed concern about her brother who was in that situation. What information can the Minister provide for parents in the category that I have mentioned?

Ms Johnson: The area of service provision that the honourable member has raised has been a very important service development area for the Government over the past couple of years. I shall need to mention several areas in responding to the question. There has been the development of services and the implementation of policies for community integration, deinstitutionalisation, and individualised service provision.

The Intellectually Disabled Services Council continues to take a lead role in the implementation of policies in these areas. This has meant: giving priority to the development of small community-based services in local communities where possible; supporting individual clients to gain access to local community supports through brokerage for local services or buying the services of a community support worker; resourcing (as has already been mentioned) a continuing program of devolution of institutional services at Ru Rua and Strathmont Centre; advocating for and supporting the integration of more students with disability into local schools; the development of a case management system within IDSC which focuses on service planning for individuals and their families; and implementing two pilots of a key worker system for people with an intellectual disability across childhood agencies and adult services to enable more effective coordination and use of, and access to, existing services.

Increased community housing has been made available to people with an intellectual disability through: community tenancies (South Australian Housing Trust) for organisations providing accommodation support; priority housing (South Australian Housing Trust); the purchase of 33 houses and lease of an additional 16 houses over the past three years by IDSC and Minda Inc. to provide increased housing for community clients; the formation of four housing associations to acquire and maintain community housing for the intellectually disabled; the secondment of a senior project officer to the Office of Housing to develop policy and strategies for housing for the intellectually disabled which will support an upgraded program of accommodation development including larger scale deinstitutionalisation; and the formation of the housing and disability forum to provide a mechanism for coordination of developments in community housing.

In the area of supported accommodation, which is providing support services so that people are able to live in an array of accommodation, we have seen the following: the creation of 35 new places in 1988-89 in supported accommodation; a move of 123 people from institutional to community living during 1988-89; a significant increase in the number of intellectually disabled adults receiving support services in their own homes and flats in both city and country locations; the formation of tenancy support programs in Port Pirie, Mount Gambier and the southern metropolitan area; and funding of three new community organisations during 1988-89 to provide accommodation support services.

The area of substitute care and family support services has also received attention. Some of these services apply to children, but some also to adults. In this area we have seen the following: the establishment of three new programs during 1988-89 to provide intensive family support services to families with urgent needs; the funding of an additional position within the special needs unit of the Department for Community Welfare to recruit and train adoptive and foster families for children with severe disabilities living in institutions or unable to live in the family home; the implementation with home and community care funding of a community-based respite care service within IDSC for 110 adults with disability (the stepping-out program); the expansion of family-based respite care services provided through Interchange Inc. from 12 families to 60 families and to include the entire metropolitan area; a consultant engaged to develop a State policy on substitute care; and the establishment of a supported holiday program through Holiday Explorers Inc. for people with intellectual disability which recruits and trains attendance carers to accompany the client and therefore provide respite for families and carers.

In the country areas the IDSC has opened offices in Port Pirie, Whyalla and Port Lincoln over the past two years and an office is to be opened in Murray Bridge by the end of 1989. There have been developments also at Minda. Ten residents moved from the Brighton campus to community accommodation during 1988-89, and four new places will be made available in community accommodation during 1989 and seven vacancies within the Brighton campus have been filled.

We talked earlier about the deinstitutionalisation of Ru Rua. The devolution of Ru Rua will cost an additional $1.27 million per year. That is primarily for additional staff to provide care for people living in group homes as well as to provide for additional day activities. Over the next year we will be looking at moving some people out of Strathmont Centre and it is hoped that over the next year or two some 150 can be accommodated under alternative arrangements.

This year through the social justice budget IDSC will be provided with an additional $400 000. This will be used to develop, in addition to the services I have just mentioned, further support services which will be available for people living with families or in their own accommodation in the community.

Mr BECKER: It makes one wonder about the purpose of this exercise when we get long, drawn out answers: we have had three in 25 minutes. I believe that the time should be divided equally. I get cross when some of the information could be conveyed personally at a later date or in writing. How many nursing positions were lost during the last three months of the 1988-89 financial year and what were the savings in dollar terms achieved by the Royal Adelaide and other major hospitals in respect of non-replacement of staff?

The CHAIRMAN: If questions asked of officers or the Minister require comprehensive answers, they will be so answered. The Chair is in no position to make any judgments on that. I am determined to ensure that everybody has a fair opportunity to question the Minister and his staff. The number of questions asked at this hearing is greater than on most committees, so things are going well.

The Hon. D.J. Hopgood: I pride myself on my track record in this respect, and those who sat on the environment Estimates Committee last year will attest to that. We will obtain that information, but from the moment the hospitals have known their budgets this year (which was in advance of the normal procedure) they have not been neglecting to replace staff. They have been replacing staff as quickly as possible not only to hold the numbers but also to increase the nursing staff to ensure that beds would be reopened. One could be referring only to the period during which it was made clear to hospitals that they would not be getting funds over and above what they had already received in order to balance their budgets for the financial year 1988-89. For that short period we will get that information, but I make clear that the impact of those so-called savings was merely to minimise the budget overruns for hospitals rather than to put any cash back into the State Treasury.

Mr BECKER: How many elective surgery operations were conducted at each of Adelaide's major hospitals during the past financial year and what were the corresponding figures for 1987-88?

The Hon. D.J. Hopgood: We understand that the hospitals run at around 1 000 elective surgical procedures per week. The 1987-88 figure was 48 553 and for 1986-87 it was 46 019. We do not yet have the full year effect of the 1988-89 figures. This gives me an opportunity to correct a figure which I gave to the Committee earlier in the afternoon. I know the honourable member was rather impressed by the figure that was given in relation to the number of postponements of surgical procedures over a particular period, and in response to a question from the member for Hartley I indicated what that meant in percentage terms of the total elective surgical procedures. I said that it was about 4 per cent. Of course, that is incorrect because it neglects the fact that the denominator in the fraction is a full year denominator whereas the numerator is not.

However, it is also true that the figures from which we are operating—the figures we gave the honourable member—are for seven months of the financial year rather than six months, and also that they covered the June-July period of the year when you naturally expect very heavy traffic in the hospitals, particularly in the ear, nose and throat section. So I want to revise that figure. I cannot give an exact figure, but I would put it closer to, say 6½ per cent to 7 per cent rather than 4 per cent. I thank the honourable member for giving me the opportunity of correcting the record as early as possible.

Mr BECKER: I appreciate that because when the figures were being called out I took them down. I said that there was about 1 150 but, in actual fact there was about 800. There was some doubling up of figures. How many people were removed from the waiting lists of each of the major hospitals in 1988-89 because patients obtained treatment elsewhere or passed away?

The Hon. D.J. Hopgood: I am not sure that the full figure is available to hospitals, let alone to us.

Dr Blaikie: I have breakdowns for the 1988-89 year for the number of people who were removed from booking lists other than those who had their surgery. The figures include those who had surgery elsewhere, those who decided to cancel and those who left the State. It is a very complicated table and they are not totalled, so I think I will have to take it on notice. Mr Chairman, I am in your hands.

The CHAIRMAN: If the Minister assures the Committee that that information will be provided within the time, I think that could be acceptable to the honourable member for Hanson.

Dr Blaikie: In respect of the Flinders Medical Centre, the Lyell McEwin, Modbury, Royal Adelaide, Queen Victoria and Queen Elizabeth Hospitals, a total of 3 641 patients were removed (other than as a result of treatment) for the year 1988-89.

Mr BECKER: How many motor vehicles were attached to each of the major hospitals, to whom were they allotted and to what department were the vehicles allocated?

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

Mr De LAINE: My three questions all relate to page 47 of the Program Estimates. A 1988-89 specific target is 'Development of a new focus on youth including cooperative research of drugs and street youth'. Could the Minister outline the details of the new focus and also give his views on the effectiveness of that particular initiative?

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

Mr De LAINE: I am interested in the effectiveness of the development of the drink-driver first offender package.

Dr McCoy: This is a program run by DAS (The Drug and Alcohol Services Council). I understand that it is a very effective program but I do not have any details in front of me. I will provide that to the Minister in due course.

Mr De LAINE: I ask for a similar report on the effectiveness of the 'Life Too Good to Waste' campaign for youth. How effective has that been?

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

The Hon. JENNIFER CASHMORE: Will the Minister indicate from which hospitals the State Government plans to buy private bed licences for Noarlunga's private hospital component? What price does it expect to pay for each bed licence and how many private bed licences are presently held by the State government for the Noarlunga Hospital?

Mr Sayers: Bed licences need to be purchased from the private hospitals in South Australia. Only nine have been purchased at this point, requiring a further 21 to be purchased. In round figures, five were purchased at a price of $33 000 and four at a price of $35 000. The five were purchased from the Western Community Hospital and the four from the Stirling Hospital. The commission is negotiating at the present time and is hopeful of purchasing some additional bed licences in the near future.

The Hon. JENNIFER CASHMORE: I understand there is a substantial difference between some of the monthly waiting list figures provided by the major hospitals to the Health Commission and the commission's own official figures. I also understand that some of the difference can be explained by the commission's decision not to include in the total people waiting for cystoscopies. I also understand that hospitals have been instructed not to include deferred and staged admissions in their waiting list totals. In view of the above, if that information is correct, will the Commission be adjusting its records in respect of people on waiting lists since January 1988 and make them publicly available so comparisons can be made of current statistics with past statistics due to the changed criteria?

Dr Blaikie: The Opposition seems to think the booking list figures are secret; they are not, of course. They are published every month and spread to all of the hospitals to do what they wish with them in their own hospitals. The patient complaints and information section of the Health Commission has copies and indeed we publish them regularly in the *South Australian Medical Review*, which is a joint Australian Medical Association, South Australian Post-Graduate Medical Education Association magazine which is forwarded to all doctors in South Australia.

I am not aware of any large discrepancies, or discrepancies between the commission's and the hospital booking list figures, except for this instance: the Flinders Medical Centre. The commission's booking list figures are provided by the hospitals, so every figure published by the commission comes from the hospital concerned. In the once instance I referred to, that discrepancy can be explained very readily. In the July edition of the *Flinders Medical Centre Bulletin* there is a discrepancy of 125 patients between the figure published by the commission from information received from Flinders Medical Centre—1 547—and the figure in the information bulletin—1 672. I refer the honourable member to appendix E of the information bulletin which shows a table indicating 70 cases of non surgical treatment; of course, that explains part of the discrepancy.

The Hon. JENNIFER CASHMORE: Is that paper available to the Committee?

Dr Blaikie: Again, it is a public document.

The Hon. JENNIFER CASHMORE: If it is not here, I cannot make reference to it.

The CHAIRMAN: It can be made available to members if they wish to look at it.

Dr Blaikie: The other point raised by the honourable member relates to cystoscopies, which are included in the booking lists from the South Australian Health Commission and in the Flinders table, check cystoscopies are not. In the month that we are talking about there were 14 cases of check cystoscopy at the Flinders Medical Centre that were, quite rightly, not included. There is nothing new in that. In November 1987, in consultation with hospitals, the South Australian Health Commission issued guidelines for the collection and submission of booking list data, as follows:

> A treatment episode is to be reported if the indicator procedure code is other than 181 (check cystoscopy) and 999 (non-surgical-treatment).

So, all we have here is the hospital using internally a set of rules that are not, by its agreement, applied across the system.

The Hon. JENNIFER CASHMORE: How many of the following professions worked in South Australia's community health centres as at 30 June 1989: social workers, speech pathologists, nutritionists, other health workers, clerical and administrative staff? How many client contacts were recorded for each community health centre for the 1988-89 fiscal year, and what were the client contacts for each of the previously named professions at each of the community health centres for 1988-89?

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

The Hon. JENNIFER CASHMORE: Has the commission now obtained data on the time each employee of South Australia's community health centres spends on various activities during a typical working day? The wording of the question indicates that the commission was seeking such data, or had undertaken to provide it.

The Hon. D.J. Hopgood: I am advised that we are commencing the collection of that information, but it is by no means complete.

The Hon. JENNIFER CASHMORE: When will it be completed? Will it be completed by the deadline for inclusion in the *Hansard* report of the Estimates Committee?

The Hon. D.J. Hopgood: It is unlikely that we can provide any appropriate information, because we are in the infancy of developing the procedure.

The Hon. JENNIFER CASHMORE: In that case, this is obviously a question to be put on notice and one that I feel could be answered within the deadline. How many motor vehicles were available to staff at each health centre as at 30 June 1989? What was the total mileage for all of those vehicles during the past financial year? How many motor vehicles were available to health centre staff as at 30 June for each of the years 1982 to 1987? What auditing of log books for vehicles used by community health centres is undertaken by the commission?

The Hon. D.J. Hopgood: My understanding is that those questions were asked in another place in the budget debate last year and that that information was made available. I guess we can regurgitate it for the honourable member.

The Hon. JENNIFER CASHMORE: I had the impression that that was not the case. However, I am not in a position to argue with the Minister.

The Hon. D.J. Hopgood: We will certainly check that information for the honourable member.

The Hon. JENNIFER CASHMORE: I am sure I would not have been asked to ask the question if the information had been provided.

Mr HAMILTON: From where I sit, the school dental service has been an excellent scheme. However, when talking to my local dentist recently, he expressed some concern about those students who leave the secondary school system and who, for one reason or another, primarily socioeconomic, are not availing themselves of the opportunity for dental treatment. Has this issue been drawn to the attention of the Health Commission? I have been advised that some students in secondary schools are also not availing themselves of the dental scheme because of curriculum requirements. Is the Minister aware of this situation? Is my information accurate and, if so, to what extent is this a problem in secondary schools?

The Hon. D.J. Hopgood: The honourable member related his question to what happens when children leave school generally. That is a continuing problem. All we can do is ensure that, through the School Dental Service, they are properly educated to visit their dentist regularly once they are beyond the reach of the service so that they do not develop problems.

Dr McCoy: There is a policy in the School Dental Service that when a child leaves school, every effort is made to communicate with a dentist nominated by the parents or by the child so that continuing follow-up care is available to that child after leaving the care of the service. An evaluation of that scheme was recently conducted, which indicated that there is quite a drop out when children leave school. SADS is very aware of that problem and is doing what it can—of course it cannot direct parents or children after they have left school; in fact, it cannot direct children at any time—to ensure that parents are asked to provide the name and address of a dentist to whom the relevant information is sent.

Mr HAMILTON: I am advised that secondary school students are not availing themselves of the dental service because of curriculum requirements. Will the Minister ascertain whether or not this is factual and, if so, to what extent it is factual?

The Hon. D.J. Hopgood: I will have to seek advice on that. The policy until now has been that students to the age of 16 have been treated under the service. We now intend to extend that to all students in secondary schools, irrespective of age. Whether or not the exigencies of the curriculum mean that students sometimes miss out, I am not sure, but I will take it up with the Education Department.

Mr HAMILTON: I note in the Program Estimates the number of people admitted to psychiatric hospitals and it appears, from page 48, that an increase in that area for 1989-90 is anticipated. My question relates not necessarily to the admission of people to psychiatric hospitals but to a problem that many members are confronted with in their

electorate offices at some time or another, when a constituent comes in and complains about a neighbour who refuses to take prescribed medication and/or is medically disturbed. Constituents ask what they can do about this matter. I know this problem cuts across a number of agencies but it is a real problem, concerning which one can only advise a constituent to go to a police officer or to take out a restraining order.

The Hon. JENNIFER CASHMORE interjecting:

Mr HAMILTON: I disagree; one cannot force people to go to a mediation service. If people are prepared to go, they can, but on a number of occasions I have encountered this problem, which is quite a delicate one. Will the Minister place on record what advice is available when such people come into my office to see what they can do to overcome or eliminate this problem, apart from their having to sell out and move? I know that, in one case in West Lakes, that was a very costly solution to the problem, but other neighbours have been left with it.

The Hon. D.J. Hopgood: I agree with the honourable member; the problem is that it is very difficult, except under close analysis, to make a distinction between behaviour that is merely eccentric and behaviour which is deliberately antisocial or which arises from a mental disability. Where the antisocial behaviour is deliberate and where it oversteps the bounds of the law, procedures are available, but I know (because I have had similar questions directed to my electorate office) that some people are particularly clever in being able to skirt the boundaries of the statute laws without actually overstepping them. Probably, where the behaviour is so bizarre as to disturb the lifestyle of the complainant, reporting the matter to the police is important.

There are circumstances in which the individual can be bound over to keep the peace. Where the behaviour is clearly not the responsibility of the person concerned, because of mental illness of one sort or another, since that person may not be capable of responding to a confrontation and being told he or she must get treatment, the only available solution is to take the matter up with the relatives or others who care for the individual and who may be able to persuade the individual to seek treatment from a psychiatric hospital or medical practitioner. It is a grave problem but, rather than take up the time of the Committee, I will attempt to get further information from my officers and bring it back.

Mr HAMILTON: I thank the Minister for that, because it is a very real problem in the community. I note from the Program Estimates the establishment of dental services in the Port Adelaide area, the development of after-hours emergency dental services for adults in country areas and also the extension of the dental clinic in the Port Adelaide Community Health Service. How successful has the Port Adelaide Community Health Service been in connection with its dental service, and can the Minister provide information about emergency dental services for adults in country areas?

The Hon. D.J. Hopgood: We do not have specific information at the table so I take that question on notice.

The Hon. JENNIFER CASHMORE: I preface my question by advising the Minister that the questions I asked on community health were indeed asked last year but they were not answered. I was not on the Health Estimates Committee last year but I am informed that that was the case. My question relates to special benefits schemes and miscellaneous services; specifically, the pensioner denture scheme, which has suffered a loss of $56 000 in real terms in 1988-89—a 3 per cent cut. Why was funding to the scheme last year $48 000 less than that provided in 1987-88; in other words, a 9 per cent cut, and why have the funds been reduced again this year? What was the waiting time for dentures in 1987-88 and 1988-89, and what is it currently?

Ms Johnson: Expenditure on the pensioner denture scheme exceeded $2 million for the fifth successive year, but it is true that, over the past five years there has not been the increase in expenditure on the scheme that one might expect. That is due to the fact that more people in our society are keeping their own teeth and fewer people are having dentures. Over the past couple of years the South Australian Dental Service has actually been redirecting funds away from the pensioner denture scheme and towards the community dental clinics, which provide services for people who have their natural teeth.

I do not have the figures on the waiting time for the scheme in 1986-87, but I do recall that at this time last year—I would need to check the figure—the waiting time was around nine months. The waiting time for the scheme at the moment is less than two months, and 61 400 people have received treatment under the scheme in the past seven years. However, the demand for that scheme is slowly being eroded and the demand for services through the community dental clinics is increasing.

The Hon. JENNIFER CASHMORE: That is good news. My next question is a similar one, about spectacles, and I do not think the same could apply to them. Why was last year's allocation of $1.93 million to the spectacles scheme a 3 per cent cut in real terms on funds allocated for 1987-88? What was the waiting period for the provision of spectacles under the scheme for the past two years, and what is it currently?

Ms Johnson: The actual expenditure in 1988-89 on the spectacle scheme was $1.933 million, and the budget for this current year is $2.062 million. This is accounted for by under-expenditure in the last financial year of some $12 000, with the addition which has been reinstated and also the addition of $117 000, which represents the 6 per cent inflation figure. The funding in that scheme is provided according to demand, and so expenditure will match demand. There is no cut-off point or limitation placed on that. If funds are required they are provided. I am unaware of the waiting time, but I understand that that relates to the time it takes to process the applications. I understand that there is no squeeze on funding in this area.

The Hon. JENNIFER CASHMORE: The disabled persons' equipment scheme appears to have suffered a 4 per cent cut. Will the Minister explain the reasons for the reduction in funds for this scheme, when the demand for it, from my own observations, seems to be substantially increasing?

Ms Johnson: As the honourable member may be aware, the disabled persons' equipment scheme began as a Commonwealth Government program of aids for disabled persons, and it was passed to the State Government in May 1987. When the Commonwealth Government administered and funded the scheme, it was limited to people who held a health benefits card, a pensioner health care card or who were in receipt of a handicapped child allowance. The funding allocation in 1985-86 was $1.656 million. At that time the scheme allowed for access by people who were in need of equipment and in the work force.

In 1986-87 the Commonwealth Government's allocation was reduced to $1.171 million, and at that time people in the work force were excluded from the scheme. That occurred before the transfer to the State Government. It was transferred in May 1987, and the Commonwealth Government allocated $1 million to the South Australian Government

to operate that scheme. From the time of transfer and because of the limited Commonwealth funding available, the scheme has continued to operate under the guidelines of the Commonwealth Government.

However, an advisory committee has been established at State level, and that is examining various aspects of the scheme, including eligibility, the method of operation and the funding arrangements. As to the specific funding of the scheme, the figures I have indicate that in 1987-88 the allocation for the scheme was $1 million. In 1988-89 that was increased to $1.382 million, while this year an allocation of $1.674 million has been made. That is a very significant increase. In fact, the increase last year alone was 32 per cent.

The Health Commission is concerned about the number of people who require equipment. In an attempt to improve the situation even more, the Statewide Health Services Division is currently negotiating with the Commonwealth Government to try to attract some additional matching funds through the Home and Community Care Program. If that funding is made available, the total allocation for this financial year will be over $2 million.

The Hon. JENNIFER CASHMORE: Will the Minister detail the reasons for the closure of 23 beds at Whyalla Hospital and six beds at the Southern Districts Hospital during 1988-89?

Mr Blight: The bed closures at Whyalla were part of a rationalisation proposal undertaken at the hospital. It involved the amalgamation of several wards. In an operational sense, it has not reduced the throughput of the hospital. There has been no reduction in public hospital services as a result of that rationalisation. It is simply more efficient to staff one ward running at a high occupancy level than to staff two other wards running at low occupancy. In respect of the Southern Districts Hospital, for some years there was a small six bed unit on that campus which was used for long-stay patients. As a result of a rationalisation exercise at that hospital, the long-stay patients were transferred to a nursing home. It did not make sense to attempt to staff that small separate unit, and so that capacity was closed out.

Mr De LAINE: I refer to the provision of a country medical practitioner education program (page 56 of the Program Estimates). One would assume that a medical practitioner in the country would have the same formal qualifications as a city doctor. What additional training do country doctors need?

Mr Blight: There is really no difference in the basic training required, except that the scope of the work undertaken by country doctors exceeds that of work done by their general practitioner counterparts in the metropolitan area. For example, many country doctors want to actively practise anaesthetics and surgery in addition to general practice; also, obstetrics is another feature of country practice. Because of the scope of the work there is, in a post-graduate sense, an ongoing requirement to keep up a very wide range of skills. Essentially, that is the problem for our country doctors. Once they go out there in practice, particularly in solo practice, as time goes by there is an increasing problem with keeping their skills and medical knowledge up to date.

The great majority of courses, training programs and workshops in the continuing medical education arena are carried out in Adelaide or in other capital cities. As a result, many doctors have to travel long distances to attend those training events, the length of which may vary from one day to a week, or even more. Another problem is that, while they are away undertaking that training they are not generating income. In fact, doctors in a solo practice have the extra burden of having to pay a locum to come in and attend to their patients for them. So, just one week of study can run into several thousands of dollars—quite apart from the problem of getting away to do it.

In recognition of that problem which country doctors have and in an attempt to redress it, during our last round of fee for service negotiations with the AMA we agreed to the creation of a fund of $400 000 to be deployed for the continuing medical education of our country doctors over a two-year period. We are now in the second year of that scheme.

The way in which we have dispersed the funds is worthy of comment. One aspect is the Rural Register Scheme which is managed by the Royal Australian College of General Practitioners through the family medicine program. Through that scheme doctors at the level of experience of registrar are employed for a period—12 months is the current period—and are then available on a scheduled basis to act as a locum for any of our rural medical practitioners who wish to attend a course or workshop. In that scheme the rural practitioner does not have the problem of, first, trying to find a locum—and that is often difficult in the remote towns—and, secondly, they are not confronted with the problem of having to pay for the locum; they simply book in with the Rural Register for the appropriate time that they wish to be on the course. In addition, we are providing funding to cover the actual course costs—or other costs if it is a clinical skills updating exercise. In deciding how we should allocate those funds, we have given first priority to the solo general practitioners so they can have first priority on the funds, and they receive the highest allowance. The next priority is two-doctor practices, and so on.

Until now we have allocated in excess of $100 000 to country general practitioners in the form of reimbursement to attend that sort of training. Further to that, we have provided substantial funding to the South Australian Post-Graduate Medical Education Association which, over the years, has been active in running training courses out in rural locations, generally on a regional basis. SAPMEA has enjoyed a high reputation with our country practitioners over the years, so it seems sensible to put further resources into that group to expand the amount of training it provides out in the country. I believe, over all, this initiative in the continuing medical education area has been positive in terms of updating the skills of our GPs, and it certainly has been well received by our country doctor community.

Mr De LAINE: In the program 'Services for families, adolescents and children' I notice that the establishment of the Child Health Research Institute will result in a major resource variation. Will the Minister outline any special assistance provided towards medical research in South Australia this financial year?

The Hon. D.J. Hopgood: A good deal of funds have been made available for research purposes since April 1987 when Cabinet approved the establishment of the Child Health Research Institute as the major South Australian health project for the 1988 bicentenary year. I will refer to that and mention two other research institutes without going into any great detail. First, the Child Health Research Institute will have received a total State Government contribution of $750 000 over the past three years ending on 30 June of the 1989-90 financial year. This contribution has been matched by the Variety Club of Australia. Any moneys that are unexpended at the end of construction in August 1989 will be used to launch a fund-raising drive for equipment for the institute. The recurrent funding for the institute will be provided by the Health Commission, the Adelaide

Medical Centre for Women and Children and various research grants, corporate and public fund-raising.

In July of this year Cabinet approved capital grants of $500 000 to the Flinders Medical Centre Research Foundation for each of the financial years 1989-90 and 1990-91. Also, Cabinet approved a CPI index loan to the foundation up to a maximum of $2 million. The project cost is estimated at $5.5 million and involves an addition to the existing animal house and the construction of a block of 22 laboratories in the north-east corner of the existing Flinders Medical Centre building to provide increased capacity for medical research. To date, a fund-raising program has raised more than $1.3 million in gifts and a further $1 million in pledges.

In July of this year Cabinet approved a capital grant of $500 000 to the Hanson centre for cancer research for the years 1989-90 and 1990-91. In addition to that Government grant, another $500 000 has been provided by the Anti-Cancer Foundation, $900 000 from RAH research funds and $100 000 from IMVS research funds. The balance will be met through a public fund-raising campaign. The project is estimated to cost $3.5 million. A four-storey building will be constructed at the IMVS campus, two floors of which will be dedicated exclusively to cancer research.

Mr BECKER: We have never considered waiting lists to be confidential, but we have never been provided with them. If those figures are contained in public documents, is it possible for the Opposition to receive a copy on a regular basis, as I understand they are not available to the Parliamentary Library?

The Hon. D.J. Hopgood: I do not know why, but the answer is 'Yes'.

Mr BECKER: The Program Estimates (page 47) under the heading 'Issues/trends' states:

> Development of a primary health care focus in these services. There is a need for a range of services to meet the needs of varied client groups and a sound quality assurance approach. Participation in and encouragement of further research is necessary.

The number of inpatients and same-day patients estimated in DASC facilities was 1 064 in 1987-88 and 1 308 in 1988-89; and the estimate for 1989-90 is 1 420—just over a 33 per cent increase. The number of outpatient attendances at the Drug and Alcohol Services Council was 73 174 in 1987-88; in 1988-89 it was 88 103; and the estimate for 1989-90 is 95 400, again an increase of some 30 per cent.

It is noted in the 'Major Resource Variations 1988-89/1989-90':

> The proposed net variation of $466 700 represents a 4.9 per cent increase. The main components of this variation are: the full year effect of salaries, wages and price increases; increase in Commonwealth funding of drug education programs; savings on general insurance as a result of SAHC becoming a self-insurer.

The biggest worry in our community is the impact of drugs and alcohol. When a 32 per cent increase is experienced in the number of persons affected and the number of outpatient attendances in a two-year period, and bearing in mind the Commonwealth Government's program—a $100 million drug offensive in this country—I am alarmed at the damage that has been done to many people in the community. It seems that at this current stage we are not making much progress. Is there anything further that the Minister can advise the Committee that his Government and the Health Commission are doing so so that we can tackle this problem head-on and try to reduce these numbers and save some of these people from the impact of dependence on alcohol and drugs?

The Hon. D.J. Hopgood: From the information that I have, I must politely disagree with the honourable member. This indicates that the amount of substance abuse in the community is not necessarily increasing. What is increasing (and this is a promising sign) is the number of people who are prepared to seek help. The number of attendances at the Joslin clinic, which is dedicated to people with problems of alcoholism, has increased and the number on the methadone program has also increased. This seems to represent more people being prepared to come forward, to admit that they have problems and to seek treatment for them. While the use of illegal substances cannot be tolerated in a community and everything has to be done to try to reduce the incidence of the use of these substances, the major health problems are in relation to tobacco and alcohol which are legal in our community and whose use, and in some cases abuse, is not only permitted but encouraged.

Mr BECKER: You can take the figures whichever way you like. The fact that more people are coming forward can mean that more people are involved in alcohol and drugs. It is great that people are prepared to get on the various programs and it is a tragedy that some are not everlasting, and I hope that we can develop programs that will be. There is a tremendous problem with drugs and alcohol within the community. We have heard very little of the Federal Government's program, and I wonder whether South Australia has had a fair share of the $100 million to tackle this problem?

What was the total number of patients from overseas treated at the Royal Adelaide Hospital and the Flinders Medical Centre in 1988-89 under the scheme launched last July to sell South Australia's medical super specialties to wealthy Asians? I can remember that Dr David David was in Hong Kong at Christmas touting for people to come to South Australia for specialist treatment because there is no waiting here and they can be well looked after. There is nothing wrong with promoting South Australia's excellent health services. The facilities that we provide are certainly well recognised in Hong Kong. That is why the Chinese are keen on Australia, particularly South Australia. They have heard of our services. However, how successful has that campaign been?

The Hon. D.J. Hopgood: At this stage these entrepreneurial activities, though they are to be encouraged, are still in their early stages. The numbers that have so far been treated under the Australia Health Scheme are lower than had been expected. With the expansion of activities, such as those in which Dr David has been involved, in the next few years we can expect the numbers to increase.

At the Royal Adelaide Hospital there have been 15 treatments for cardiothoracic problems, two under neurosurgery and two under craniofacial, making 19 in all; and at the Children's Hospital there has been one neurosurgery and one cancer. The honourable member posed another question in passing asking how South Australia was treated under the national drug program. We are reasonably happy with the resources that have been made available to us to date under the Commonwealth program.

Mr BECKER: What was the total number of live births at each of the major hospitals in the 12 months to 30 June 1989?

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

Mr HAMILTON: I have been asked by a constituent who is involved in the South Australia Huntington's Disease Association to ask whether the Government intends to provide a second medical geneticist in South Australia and, if not, why not?

The Hon. D.J. Hopgood: There is no resolution at this stage, but it is under active discussion and consideration.

Mr HAMILTON: I would certainly appreciate getting advice from the Minister's office when that information

becomes available because my constituent is committed to that area. Will the Minister tell the Committee how far the amalgamation of the Adelaide Children's Hospital and the Queen Victoria Hospital has proceeded to date?

The Hon. D.J. Hopgood: In addressing myself to this question, Mr Chairman, I seek your advice on a procedural matter. We have some information at the table in relation to a couple of earlier questions which were answered in part and we offered to get further information. The most recent matter is in relation to live births. I will be guided by you as to when we should give the information to the Committee or whether it should be made available at a later date.

The CHAIRMAN: We have only half an hour left to deal with the Minister of Health's lines. If that information were provided to the Clerk, we could insert it into *Hansard* without necessarily taking up the time of the Committee, if that is agreeable.

TIMES SERIES FOR BIRTHS IN THE MAJOR METROPOLITAN HOSPITALS. TIME PERIOD ENDING 30 JUNE.

Hospital	Number of Births		
	86-87 Seps	87-88 Seps	88-89 Seps
ACH	0	0	0
FMC	2 487	2 581	2 576*
RAH	3	3	1
TQEH	1 368	1 310	1 429
LMHS	1 432	1 523	1 445*
MOD.	1 063	1 077	977*
TQVH	3 543	3 404	3 160*
Total	9 896	9 898	9 588

	Number of Births		
	86-87 Seps	87-88 Seps	88-89* Seps
All Metrop Public Hosps	10 373	10 357	10 070

* These data are incomplete for June 1989

The Hon. D.J. Hopgood: To get to the gravamen of the question, detailed planning for the new facilities, at an estimated cost of $37.5 million, has commenced. I will not go into all the details of what the new project will include, but amongst the developments is the construction of a self-funding multistorey car park for 600 cars. The construction of that facility has commenced. The construction of the new Queen Victoria building at the site of the Adelaide Children's Hospital is scheduled to begin in 1990-91. Construction will be completed by December 1992 and the Queen Victoria Hospital services will transfer to the Adelaide Children's Hospital site by February 1993. At that stage the whole of the amalgamation will be complete.

Mr HAMILTON: What special service provisions have been made available to farmers on Eyre Peninsula who have been sadly and seriously affected by drought?

The Hon. D.J. Hopgood: A comprehensive counselling service has been established for rural families on Eyre Peninsula. It has been established as a combined operation of the commission and the Departments of Agriculture and Community Welfare. It has been specially designed to provide support to farming families experiencing financial and/or emotional difficulties because of the drought. The rural counsellors are provided by the Department of Agriculture. They are the first point of contact with the service. The counsellors are supported by a half-time social worker provided by the DCW and a half-time social worker and half-time community mental health nurse provided by the Port Lincoln health and hospital service. These professional health care workers provide the backup in difficult cases for the rural counsellors. As the Committee will know, the Department for Community Welfare provides emergency funding assistance.

The Hon. JENNIFER CASHMORE: I refer to page 48 of the Program Estimates, 'Services for mental health.' The budget for 1988-89, by comparison with the previous year, shows a 4.8 per cent increase which is well below inflation. Will the Minister explain the reduction in spending in this vital area, particularly as admissions to psychiatric hospitals rose from 4 274 to 4 530 and the expected increase this year is 4 850, which is 7 per cent above previous years?

The Hon. D.J. Hopgood: In all services with wage and salary increases, such increases will be met from round sum allowances. If the honourable member is comparing what was actually spent last year with what is being allocated this year, it is again an apples and pears situation. I will ask the Executive Director, Statewide Services, to explain exactly what is going on here.

The Hon. JENNIFER CASHMORE: Will the total budget for the coming year not only match inflation but also allow for the anticipated rise in admissions which is expected to be 7 per cent above the previous year?

Ms Johnson: There are some difficulties, as the Minister has stated, in looking at the figures for last year and this year and trying to compare them because there are various costs and expenditures for this year which have not yet been added into the budget. I am prepared to make available, if need be, the explanation of the budgets for the various parts of mental health. However, in summary the two major psychiatric institutions received a 6.5 per cent increase in their allocation this financial year. That was .5 per cent greater than the estimate for inflation for the coming year. The remainder of the community-based services received a 6 per cent inflation factor.

In relation to the reference about admissions and activity, whilst it is true that admissions to Glenside and Hillcrest have gone up markedly in recent times, it is also true that the length of stay has been much shorter. In other words, it seems that people are being admitted more often but staying for a much shorter time. It would seem that the reason for this is the development that has occurred over the past couple of years of outreach teams. This has enabled workers and other staff—carers and so on who are in contact with the outreach teams—to detect a period of illness earlier, to admit earlier and to be able to head off crises, and also discharge people from hospitals earlier. This has meant that the allocation spent in inpatient services has decreased over the past few years and the two major psychiatric institutions have been spending that money instead in the area of outreach and outpatient activities.

Mr OSWALD: I refer to page 1 of the Blue Book and to the heading 'Payment of recurrent nature of health services—service for the aged and physically disabled'. The proposed expenditure for this year is $85.074 million. Whilst this is an increase of $1.847 million over last year, it represents an increase of only 2.2 per cent—well under the rate of inflation. The explanation provided on page 46 of the Program Estimates under 'Resource variation for 1988-89 and 1989-90' states that the full year outline takes into effect salary, wage and price increases. What services will be cut to ensure that the program remains within its reduced budget? It would appear from figures provided in the papers that the 2.2 per cent will barely pick up the salary line increases, and does not seem to take into account any services. Indeed, services will probably be cut if wages reach their full expectation for the year.

Ms Johnson: The Health Commission funds several disability services. Those services have not received a cut in funding. All of the services, with the exception of the Royal Society for the Blind, have received a 6 per cent inflation factor as for all other services. In addition, we have some provision for expanded services. We referred earlier to additional funds made available in intellectual disability for the devolution of Ru Rua. That was a carry-over cost of over $1 million which would be new money this financial year, and $400 000 has been made available for additional support services in intellectual disability.

I referred to additional funds earlier for the disabled persons' equipment scheme. In addition, the State has made some provision for services for people with a brain injury, which is the subject of Commonwealth discussion currently. There has been no cut in disability services but, rather, an inflation factor on goods and services is not available to the Royal Society for the Blind at this time. It will be subject to an ongoing review with the Commonwealth, the Society and the Health Commission to look at the activity levels of that organisation and its requirements for funds this financial year.

Dr McCoy: Part of the explanation is that the Lyell McEwin domiciliary care service this year had $121 000 less this year for motor vehicles. At Western domiciliary care it was $300 000 less for motor vehicles than last year. At Tregenza Avenue there was $170 000 less this year for workers' compensation. At the Hampstead nursing home there was a $200 000 lesser requirement this year because of a change in the number of beds effected last year.

Mr OSWALD: I refer to Foundation SA. Will the Minister list the relevant sporting associations and how much they have received in grants from Foundation SA? Will the Minister explain the treatment of the East Torrens Cricket Club in its application for grants from Foundation SA?

The Hon. D.J. Hopgood: We do not have that information because it is not budget information. I am only too happy to obtain it for the honourable member, but I make the point that it is not budget information as such and Foundation SA (although its legislation is formally committed to me), is not in any way under my direction or control, as is made perfectly clear by the legislation. I am not aware of the East Torrens Cricket Club being treated differently from any other sporting body that makes application to the foundation.

Two basic principles are brought to bear here; first, I understand that it was agreed during the passage of the legislation that Foundation SA would be concerned with replacement sponsorship for those bodies which traditionally obtained tobacco sponsorship. If the East Torrens Cricket Club was not in that position, it does not qualify in that way. Over and above that, anybody who has a good case to put is eligible for assistance once the commitment for replacement has been discharged, but the foundation has taken the attitude that it should, for the most part, fund associations rather than individual clubs.

My understanding is that, if the East Torrens Cricket Club has not received funding, the Prospect Cricket Club and the Glenelg Cricket Club probably have not received funding either but the South Australian Cricket Association almost certainly has. However, I will get what details I can from the executive officer of the foundation.

Mr OSWALD: The funds generated by Foundation SA are, in fact, public moneys and I think we should have an opportunity of asking a Minister to account for it. Earlier it was suggested that perhaps we should not be asking a question in this matter, but I think we should. Can the Minister advise the Committee on the companies involved in public relations and marketing services to Foundation SA, and what amount was paid to these companies during 1988-89? I am happy to take it on notice.

The Hon. D.J. Hopgood: I will get that information. I would not presume to dictate or even suggest to members on either side of the Committee how they should ask questions or what is appropriate or not. I was merely offering an explanation as to why the information was not available at the table.

The CHAIRMAN: There are other more appropriate forums of the Parliament at which questions of that nature can be asked of Ministers. But where there is no budget line during the process of the Estimates Committee then the Minister is not in a position to answer those sorts of questions but the Minister has undertaken to provide that information.

Mr HAMILTON: On page 58 of the Program Estimates it says to monitor and develop programs for communicable diseases with priority to measles, tuberculosis in specific groups, rubella and hepatitis B. That is in the 1989-90 specific target and objectives. I notice on the left column of the same page that measles immunisation was to be extended. In relation to measles specifically, how successful has that program been (and I agree with it) and why is it necessary to develop these programs even further, taking into account tuberculosis, rubella and hepatitis B?

Dr Kirke: The extension of the measles vaccination program was based on the fact that the Commonwealth Government gave the State funds to carry out some functions in relation to immunisation that had previously been run by the Commonwealth, so from a State point of view there was an extension of the program. I am pleased to say that the promotion of measles vaccination in this State has got the immunisation rate up to about 90 per cent which is a good long way towards our goal of 95 per cent coverage. We would anticipate that measles could not spread within the community. It has come up from well below 80 per cent to up to 90 per cent and we are hopeful that in a year or two it will be 95 per cent.

Mr HAMILTON: What about tuberculosis in specific groups and hepatitis B?

Dr Kirke: The issue of tuberculosis in special groups is of some concern to us. There are some immigrants who are coming to Australia from countries where tuberculosis is endemic and we have no effective way of screening them on arrival or even knowing who they are or when they arrive, and this is a problem for us. Other groups to which the honourable member was referring would be some Aboriginal communities where it is known that the prevalence of tuberculosis is higher than the State average and in people who live in some institutions such as nursing homes who also, in some cases, have a higher prevalence of the disease and workers in some meat works suffer from a higher incidence of bovine tuberculosis. We are currently endeavouring to work up a program for dealing with this issue.

As to the other question about hepatitis B, there has been a lot of publicity on that lately and I think the issue of a particular drug company using tactics which have not been found acceptable by any State health authority to, in effect, promulgate their own product, has brought this to a head. Hepatitis B is a nasty disease. It is spread in very much the same ways as AIDS is spread so there are definable high risk groups and our policy at the moment is that those high risk groups should be targeted with educational material and immunised as widely as possible.

The Health Commission distributes hepatitis B vaccine free to those identifiable high risk groups and agrees that

anybody else who wants the vaccine is perfectly free to have it. However, at this point we are not suggesting that it should be a universal immunisation. The money involved certainly does not warrant the small benefit of immunising everybody and we believe also that targeting and the educational program is much more likely to hit the high risk groups than if we put our resources into a more general program.

Mr HAMILTON: I heard just recently on a radio news service a statement to the effect that people who have been immunised against poliomyelitis many years ago should now consider having a booster. Can the Minister detail that information to the Committee, because I am not sure myself as to what I should do and particularly I would like to be able to advise my family and my constituents?

The Hon. D.J. Hopgood: It is of some concern to us. I do not know whether the honourable member is looking for a free consultation here, but he should certainly get an update. The encouraging sign is that programs are run in various local government centres from time to time and more recently in the city of Marion. Yes, I would strongly advise the honourable member, if he has not had an update of polio immunisation over the past 10 to 15 years, to get himself immunised—and the public generally.

Mr BECKER: I disagree with the Minister's remarks made just a minute ago in relation to Foundation SA. I understand that he does supervise the legislation of Foundation SA. Recently, I asked some questions on the parliamentary Notice Paper which were not answered to my satisfaction. As a matter of fact, I got the impression that they were just wiped off by the staff and the members of Foundation SA. One of them was: which sporting clubs and other organisations received grants from Foundation SA since the inception of the funding?

I have been advised that the tobacco industry was supporting organisations in the State to the tune of $2.6 million, yet the Auditor-General's Report indicates that grants and payments have only been about $1.6 million. I take umbrage when I ask for information and I am just wiped off by those to whom we give the privilege of looking after that information, I wonder if you could advise the Foundation SA staff and members that we do require them to answer the questions on the parliamentary Notice Paper and would appreciate the information in future?

The Hon. D.J. Hopgood: The legislation is committed to me, because all legislation has to be committed to a Minister, but that same legislation puts all sorts of qualifications, quite properly so, around just exactly what information or instructions, or anything like that, I can give to Foundation SA. Members of Foundation SA can read *Hansard* as well as anyone else—and no doubt they do—and will note the honourable member's comment. However, my role will be simply to convey that information to the House in the appropriate manner. In general terms, the $5 million to be expended by Foundation SA in this financial year will be split in a rough ratio of 1:3:1 between the arts, sport and recreation and health promotion. Therefore, the $3 million, which will go to sport and recreation, is considerably in excess of the amount going to sport and recreation from tobacco sponsorship prior to the passing of this legislation.

Mr BECKER: I concede that point. When we seek information, I think we are entitled to it; it is not a State secret. If I wanted to, I could ask my colleague, the Chairman of the Public Accounts Committee, to exercise the powers of a royal commission to demand that information. After all, I once threatened to put one of my own colleagues in prison if he did not come up with information. Mr Chairman, you will remember that you were on the Public Accounts Committee at the time, and we were going to exercise those powers to their full extent. You were behind me all the way.

Referring to page 50 of the Program Estimates, I note that in the services for Aborigines there appears to be no ongoing funding to carry out many of the recommendations of the UPK report, which is a blueprint for rectifying many of the health problems besetting Aborigines on the Pitjantjatjara lands in South Australia's Far North-West. I note that there is nothing in the Government's social justice strategy for ongoing responses to the UPK report. Yet, I would have thought any measures that could reduce many of the health problems of Aborigines in this State—who live, on average, 20 years less than their white counterparts—would have fitted the social justice criteria. Whilst $56 000 was spent on a nutrition study of Pitjantjatjara Aborigines last year, there seems to be no continuing commitment for the many other recommendations. Does this indicate that the Government has abandoned its commitment to the UPK report recommendations and to the Aborigines of South Australia's Far North?

Ms Johnson: The UPK report focuses on health hardware, health management and healthy living practices. It is central to an integrated Government program to provide services and facilities to Aboriginal people that will improve their health status. The implementation program involves an essential services committee composed of officers of agencies such as Sacon, ETSA, E&WS and the Commonwealth Department of Aboriginal Affairs. That committee is now looking at the problems highlighted in the UPK report. As the honourable member has mentioned, in 1988-89, $56 000 was provided as part year funding of a public health unit within the Nganampa Health Service to commence a community nutrition program and to work with the Anangu people towards improving their living environment—$105 000 has been provided to continue this work in 1989-90.

Mr BECKER: I note that in the health estimates for 1989-90 there are proposed expenditure projects for virtually every line except for the State Clothing Corporation at Whyalla. What is the likely expenditure on this facility for this financial year, given that additional grants of more than $500 000 were required in 1988-89?

The Hon. D.J. Hopgood: In brief, the answer is $300 000.

Mr BECKER: How much do the Royal Adelaide Hospital and the Adelaide Children's Hospital benefit by the additional income from providing specialist medical services to wealthy Asian patients, of whom I believe 19 patients have been to the Royal Adelaide Hospital and two to the Adelaide Children's Hospital? If the information is not available, I am quite happy for the question to be taken on notice. Can the Minister provide a detailed breakdown of the number of people waiting for elective surgery, at each hospital in specialty areas, who have been waiting 12 months, two years and longer, three years and longer and four years and longer?

The Hon. D.J. Hopgood: The honourable member's first question relates to the AusHealth question I answered previously, when I gave the actual figures. I do not have the precise information at the moment, but I think the breakdown is that 80 per cent of the profit goes back to the Royal Adelaide Hospital. I will obtain the details in relation to longer-term patients waiting for elective surgery, but my guess is that if anyone has been technically on the list for three years they do not need the surgery at all.

Mr BECKER: Will the Minister explain why, in the capital works program for 1989-90, the Marion Community Services Development and the Port Pirie Regional Health Service are listed as new works when, in fact, both projects were in last year's capital works program as new projects?

The Hon. D.J. Hopgood: I assume that it is because the amount proposed last financial year was not, in fact, expended. Therefore, we can say that this is a new project as of this financial year.

The Hon. JENNIFER CASHMORE: I would like to pursue the question asked by the member for Albert Park about tuberculosis. The answer to the question was given in general terms. Can the Minister indicate what was the increase in cases of tuberculosis detected in South Australia last year? What are the projections? What representations, if any, have been made by the State Government to the Federal Government to ensure that adequate resources are made available to our overseas missions to screen migrants? That is where the screening process should be undertaken, where it has traditionally been undertaken and where it is now not undertaken effectively.

The Hon. D.J. Hopgood: I understand that representations have been made. I will get specific figures for the honourable member. However, from memory—and from discussions with doctors at the Royal Adelaide Hospital—there has been a slight increase in the incidence of tuberculosis. Of course, that is worrying.

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

Works and Services—South Australian Health Commission, $63 685 000—Examination declared completed.

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

Community Welfare, $140 082 000

Chairman:
The Hon. G.F. Keneally

Members:
Mr H. Becker
The Hon. Jennifer Cashmore
Mr M.R. De Laine
Mr T.R. Groom
Mr K.C. Hamilton
Mr J.K.G. Oswald

Witness:
The Hon. D.J. Hopgood, Deputy Premier, Minister of Health, Minister of Community Welfare and Minister for the Aged.

Departmental Advisers:
Ms S. Vardon, Chief Executive Officer.
Mr G. Boxhall, Director, Administration and Finance.
Ms A. Howe, Executive Director, Operations.
Mr P. Bicknell, Manager, Non Government Welfare Unit.
Mr R. Bos, Manager, Financial Services.
Mr R. Leahy, Manager, Home and Community Care Unit.
Ms K. Dwyer, Coordinator, Health/Welfare Child Protection Unit.
Ms S. Castell-McGregor, Executive Officer, Children's Interests Bureau.
Dr A. Graycar, Commissioner for the Ageing.

The CHAIRMAN: I declare the proposed expenditure open for examination.

Mr OSWALD: The Liberal Party notes that the department has engaged in a major restructuring of programs for the current financial year, with only one of last year's 13 programs remaining intact. This exercise has made it an extremely time consuming and taxing task to try to appreciate the impact of this year's budget allocations on DCW policies and programs and to compare this year's financial forecasts with last year's result. In passing, I note that the budget paper 'The Impact of the Budget on Women', when commenting on the DCW's lines, noted that 'program reoranisation has made resource comparison inappropriate'.

The restructuring appears to reflect a far more positive approach by the department in respect of its statutory responsibilities, in relationships with individuals and families and its focus on community development and the prevention of problems before they reach the point of crisis. The Liberal Party supports these new directions and will monitor with great interest whether the rhetoric is translated into practice.

In relation to the current financial year, we believe that one of the most challenging issues for the welfare sector will be the ramifications of the proposed new Social and Community Services Award, currently before the State Industrial Commission. While the application by the Australian Social Workers Union (ASWA) is subject to negotiation with employer representatives, which will affect its final form, there is little doubt that the granting of such an award will lead to a major shake-up in the sector—with many people predicting that it may create as many problems as it solves. The prospect of the award compounds the funding problems which non-government organisations are confronting in their battle to meet current needs. Other issues of importance are: the provision of services for the frail aged, the disabled and their carers; child protection practices; and the quality of substitute care programs for children. We recognise the move by the Government to establish the position of Minister for the Ageing—an initiative which reflects a Liberal Party commitment of some 14 months ago. We also recognise that the Minister is the third Minister to be responsible for Community Welfare within a period of three years—a rapid turnover which the Liberal Party considers has added little to the status of the portfolio nor to the confidence of staff working in the complex area of inter-familial relationships.

The CHAIRMAN: Does the Minister wish to respond to those comments before questions?

The Hon. D.J. Hopgood: It is important that I say one or two things generally about the budget as I see it. I also have a couple of documents that may be of assistance to members. The major policy objectives for social welfare services in South Australia were revealed in the Government's White Paper 'New Directions in Welfare: the Next Five Years', released in December 1988. The paper emphasises the importance of the family as the basic unit of society and as the best environment for the growth and well-being of children. It also emphasises co-operation and the sharing of responsibilities across agencies, both Government and non-government, in particular to ensure the achievement of social justice for all South Australians. The department's operations during the year aimed to reinforce the objectives of the White Paper and of ensuring the highest quality service to clients.

In recognition of the invaluable role of the non-government (and frequently non-agency) sector, a Family and Community Development Grants Fund was established, integrating community welfare grants, grants to community centres and neighbourhood houses, and family support program funding. Among other such support initiatives, a $90 000 grant was made to SACOSS to provide training to the non-government sector.

The Burdekin report was released during the year, emphasising the extensive needs of homeless young people. Whilst this State's services require further improvement in this area, South Australia was acknowledged as being in the forefront of constructive programming for young people. Specific reference was made to the Adolescents at Risk Program. An additional program, the Intensive Adolescent Support Scheme, was established during the year to further extend the range of services.

Aboriginal young people have been particularly targeted for assistance in welfare programs. The Metropolitan Adelaide Youth Team and the Cautionary Diversion Program are both aimed at decreasing the number of Aboriginal youth in detention. Social Justices funding has been directed to other programs for Aboriginal people, including in particular the Aboriginal Family Care Program.

The department has rigorously reviewed its program structures and therefore directional responsibilities, in order to ensure better integrated planning and delivery of welfare services. This restructuring has been guided by the White Paper's concern to signal a shift towards more prevention, and this direction is being reflected in planning in many program areas, such as substitute care.

The major priorities of each departmental program, identifed in the annual program reviews, have been documented in a 'Strategies' booklet distributed to all staff, to reinforce knowledge of and commitment to our service directions. A copy of that book is available for members tonight. I confirm that the streamlining of the programs has made the presentation of the estimates papers somewhat complex this year. If it is of any comfort to the honourable member, he should know that I and my officers have probably had as many problems with it as he and his colleagues have had in getting a cross reference. To assist members, we have a reference which links last year's budget and this year's budget. I am sure members will find that of considerable assistance in working their way through the maze of paper.

I say only two other things in conclusion: first, I welcome the honourable member's support for the restructuring that has taken place. The matter of changing ministerial personnel is one that is not unique to South Australia but, so far as I am aware, the better context in which he could have put it was that we have had three different Ministers of Community Welfare in seven years, because of the reasonably long occupancy of the portfolio by Dr Cornwall. Finally, I noticed in this afternoon's Committee that, for the most part, members were interested in fairly detailed information being supplied. In that spirit, I did not scruple to handball a question from time to time to my officers. I believe that members find that very useful; therefore, I will continue to do so.

Mr OSWALD: I will be quite happy if the Minister takes the first question on notice and provides the information at a later date. Will the Minister provide an itemised account of spending in the last financial year plus the budgeted spending for this financial year under the following headings: salaries, wages and related payments; administration, operating expenses, minor equipment and sundries?

The Hon. D.J. Hopgood: We have some of that information but, if the honourable member prefers, we will take it on notice in the interests of keeping the ball rolling.

Mr OSWALD: The Minister may wish to take this question on notice also: with reference to EO and AO officers under Support Services, how many officers are currently employed at EO and AO level? Further, will the Minister provide information on the current salary of the Chief Executive Officer and the salary applying as at 30 June 1988 and 30 June 1989; and will he detail what allowances, including their value, the Chief Executive Officer receives in addition to salary?

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

Mr OSWALD: Under 'Support Services', can the Minister provide information on the amount of sick leave taken during the last financial year? How much of that leave was taken on a Monday, a Friday, and the days immediately before and after holiday weekends?

The Hon. D.J. Hopgood: We have some information on sick leave. I am not sure whether we can provide a breakdown as to the days of the week, but we do have comparisons taken during sample months in the past four financial years. In 1988-89, the sample was 3 219 days, compared with 3 665 for the comparable period in 1987-88. We will get more detailed information but, on these figures, it would appear that the number of sick days taken is actually declining.

Mr HAMILTON: I refer to 'Strengthening individuals and families' on page 65 of the Program Estimates where an amount of $4.34 million is specified for family and community development grants. In its pre-election statement, 'A Fair Go For All', the Bannon Government gave a commitment to fund 20 new neighbourhood houses in this term of office. Has this pledge been fulfilled and how successful has that program been?

The Hon. D.J. Hopgood: We have some information on that. With the bringing down of this budget, the commitment to which the honourable member refers will have been discharged. Prior to the election commitment of 20 new neighbourhood houses, in 1986 the Government provided a mass input of $300 000 to the neighbourhood house program. This enabled the establishment of 12 neighbourhood houses. Over and above this initial boost, the Government has provided an increase of $406 000 over the past four years to provide 20 new neighbourhood houses. The 20 houses commitment will be fulfilled next year when a further $130 000 expansion of funding will be allocated to six neighbourhood houses, thus completing the Government's four-year commitment.

We regard this as a very important program and we are very pleased that it has been possible to identify the resources for it to happen. Of the 20 new houses, a significant proportion have been established in suburbs which have traditionally been working class and low income areas and where residents have experienced long-term socioeconomic disadvantage. Suburbs such as Ottoway and Hindmarsh and the Parks area have received neighbourhood house funding.

Mr HAMILTON: I refer to page 67 of the Program Estimates under the heading 'Support to adolescents and their parents'. An amount of $4.22 million is specified for youth supported accommodation assistance. Following the release of the national inquiry into homeless children by the Human Rights and Equal Opportunity Commission (often called the Burdekin inquiry), there has been considerable media and public interest in the plight of homeless children in Australia. What has the South Australian Government done in recent years to respond to the causes of homelessness amongst young people and the difficulties faced by them and from family relationship breakdowns to the extent that they are left without a home?

The Hon. D.J. Hopgood: In view of the honourable member's obvious interest in this matter—on which I congratulate him—I will very briefly summarise some of the salient points that could be made. Obviously, the Government welcomed the report of the Human Rights and Equal Opportunity Commission on Homeless Children. We have used the report as an opportunity to review the range of State Government programs and services which respond to

or, indeed, may prevent homelessness amongst young people. The report has been considered by the Human Services Committee of Cabinet, which instructed the heads of human services departments to review their services in the light of the inquiry's findings. The Cabinet committee appointed a State Burdekin coordinator and an interdepartmental committee to prepare a South Australian Government response to the report and to develop services appropriate to identified needs in this State.

Over the last several years, the Government has given a particular priority to the needs of 'at risk' young people and steps have been taken in all human service departments to reduce factors contributing to homelessness. I will list five of them. A cautionary-diversion program has been established between the Community Welfare Department and the police, aimed at reducing the number of street offences amongst young Aboriginal people in Adelaide. These young people are now less likely to be 'trapped' into offending, custody, and destructive reactions. The Education Department, my own department and the South Australian Health Commission have developed a joint program to respond to very difficult behavioural problems in schools as an alternative to corporal punishment or suspension.

The Health Commission has established the Second Story adolescent health service providing a comprehensive range of adolescent services in the inner city area. The South Australian Housing Trust has established the Direct Lease scheme, providing access to medium term public housing to young people, and the Department for Community Welfare established Adolescent At Risk teams throughout the State to assist young people who are at risk of harm through abuse, neglect, family breakdown, homelessness or subsequent abuse.

Mr HAMILTON: I refer to page 67 of the Program Estimates under the heading 'Support to adolescents and their families', which specifies an amount of $4.22 million for youth support accommodation assistance. The first Supported Accommodation Assistance Program (SAAP) agreement expired on 30 June 1989—did it achieve its stated objectives?

Ms Vardon: The first SAAP agreement was introduced, as we know, on 1 January 1985. The objectives included a clear commitment to improve funding for new services in higher needs areas and to move towards improvement in wages and conditions of workers. Over the past 4½ years, the program has made significant progress in achieving these objective. Funding has increased above inflationary levels. In 1989-90, $10 million will be allocated under the program and this compares with $4.4 million in the first year of operation. This represents a 100 per cent increase over the funding life of the first agreement.

As an initial priority in the program, wages and conditions of SAAP funded staff have improved in 1985 through increases in salary levels to two minimum standards and the introduction of a 17 per cent on-cost loading for all salaries. This improves staff conditions through the provision of funding for items such as long service leave and relief staff for sick and annual leave. More recently, increased training opportunities for SAAP funded staff management committees have been developed. We piloted a training program in 1988 which has been very successful. We have appointed a full-time training officer for SAAP services. We have improved services in new areas where there is high need. There are, in fact, many other things that we have done. We have paid particular attention to providing emergency accommodation for young people in Port Pirie and Whyalla, and services for homeless single men have been improved.

The Hon. JENNIFER CASHMORE: On 4 August last year, His Excellency the Governor noted that the Government's legislative program could include a Bill providing for a major revision of the Community Welfare Act. No such Bill was introduced and, a year later, the Governor's' address contained no reference to any such legislation in the current session. Will the Minister advise the Committee why the Government did not act to introduce a Community Welfare Act Amendment Bill in the last session and what plans, if any, does the Minister have for introducing and seeking to secure the passage in this session of such a Bill recognising that, with a State election imminent, time is running out for a Bill to be considered in this session?

The Hon. D.J. Hopgood: It is unlikely that we will make the timetable for this session. There is a Bill, the broad outlines of which have been concluded, and some drafting has taken place. Because of the doubt as to whether we would make the timetable for this session, it was not included in His Excellency's speech. However, that is not to say that the plan for new legislation has been abandoned. That is not the case. We imagine that it may be ready for the autumn session.

The Hon. JENNIFER CASHMORE: My question relates to industrial awards. The introduction of industrial awards is mentioned as one of the department's specific targets in 1989-90. In relation to the awards it is noted that the non-government Welfare Unit will work with SACOSS and non-government agencies to assist all parties to adjust to the introduction of awards in this sector. I note, however, that the major concern for that sector relates to whether or not funding bodies such as the DCW will increase grants to cover projected increases in cost resulting from the terms of the wages and conditions laid down in the proposed new award.

Has the department or the Government calculated the cost of the application by the Australian Social Welfare Union to the State Industrial Commission for the implementation of a social and community services award? Has the Government determined a policy on whether DCW as a major funding body to the non-government sector will increase grants to cover increases in costs? Has any provision been made in the allocation of funds in this financial year as a contingency to cover award wages and conditions? If so, what is the sum, and how does the Government propose that it should be distributed?

The Hon. D.J. Hopgood: This matter has the non-government welfare sector scared stiff, and I can understand why. Every second deputation that I have received since I came into the ministry wearing my community welfare hat as opposed to health has been concerned about this matter. I will ask Peter Bicknell, who advises me on these matters, to speak briefly to the Committee in a moment. I understand that there has been no appropriation for this year, because it is not anticipated that a determination will be made before the end of the financial year. Calculations have not been made on the basis of the actual claim because, if I can bend scripture a little, man proposes but the Industrial Court disposes.

At this stage we have no way of knowing the exact outlines of the award which will emerge from the deliberations which are proceeding. We know that there will be one. It is inevitable in the nature and shape of the Australian industrial and arbitration system that some award will emerge, and that will cost. At this stage, it would be a waste of time to try to make any guesstimate about the cost. However, as my officer will explain, some preparatory work has been undertaken by the department and by the non-government

welfare agencies which rely upon the Government for funding.

Mr Bicknell: We are talking about two awards which affect the non-Government sector in South Australia: one is the Federal award, which is called the Crisis and Supported Housing award (CASH), which is being heard in the Federal commission; and the other is the State claim which is a social and community services award. Both awards are being pursued by the Australian Social Welfare Union. At the moment both hearings are at an early stage. The Federal commission is hearing objections to the award, and that will take a long time. I understand that it will be some time before it finishes hearing objections and there would be little chance of that being completed this year. It is also an ambit claim because of the nature of the Federal system. With the State award, there are also disputes with the union because other groups are seeking to dispute their coverage. There is very little possibility that that matter will be finished in this financial year.

The Government, particularly through the Minister as Chairperson of the Human Services Committee of Cabinet, has looked at this matter and established a working party including officers of the Treasury and other Government departments which will be affected by either of those two awards. We are now in the process of examining the implications for the non-government sector and for the Government. We have also funded the Community Employers Association, which is now being developed, because it is very important that employers have a strong voice in this process. We funded SACOSS for extra money as well so that it can work with the funded bodies in preparation for the award.

We have given high priority to the training of management committees. Over the next 12 months the training officer that we have now employed and an extra training officer funded by SACOSS will work mainly with management committees looking at management processes and trying to assist them to understand the implications of the award. The implications of the award are quite severe for funding bodies. The funding bodies are not only Government. Many of the groups raise a lot of money, particularly groups such as the Salvation Army, and so on. We need to understand the implications for them and for the Government. We need to look at what it means in terms of relationships between employers and employees in the non-government sector and what it means for the nature of service delivery.

The Hon. JENNIFER CASHMORE: I refer to non-government organisations at page 71 of the Program Estimates, under 'Strengthening individuals and families'. The Lotteries Commission proposes to trial keno in about 40 clubs from February. Non-government organisations fear that if this leads to keno being played in hotels they will lose more than $500 000 a year through the loss of money that they make annually from instant bingo and beer tickets. Is the Minister aware of the fear among charity fund-raisers of the move by the Lotteries Commission to introduce keno into clubs and potentially hotels, and does he support that move?

The Hon. D.J. Hopgood: At no stage has any voluntary organisation raised with me its concerns about the matter. I will ask Mr Bicknell to indicate to the Committee whether, in his discussions with these people, it has been raised. We have not made provision for a matter about which I have not been advised.

Mr Bicknell: A certain section of the non-government sector, which has got together in a group that raises considerable amounts of money from small lotteries in hotels especially, has expressed its concern, but I am not aware of any deputation to or contact with the department on that issue.

The Hon. JENNIFER CASHMORE: Does the Minister contemplate such a move, that is, keno in hotels?

The Hon. D.J. Hopgood: I have no particular interest in any form of gambling, so I am not the person to consult on these matters.

The Hon. JENNIFER CASHMORE: You vote on it, Minister.

The Hon. D.J. Hopgood: I tend to try to drop off when these things are discussed in Cabinet because, as I say, I have no interest or expertise in any form of gambling, horse racing, or anything like that.

Mr De LAINE: Page 62 of the Program Estimates shows that expenditure on family maintenance, counselling and advice increased from $1.7 million to $2.026 million in 1988-89, although it had been anticipated that the introduction of the Commonwealth Child Support Scheme would take over most of the State involvement in this area. I further note that the reference on page 74 of the Program Estimates which says that there may be a reduction in expenditure in 1989-90 due to the continued transfer of functions to the Child Support Agency. Would the Minister please explain what accounted for this increase in expenditure and what will be the respective roles of the department and the Child Support Agency in family maintenance matters in the future?

Mr Boxhall: The increase in expenditure last financial year was due to two factors: the increase in demand for services from the Department of Social Security recipients and a slower than anticipated impact by the introduction of the Commonwealth Child Support Agency. Perhaps if I could just outline briefly both of those areas. First, the introduction by Social Security of more stringent requirements for all supporting parent recipients in initiating action to try to obtain maintenance resulted in an increase of approximately 30 per cent in the total number of active cases that were handled by the department.

This caught us a little bit unaware and meant long delays in interviewing clients, high case loads for our staff and also required us to divert some of our attention from enforcing the existing maintenance payments. As a consequence, we recruited eight additional temporary staff both in Adelaide and other locations so that we were able to promptly handle all the social security people who wanted to initiate action through our department. We also introduced a policy of means testing new clients so that we could ensure that our services were targeted towards pension beneficiaries or other people receiving a low income. As a result of that, we have now been able to take care of that backlog.

In the area of the child support initiatives, members may recall that the Commonwealth announced several initiatives in this field in 1987. One of those involved amending the Family Law Act to place a primary responsibility on parents to maintain their children. That has already had an impact and we have seen that custodial parents have been receiving a higher level of maintenance now as a result of orders made through the Family Court.

The other initiative of the Commonwealth was the introduction of the new Child Support Scheme, in two stages. Stage 1 involved the Commonwealth Taxation Office collecting a large proportion of the maintenance payment. The department now has fewer new agreement orders being sent to it for collection. However, as yet, we have not transferred very many of the existing cases to the Commonwealth, and currently we are still handling 7 500 maintenance payments, compared with 8 400 a year ago.

The Commonwealth has also recently announced that stage 2 of the Child Support Scheme, which is the introduction of an administrative formula for assessing the level of maintenance, will be introduced on 1 October. We expect that after six months or so that may involve a lower demand on some of our family maintenance activities. However, at this stage it is not known and we are still discussing with the Commonwealth what form of representation custodial parents may be able to receive through the Department of Community Welfare. I should point out that the additional expenditure that was incurred last year because of those increased demands will be offset by adjustments in the Commonwealth reimbursement to the State for services provided under the Family Law Act.

Mr De LAINE: Under the program 'Strengthening individuals and families' at page 65 of the Program Estimates, an amount of $4.34 million is shown for family and community development grants. What programs are being funded to assist families who lack skills to provide appropriate care for their children or who may maltreat or neglect their children and whose children might be at risk of being removed and placed in foster care?

The Hon. D.J. Hopgood: Many of the services funded by the Commonwealth, of course, support families. For example, there are family shelters and neighbourhood houses. However, the Family Support Program is the main funding program for such services. It will receive $1 753 750 this year, directed towards projects which provide services for a great many families where the children are not receiving appropriate care, are victims of child maltreatment or neglect, or are at risk of being removed from the family and placed in foster care. The projects which will receive the highest priority under the Family Support Program are those which assist families to develop their coping abilities and increase their skills to care for their children.

I will briefly go over some of the major aspects of the program. There is the family homemakers scheme, for which a little over $500 000 will be provided. There are home intervention programs which employ women on a part-time basis to work with families in family homes, based on a one-to-one approach, providing support and teaching family skills, and modelling child care to families where it is identified that the family is having problems with the care of children.

There is the Aboriginal homemakers program, and a little less than $250 000 will be provided to employ family support workers to work with Aboriginal families in both the outback communities and urban areas. As to ethnic families, $121 674 will be provided to organisations for family support services for families in ethnic communities. These projects vary from counselling and support to training and development. There will be an additional $198 000, in round terms, for families in new suburbs, and $170 000 for direct counselling and intervention. Some $173 000 will be allocated to programs focusing on single mothers and, in particular, very young mothers who are likely to have difficulties in coping.

Further, there is $69 000 for parents' education, and a remaining $207 000 will be distributed to a range of projects, including one to provide support for families where there are multiple births. There will be another to work with the wives and families of prisoners or ex-prisoners, where the risk of maltreatment is very high. A number of projects are based on communities which have a very large number of high risk families, and several will focus on parent education. The Government's commitment can be seen from the increase from $832 000 in 1986-87 to $1.75 million this year.

Mr De LAINE: A 1988-89 specific target/objective referred to at page 82 of the Program Estimates concerns a system of block recruitment of community welfare workers to be developed and implemented. Can the Minister explain the system and comment on its effectiveness?

Ms Vardon: Two years ago we had an unsatisfactory system of recruitment in our organisation. People came in on the side through a register which was attached to our organisation and, as the practice had been over the years, people slipped into the organisation without much training to start with.

We decided to increase the professional behaviour of our organisation and the quality of our staff by giving them better training as they entered our department because some very specific legislative, child protection and substitute care skills we expect people to know, and this is not taught in universities. We are now on our third block recruitment. Last year we recruited in a block about 30 people and we now bring in about 30 people at a time, put them through four weeks in the first two blocks and six weeks training in the current block. We have been very happy with the quality of staff we have been able to get and we are happy with the training given to them.

Mr OSWALD: I refer to the program 'Planning with people' and refer to the health and social welfare councils. In his recent book *Just for the Record* former Minister Dr Cornwall states:

> Community involvement through the creation of health and social welfare councils was never supported within the department.

He refers to the establishment of three pilot councils last year and a proposal for two more this financial year. How was the performance of the three pilot councils assessed, what has been the impact of the health and social welfare councils on departmental decision making, and will the two future councils mentioned in the former Minister's book be established? What local council areas will they cover?

The Hon. D.J. Hopgood: The honourable member has the advantage on me in that he has read the document to which he refers and I have not. However, in relation to the ongoing experience of this initiative, I will ask the Chief Executive Officer to report.

Ms Vardon: If I may be so bold, many things in that chapter on social welfare surprised me, and our lack of commitment to health and social welfare was one of them. The department has supported those councils from the very beginning. Our staff person, Wendy Heath, was assigned about half time to assist the social health unit of the Health Commission. A number of our managers are on those committees. They started off originally as health councils and welfare was added somewhere close to their being introduced. If concern existed it was that some of the welfare issues had not been thought through. We said that that would happen when they get off the ground.

I recently spoke with one of the people who runs one council. There are now four councils because the one in the Murraylands broke into two as the area it covered was too large. Upon speaking to the person concerned recently, I found that the issues with her council focused much on health. I said that I was particularly concerned about our programs and I invited myself to meet with them. When they have special issues relating to our portfolio we want to hear it as we are open and our managers are involved. If it comes to specific details of policy they have influenced, it is early days because the councils were established in two phases, the first being to establish a council. We had a fair amount of community development before the councils were appointed by the Minister. The issues that have been put on top of the priority list are mainly health issues. We

have an open mind on them and will continue as we are doing now in working with and listening to them.

Mr OSWALD: Are you in a position to advise whether or not there are two new areas to be established and, if so, where are they? The former Minister referred to two additional areas. Is there any basis of fact in that or is it something that Dr Cornwall floated?

The Hon. D.J. Hopgood: We are not aware of any new ones. There were originally three; one has broken in two, so it is now four. We will take that question on notice and, if any further information is available, we will give it to the Committee.

Mr OSWALD: I refer to support services and the Justice Information System. Last year during Estimates the Liberal Party raised questions about child protection statistical information and the transfer of such onto the JIS. In reply, the Chief Executive Officer indicated that the whole program of statistics was being reset. It was hoped that a 'user committee' working with the JIS would be set up by the middle of 1989. Questions about how long a child's name stays on the files were to be fixed by the user committee and guidelines were being prepared for confidentiality and access.

What progress has been made on each of these four matters in the past year? What decision has been made in relation to the length of time a person's name in relation to child protection matters remains on the files?

Ms Vardon: The JIS is very important for our organisation and this week the substitute care program is being loaded from one main computer to another. Shortly we will have the substitute care program off the ground. The child protection program is still being designed. We have the first draft of stage 1 on child protection. We are at a point of signing off. Some technical questions are being considered with me and it is a headache trying to determine the exact nature of the child protection system. The issues of privacy have been uppermost in our minds with the JIS.

We have identified, for terms of confidentiality, 10 principles of privacy protection covering the collection, storage, access, correction, use and disclosure of personal information. Those principles are consistent with the Government's handbook on information privacy principles and access to personal records. I will ascertain whether we have made a decision on how long a person's name stays on the register and ask Ms Kim Dwyer to reply.

Ms Dwyer: One recommendation is that a child who is notified to the system will have their name on the system for two years if the case is not substantiated. If it is substantiated, it will stay on for five years or until the child reaches 18 years—whichever comes first after the closure of the case.

Mr OSWALD: Was a user committee ever set up?

Ms Dwyer: Yes, a user committee on child protection was set up in relation to the JIS.

Mr OSWALD: When the JIS was first established it was proposed that a number of departmental programs would be computerised as part of the system. You mentioned child protection, but other systems included the emergency financial assistance and a domestic violence information system. Have those two important areas been programmed or is it planned that they will go on to the JIS?

Mr Boxhall: Current planning is that there will not be specific separate applications for the two areas that the honourable member mentioned, but that all relevant information will be collected through a system called 'contact history', which is similar to an office card system. We will have a record of the nature of a client's contact with an office and will be able to record that they did come for emergency financial assistance or for domestic violence reasons. We will be able to maintain the relevant information on the JIS.

Mr HAMILTON: I refer to page 62 of the Program Estimates—'Concessions': in relation to transport concessions for persons of 60 years and over, can the Minister indicate, at this early stage, how much interest has been shown in the seniors card and how many people, thus far, have applied for those concessions?

The Hon. D.J. Hopgood: We anticipated this question, which is just as well, because it is information that we must get from my colleague the Minister of Transport. Today was the first day that the STA received completed application forms, which is not surprising, given that the availability of application forms was advertised only on Monday. Today, 3 500 applications flooded in. So, this Government initiative will be extremely popular. There are about 65 000 eligible people 60 and over, and I hope they will all take the opportunity to benefit from concession rates of travel. On present indications, the figure will be very close to that.

Mr HAMILTON: On page 72 of the Program Estimates, under 'Specific Targets/Objectives', a community education package on child protection is to be completed, as will a strategy for a national awareness campaign. Can the Minister elaborate on this very important issue?

Ms Dwyer: A community education package has been completed and distributed. Primarily, it is aimed at helping workers in both the health and community welfare offices to provide information to the public, other agencies and groups who ask the officers to come to talk to them. It has core information about child protection, the law and the system generally. In addition, it gives information about how to run a one-day workshop or a two-day talk, or whatever it is. There is a whole variety of different methods of presenting that information.

Mr HAMILTON: Page 72 of the Program Estimates, under 'Specific Targets/Objectives', refers to national and state campaigns to raise awareness about domestic violence, which campaigns appear to have had a significant impact on the community. Can the Minister tell the Committee what is this significant impact? Will the Minister elaborate on this point?

Ms Dwyer: As members will be aware, the National Domestic Violence Campaign was a joint campaign on the part of the Commonwealth and the State. It ran in April this year, which was National Domestic Violence Awareness Month. All reports so far indicate that it has been extremely successful. This is the first year of a three-year campaign. At this stage, the evaluation is that a large percentage of the population were aware of the campaign, and a number of changes in various States, in relation to laws, have been proposed as a result.

Mr HAMILTON: Can the Minister give some details and specific numbers as to the representations that have been made? I would imagine those representations would have been made to the various agencies by women in the community.

The Hon. D.J. Hopgood: I will take that question on notice. We do not have that detail.

Mr BECKER: I refer to page 70 of the Program Estimates—Planning with People: this appears to include volunteers and community aides, who have been transferred from community participation and welfare. Last year's expenditure on this subprogram was $425 000 and involved the employment of 10.5 full-time equivalents. Why has no subprogram reference been made this year to volunteers and community aides? What, if any, is the proposed expenditure on this program this year?

Ms Vardon: The community and volunteer program is very important to our organisation. We have upgraded the number of community aides in our organisation. There was a slight drop last year from the year before, but the numbers have gone right up again to 498 as at the end of June this year. The type of work that the volunteers undertake has been widened and extended. Training programs have been established in about five or six offices—it is quite extensive.

A number of offices have set aside staff to train and recruit volunteers. However, we now have volunteers undertaking a lot of supervised access with non-custodial parents; in fact, we are very heavily reliant on those people. They are working with adolescents at risk and many of the young children are going back into school, as a result of the work of volunteers—these were children who would have been excluded from school. We have volunteers supervising young people on bonds—although legally they are supervised inside our organisation and more attention is being paid to their needs because we are able to enhance our work with volunteers. Volunteers are doing a tremendous amount of work in supporting foster parents and taking children on camping trips. For example, in Ceduna, one of our community aides provides a bus and breakfast program for local people.

Mr Boxhall: This amount is now included in the Planning with People Program. The full amount spent under the previous subprogram—'Welfare development in the community'—has been incorporated in the new Planning with People Program. The actual expenditure last year under that subprogram was $425 000 and expenditure of $438 000 is proposed for this financial year.

Mr BECKER: Has the department developed a charter on volunteering and, if so, could the Minister make a copy available?

The Hon. D.J. Hopgood: I am advised that there are a number of principles on volunteering. We have never used the term 'charter', but there is no reason why that information could not be made available to the honourable member and to the Committee.

Mr BECKER: Are both community aides and volunteers reimbursed for out-of-pocket expenses and, if so, what is the sum and how many people receive such payment?

The Hon. D.J. Hopgood: I will take that question on notice and provide the honourable member with the information.

Mr GROOM: There is a serious community problem about debt and over-commitment. Most people are getting into financial difficulties as a consequence of getting overcommitted. At page 65 of the Program Estimates, $536 000 is proposed for financial counselling: will the Minister outline the department's program to help people in financial crisis?

The Hon. D.J. Hopgood: It is certainly true that some people use credit to live from day to day. Financial problems brought about by this sort of practice often lead to a deterioration in health, a reduction in living standards and that sort of thing. Also, financial problems are often factors in the cause of domestic violence and child abuse. The department has established the Financial Counselling Service, which was officially launched on 11 July this year to replace what was called the Budget Advice Service. Staffing level for 1989-90 will be 12.1 FTE's as opposed to 11.6 FTE's in 1988-89, plus an additional four positions created under the Government's Social Justice Strategy to improve services to disadvantaged groups. The objectives of the Financial Counselling Service are to:

provide a counselling and advocacy service to clients in financial difficulties;

affirm the rights and dignity of individuals and empower them towards better money management;

advocate for social and/or legislative change so that the individual has improved rights and powers in the financial market place; and

improve community knowledge and awareness of financial counselling issues through advocacy and education.

This is a statewide service through all departmental offices. It is staffed by casual and part-time counsellors who have specialist skills in areas such as budgeting, credit and debt management, debt recovery and court procedures, bankruptcy and social security. Staff training has been a priority in this area, and the Financial Counselling Service has involved itself with ETSA, Sagasco, the Energy Information Centre and other such services; collaboration and co-operation with Trade Practices, the Consumer Affairs Division, Legal Services Commission, and Court Services Department. It has established formal links with the credit industry and has developed and implemented a data system used by both departmental and non-government financial counsellors. A good deal further advice could be given. The Financial Counselling Service handled 4 277 clients during 1988–89.

In conclusion, two important initiatives include financial counsellors to work with Aboriginals in the Riverland and in Port Augusta, and the social justice budget, which is part of the broader State budget, has made provision to set up a debt hot line to significantly improve access to expert advice for clients throughout the State.

Mr GROOM: Referring to page 64 of the Program Estimates under 'Adolescents at risk', I note that an amount of $3.9 million is specified for adolescent support. Will the Minister outline the progress that has been made for intensive adolescent support in schools and say what the Adolescent at Risk Program is doing in relation to adolescent suicide?

The Hon. D.J. Hopgood: In relation to the implementation of the Intensive Adolescent Support in Schools Program, it matches adolescents who are at risk with mature and concerned members of the community who act as mentors or 'counsellors'. An IAS worker works with a young person for about 10 hours a week and is a stable caring person in whom the young person can trust and confide. The IAS workers are selected, trained and supported by staff of the adolescent support team. Some initial concerns were expressed regarding whether the department would be able to recruit such people. At the end of the financial year 68 individual workers were working with young people and approximately 200 IAS workers across the State had been recruited and trained.

In relation to adolescents at risk of suicide, these people form a significant percentage of the case-loads of workers in the adolescent support teams as they do for district offices. Not a lot is known why adolescents commit suicide, and the evidence is inconclusive as to what are the best methods to intervene. In recognition of this the department appointed a temporary project officer to look at strategies and programs to address the needs of adolescents whose behaviour is life threatening as we might understand it. A background report has already been produced providing a profile for workers.

This report has been praised not only by workers within the Department for Community Welfare but by workers in youth agencies and therapists in private practice as most instructive. The report has underlined the need for more work in this area and a co-ordinated response across the welfare and mental health area. The department will be

seeking to work more closely with CAMHS and other agencies. The department is also seeking to broaden the knowledge and skills base of its own workers through this process. In that way, we hope to have some success in resolving what is a very distressing problem.

Mr De LAINE: Referring to page 65 of the Program Estimates under 'Family and Community Development Grants' totalling $4.34 million, I ask: is the Minister aware that a number of community groups funded through family and community grants have difficulty in obtaining and paying for professional insurance for staff and volunteers, and is the department able to offer assistance to these groups?

The Hon. D.J. Hopgood: Over the past few years non-government welfare groups hve been increasingly concerned, as the honourable member has said. The Government shares this concern, especially since insurance covers in the groups funded by the department vary greatly from group to group and appear to depend a great deal on such factors as contacts within the industry and personal knowledge of management committees.

As part of its attempts to support the non-government sector, the Government has funded the South Australian Council of Social Service to employ Ms Margaret Hunter to consider such administrative issues as insurance in the non-government sector. Ms Hunter works to a committee chaired by the Manager of the Non-Government Welfare Unit, which includes representatives of the Commonwealth Department of Community Services and Health and the non-government sector. The main issues of concern are public and professional liability and volunteer insurance. The advisory committee, in consultation with the Public Actuary, called tenders, and a broker—Alexander Stenhouse Australia—has been endorsed by the Family and Community Development Advisory Committee, and it also has my endorsement.

The policy will provide a combined public and product liability which will include professional liability. The volunteer workers' personal accident cover will cover volunteer workers 16 years of age and over. Participation in the scheme will be voluntary for groups. However, funded groups will be expected to have at least this level of cover. It is not anticipated that there will be any ongoing cost to the department.

The Hon. JENNIFER CASHMORE: Referring to 'Specialised Child Protection Services' on page 78 of the Program Estimates, under 'SpecificTargets/Objectives', I note there is no reference to the issue of interviewing children, yet the subject of audio and video recording of interviews with children was addressed last year by a working party established at the request of the department. Its report to the Minister is dated 5 April. That report contained five recommendations, the first being that the departmental branch head circular No. 1904 be rescinded. This matter refers to an instruction, signed by former Deputy CEO Ms Mann, that:

> Until further notice, tape recorders are not to be used in interviews with children under any circumstances.

Has the departmental branch head circular No. 1904 been rescinded? If so, when; and, if not, why not?

The Hon. D.J. Hopgood: I will ask Kim Dwyer to respond at least to the first part of that question. I may have to call on the Chief Executive Officer in relation to the second part.

Ms Dwyer: In relation to the working party report that was provided to the Minister, it has come to the department and has been looked at by child protection specialist workers. A number of recommendations in relation to the implementation of the report have been sent to the executive of the department, and there is a major resource implication in actually implementing the recommendations as they stand. So, at this point, those matters are being looked at in terms of the how the training can take place. In respect of the cost of providing tape recorders of an acceptable quality, and so on, the recommendations have not been implemented at the moment. A number of matters shall need to be resolved.

Ms Vardon: It is very difficult to have people going around with audio tapes until the issues that Ms Dwyer has referred to have been resolved. We want to get the whole process off the ground and working, and this requires a lot of special training. So, the branch head circular is not rescinded until such time as we have a proper procedure for audio taping. It will be rescinded.

The Hon. JENNIFER CASHMORE: The obvious question arising out of that is: if it is going to be rescinded, when will that occur in the light of the present planning and, assuming that it will not take 10 months, what provision has been made this year for the purchase of suitable audio recorders for commencing trial programs in two or more identified district offices and for the introduction no later than 12 months from the date of the report which would be April 1990 of a general practice of audio recording interviews with children?

Ms Vardon: It is very difficult to provide a definite answer in terms of months because it requires so many people like lawyers and others to give advice. We do not want to hold it up. We want good evidence that is acceptable and we want evidence that does not force a child to be interviewed again and again. We are outside the knowledge and skills of our own department here because there are so many other legal considerations to be taken into account. We want this to happen and we do not want it to be this time next year and not be in a position where we are audio taping. We want to get it off the ground as soon as possible.

I regret that I cannot provide an exact date at this stage. The honourable member asked about having money set aside. I spoke recently to our staff development people who have a considerable amount of equipment and looked at the possibility of a couple of offices. In fact, a Woodville office has been suggested to me as a place where we could start the trial. We have sufficient funds in this year to buy the necessary equipment for the few officers we will start the trial with.

The Hon. JENNIFER CASHMORE: I refer to 'Specialist child protection services' at page 78 of the Program Estimates, and in particular, the turnover of staff. In a recent submission to the select committee reviewing the department's child protection policies, programs and practices, the Children's Services Office highlighted the rapid turnover of staff in DCW district offices as a continuing concern for CSO field staff. The submission noted on page 10:

> Reporting a suspicion of abuse is a serious undertaking. The process is much less traumatic where the notifier has had the opportunity to get to know the local DCW workers. CSO staff are encouraged to take the initiative in getting to know local DCW officers, but all too often this process needs to be repeated every few months in order to keep up with staff changes.

My question is: does the Minister acknowledge that rapid turnover of staff at DCW offices is a problem, not only for CSO officers but also for the family involved in the case as well as the department in seeking to provide specialist child protection services? How is the Government aiming to address this problem which we suspect is more acute in areas that record a high level of notifications thereby compounding the problems identified by the CSO?

The Hon. D.J. Hopgood: As a general rule, my advice is that there is not an abnormally high turnover in the Department for Community Welfare if it is compared with comparable Government agencies such as the Education Department, the Health Commission, and that sort of thing. There are some problems in some offices, particularly in the north, though again I would not see that as very much different from what happens in health units in the northern suburbs. I undertake to obtain some more definite information for the honourable member. I do not want to mislead the Committee in any way, but I think I would have to take issue in part, though not in total, with the premise on which the question is based. It is a problem in those areas where there is rapid turnover. As a general rule within the department, that is not the case and in fact some of the problems we have with Treasury relate to the reasonably stable nature of the department and what that does to our funding base.

The Hon. JENNIFER CASHMORE: In the areas where the Minister and the department acknowledge that it is a problem—and I sense that that is given—what is the Government doing to address that problem?

Ms Vardon: There are a number of offices that come to mind where it is difficult to hold people because of the high level of the workload that comes in, and it is not the most pleasant work in our organisation. It is highly skilled work. It is hard work and, because of certain streamlining, most of the notifications we have received of child abuse are serious cases, and there is not a lot of lighter work in some offices. Block recruitment has made a difference. We have people trained before they go out. We are training the seniors. All of the managers have been out on a training course this year. We have built in specialist child protection staff and we are now in some offices developing specialist child protection teams. I think immediately of Noarlunga where there had been a problem and the development of a special team known as CARO has made a big difference. However, even then, the team officers are allowed to stay in the team for only two years because of the nature of the work and it is a way of protecting our staff. It is a problem that faces the whole of the world—it is certainly not an issue for South Australia alone. We try our hardest to support those officers who go into those difficult areas.

Mr HAMILTON: I noted with interest the booklet on strategies that was supplied to members of the Committee, in particular paragraph 5.4.3 on page 31—the objectives in relation to services for Aboriginal people. The Minister may recall that I raised the question of working with the Minister of Housing and Construction in relation to a matter in my electorate. More specifically, I raised the question of resourcing a pilot program. I might remind the Minister of some of the difficulties. The local constabulary, in conjunction with an Aboriginal worker, went amongst the community and tried to overcome a conflict in that area. One of the requests that was made to the Minister related to assistance for the Aboriginal homemaker scheme. I understand that the Minister of Housing and Construction was to have a discussion with the Minister in relation to this matter in terms of resources. Has any progress been made in that area?

The Hon. D.J. Hopgood: I understand that there have been officer level discussions, but I shall have to get information for the honourable member.

Mr OSWALD: My question relates to the Office of the Commissioner for the Ageing. Under what program is the Office of the Commissioner for the Ageing funded? What was the expenditure last year? What is the proposed expenditure for this year? How many staff are associated with the office?

Dr Graycar: In terms of the specific program, I can give the details later, but the staff component is 7.8 and the budget is about $250 000. I think I would rather take on notice the specific figures and supply them later.

Mr OSWALD: Does the Minister propose to appoint officers and/or to establish an administrative unit to support him in his role as Minister for the Aged, or does he intend that this function will be performed by the Office of the Commissioner for the Ageing? If the latter, has consideration been given to the impact that this arrangement may have on the independence of the Commissioner in his role as an advocate on behalf of older people as defined in the Commissioner for the Ageing Act 1984?

The Hon. D.J. Hopgood: I do not see any conflict here. The honourable member is correct in his assumption that there is no attempt to set up any alternative empire. Indeed, the advice that has always come to the Government through the Commissioner will continue to be the major source of advice in this area. This is by no means confined to this aspect of my portfolio; it is general throughout the Government. A number of agencies have responsibilities in respect of the aged. Earlier, in response to another question, I instanced the fact that the State Transport Authority is handling the arrangements for transport concessions which were announced not so long ago. I could quote examples of other agencies with specific responsibilities for older people just as they have for the youth in this community. The Commissioner's role is in relation to advice to me and, through me, to the Government in this area and also the advocacy role to which the honourable member referred. I do not see any conflict between that and his continued responsibility to the Government as the principal adviser in this area.

Mr OSWALD: As a supplementary to that, I go back to my original question. Does the Minister propose to appoint officers and/or to establish an administrative unit to support him in his role? Rephrasing that, has the Minister, for electoral consumption, tagged on this title of Minister for the Aged and, other than that, has no other role, staff or advisory personnel and will continue to use the Office of the Commissioner for the Ageing for advice, or does he intend to establish some administrative unit to go along with this new title which he has had added to his name?

The Hon. D.J. Hopgood: The Office of the Government Management Board is reviewing the structure under the Commissioner at present, and we will see what comes out of that. I repeat: I would not anticipate that there would be many more, if any, salaries outside the Commissioner's area that would be established. That is not to say that the assumption of the title on my part is for electoral consumption, which is what the honourable member mentioned. That betrays a state of mind which suggests that the only way in which one can give reality to a particular set of programs is by employing more public servants.

I would have thought that that is a mind set which many of us abandoned a long time ago. You can have a very, very important thrust in a particular area, such as the aged. I believe we have already had that as evidenced by the production of the support care and dignity document. You can do that using existing resources. You may be using them in a rather different sort of way. So, it is true that there is a review being undertaken of the structure through which the Commissioner advises me. That is not to be interpreted as setting up any sort of additional empire, and nor should that be interpreted as meaning the whole thing is simply some sort of facade. Judge us please not by the

number of people we employ to do the job, but by the services and policies that we develop and deliver.

Mr OSWALD: In relation to Ageline, which is due to start on 1 November this year, why is it being established in the Office of the Commissioner for the Ageing? What is the nature of the information to be collected for the data base that is there? Is it the Government's intention to provide comprehensive information, or will it act purely as a referral agency to agencies such as SACOTA? If referrals do go to SACOTA, what additional resources will be provided to such agencies to help them with the additional workload—that is, if Ageline acts purely as a referral agency? Finally, I notice that the document the Government put out on support and care and dignity for the aged provides a cost line of $85 000 for the aged. In actual fact, this is going to cover staff, desks and telephones.

However, going through the booklet one sees that there will be involvement in bed vacancy services, provision of information, accommodation services—and there is at least another half a dozen dot points. Can that be achieved out of $85 000, which is not very much? We would like a lot of information on Ageline: where it will be established, its nature, and whether it will be referring matters to SACOTA, which means that SACOTA will then have to have staff because Ageline will be suddenly pouring a lot of business its way. SACOTA would therefore need to be provided with extra resources. Can we be provided with a whole conceptual picture of what Ageline is all about?

The Hon. D.J. Hopgood: First of all, it will not be a purely referral service. It will provide a comprehensive information service. The two additional staff who will be taken on to provide the service obviously will be very busy people indeed. I believe that as they develop expertise they will be sufficient to be able to provide the service. With regard to the location of the service, I think it is very important that it be located in the Commissioner's office, firstly because of the back-up support that is available from the Commissioner's office, given that the calls to the Commissioner's office have steadily increased over the last three years from 176 calls in 1985-86 up to 1 197 in 1987-88. Also, because it seems to me that the Commissioner's office is both sufficiently independent of Government for it to perhaps win the confidence of the people who may be a little deterred if they felt they were ringing a Government agency in the actual sense of the word. At the same time, it is sufficiently close to the Government to be rather more authoritative in what it says about Government services than a fully private Government organisation such as SACOTA might be. Hence, the justification for it being located where it will be located.

Mr HAMILTON: On page 77 of the Program Estimates, I note under 1988-89, specific targets/objectives a reference to increased emergency financial assistance. Funding has been made available to assist domestic violence victims to re-establish themselves. Whilst I applaud that, it has been my experience in a number of cases that women in such circumstances have been tracked down by their former partner and have had to move on. I see that as a problem for the department. What other avenues are being explored?

Ms Vardon: The department over the past two years has increased its priority on domestic violence and all our officers now have a domestic violence contact officer. It is not a full-time position, but somebody who has the job as well as other jobs. We have also applied to the Commonwealth for additional funds via the Social Security Department for increased cash for some women incurring big expenses in needing to flee. The Commonwealth was not able to help, so we looked at our own budget to ascertain how we could increase the small allowances to individual families so that they could go interstate safely, with us picking up train fares rather than simply supporting them around a corner in a friend's house.

We were privileged to have the Emergency Housing Office come in with us and we work together to make substantial allocations to women in danger in order to make them safe or to put them into satisfactory accommodation. We know that there will always be women who will be tracked down. A code exists between women's organisations in various States. If a woman moves interstate, as much protection as possible is given to her. However, recently a women was tracked down to a shelter and the man broke into the shelter. The fact that he found the shelter was amazing. Everything was smashed, the police came but by then everyone was terrorised. We cannot do a lot under those circumstances. Those cases are rare and we make satisfactory arrangements on behalf of people in danger.

Mr HAMILTON: One of my constituents has a husband in gaol. He is threateninng all sorts of retaliatory action when he is released. All members would share my concern about protection of women and their families. I refer to page 79 and to 'Specific Targets/Objectives' wherein it refers to a new model for the recruitment and selection of prospective adoptive parents of Australian-born children being developed. Will the Minister elaborate and give us some idea of the direction in which the Government is heading?

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

Mr HAMILTON: On the same page under 'Issues/Trends' I note that there is continuing pressure to find placements, especially for six to 12 year olds with difficult behaviour, teenagers, children with multiple placement histories and those with intellectual and/or physical disabilities. Will the Minister provide information on the people who assist in terms of placement? I applaud such people for so doing. What assistance is provided by the department?

Ms Vardon: This has been one of the most difficult problems in our organisation. We have been pleased that the Catholic Family Services Agency is proposing with our funding to take on this group with a special program. It has had great success with a young lad who was unable to be tamed, for want of a better word, in any other placement.

This is an example of our very close working relationship with the non-government sector in the area of substitute care. This year's budget provides additional funds for the non-government sector to help in developing these placements. We look forward to making some progress this year. We have also had conversations with the Health Commission, and the Chairman of the Health Commission and I am going out to meet with a number of people to try to develop a health facility for these very self-destructive children who are very hard to place.

Mr BECKER: There is a growing alarm among voluntary agencies providing substitute care programs about the adequacy of Government grants to meet the current needs, to the degree that I understand some agencies are questioning whether they can continue to meet the growing shortfall between the value of the grant and the cost of the service. It is important to note in this context that DCW community cottages for children cost $116 000 per child per year, or about $2 230 per week, or $318 per day for an average of three children per cottage. This figure is more than most voluntary agencies receive for the entire range of their substitute care programs. What amount—and proportion—of early intervention foster care and residential care subprograms was allocated to voluntary agencies for substitute care programs last year? What is the allocation to each

agency this year? Does this figure represent an increase that not only reflects CPI adjustments but also current needs?

The Hon. D.J. Hopgood: We will have to take the majority of that question on notice. However, the new funding of $421 000 this financial year to the non-government sector will see the implementation of what we are calling a three-year plan. A major focus on substitute care in the past year has resulted in the development of a joint Government/non-government three year plan to upgrade the quality of service provision, the quality of practice and the consolidation of services within the non-government sector. In total, we are talking about a figure of $2.149 million allocated for the funding of substitute care services in the non-government sector for 1989-90. This provides for a 6 per cent inflationary allowance on the 1988-89 allocation, other than the 1988-89 carryover funds, plus a further $421 000 in expansion funds through the social justice budget. We see this as a very important area and we are trying, as resources permit, to make a greater commitment.

Mr BECKER: What positive action is being taken to reduce the cost of residential secure care and residential non-secure care? Page 46 of the Auditor-General's Report refers to the provision of residential secure care. The cost per average occupant of the South Australian Youth Training Centre is $130 968 per annum; $2 518 per week; or $359 per day for 1989. The average occupancy was 32 persons; the capacity is 80 and the staffing 103. For the year 1988, there were 119 staff members; the capacity was still 80 and the average occupancy was 31. However, the cost was $135 806 per person per annum; $2 611 per week; or $373 daily. Regarding the South Australian Youth Remand and Assessment Centre, for the year ended 30 June 1989, there were 61 staff members; the average occupancy was 13, and the cost per person was $171 076 per annum; $3 289 per week; or $469 per day. That is compared with the previous year, when the costs were $115 428 per annum per person; $2 219 per week; or $317 per day.

In relation to the provision of residential non-secure care, in 1989 it cost $65 092 per person per annum; $1 251 per week; or $178 per day as compared with 1988, when the cost was $66 367 per annum per person; $1 276 per week; or $182 per day. In 1987, the cost was $60 019 per year per person or $1 154 per week or $164 per day. Those figures reveal that a frightening cost level is written in. The difficulty is that you must provide a certain amount of staff, particularly in the secure care area, to look after the various places, and there has been a slight drop in the cost of the youth training centre by about $5 000 per year per person or about $100 per week. However, in the youth remand and assessment centre, that cost grew by about $56 000 per person for the year. That is why I ask: what positive action has been taken, or is it possible to reduce or maintain the cost, or is there some other alternative system that we can look at?

The Hon. D.J. Hopgood: The problems we face in this area are not dissimilar from the problems faced in the Department of Correctional Services. As I recall, Mr Chairman, when you occupied the interesting dual position of Minister of Correctional Services and Minister of Tourism, you were rather fond of quoting the cost of keeping a person in Yatala on the one hand and keeping a person in the Hilton on the other hand. The difference is that we build a fence to keep people inside Yatala. I guess you would want to build a fence to keep some people outside the Hilton.

As soon as there are security problems, obviously there are considerable problems relating to cost. We are looking at reducing the number of young people admitted to secure care by providing more effective and less costly supervised care in the community—for example, intensive neighbourhood care—and to providing high quality secure care and a broad range of programs to maximise the development of personal, social and technical skills of the young people detained. The construction of new secure facilities will ultimately resolve at least part of this problem. Certainly, keeping young people out of these institutions is better, both from a budgetary point of view as well as for their own personal well-being.

The honourable member quoted some figures relating to the differences in the annual daily average occupancy rate. The figures qoted for SAYRAC reflected a dramatic reduction in the annual daily average occupancy of 33 per cent, whereas SAYTC had a slight increase of 9.7 per cent compared with the previous year. SAYTC had a significant reduction in the average cost per day from $411.80 to $371.71, and that was derived from two factors: an increase of two children per day at the centre; and a real reduction in DCW expenditure between the two years resulting from the benefits of restructuring residential units in 1987-88 and redirecting funds. Conversely, SAYRAC had a major increase in the average cost per child per day from $312.55 to $477.71, mainly due to the reduction I have already indicated in the average occupancy in the centre by seven children per day between the two years.

However, there was also a real reduction in net DCW expenditure due to less pressure on staffing numbers and overtime payments resulting from lower resident occupancy. We do look eventually to the construction of new secure centres which will have some impact on these costs in a way we would regard as ideal or desirable, and that is that the centres continue to operate at the reduced staffing levels implemented in the 1984-85 financial year as a result of what became known as the Cossey Report. But for that, the figures which the honourable member was quoted and which I have quoted would be higher still.

Mr BECKER: There has been talk for some years of selling off some land occupied by the training centre and the remand and assessment centre and new facilities being built. How close are we to plans being established for those centres?

Ms Vardon: We are very pleased to report that we think we have a block of land. It is still, of course, subject to Cabinet approval and a whole lot of other things. It does not have any neighbours, and we know that SACON is ready to start. A significant amount of money has been set aside this year in the capital budget for our organisation, and we are hoping to turn the sod and get going this year.

Mr BECKER: In respect of the Program Estimates (page 79) 'Early intervention and substitute care', Liberal members are aware of numerous complaints by 18-year-olds wishing to lodge a veto but they have been grilled and/or intimidated by DCW staff. These are some of the allegations that have been made to other members of the Party. These young people say that this has happened when all they wished to do was register or sign a form indicating their desire for no contact.

What steps is the department implementing to ensure that administrative procedures reflect the spirit of the legislation and are not oriented overtly towards the values of those charged with this administration? Can vetoes be lodged by mail and, if not, will the Minister consider the merits of implementing such a practice in circumstances where verification of identity is proven and the individual confirms that he or she has understood the implications of their actions, and would a statutory declaration be satisfactory?

Ms Vardon: I have spoken with the honourable member and a number of his constituents and others who have been

concerned about this. I was concerned to think that our staff might be intimidating people. I did not believe it because the adoptions people are usually very nice, but I went out the next day and spoke with the adoptions people. I then directed—and they are now doing this—that there will be no grilling or questioning of anyone who comes in for a veto form. In fact, one woman, well-known to the honourable member, has been in now three times collecting handfuls of forms, uninhibited and unhindered.

The difficult end of this spectrum, of course, is making sure of the identity of the person who puts in the veto. The process we have developed is that a person should come in individually and speak with a social worker and prove that they are the person indentified in the form. We think there could well be people who want to put vetoes down on other people's behalf, without the other person knowing their rights and responsibilities. I would have to take away the suggestion of a statutory declaration. We would certainly have to get Crown advice. We would only do it legally. We would not impose our own value system on it. We have to do it within the spirit of the legislation.

If the Crown were sure that a statutory declaration was sufficient to identify a person under this legislation, we would consider it. I have to keep an open mind on that, but there is an important counselling side to it to make sure the person actually knows their rights under the legislation, because some of our people believe that not everybody has been told of their rights. However, certainly, following your representations, I did immediately go out and speak to the staff about their attitude and the telephone conversation. They assured me that, if they had come across the wrong way, it was unintended. I told them that certain throw-away lines were no longer acceptable, for example, 'Be grateful you don't live in Victoria', and so on. They are not to say that any more. They also talked about being harassed and intimidated. I said, 'Well, all bets are off. We are going to be very nice to everybody'. I understand that that is now the situation.

Mr HAMILTON: I offer my comments on page 79. As regards the 1989-90 specific targets and objectives, it is stated that a new model for the recruitment and selection of prospective adoptive parents of Australian-born children will be developed. Can the Minister elaborate on that? Specifically, what are the problem areas? Will he explain why we are looking for a new model?

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

Mr HAMILTON: In terms of adolescents at risk, can the Minister advise what intervention programs and services will be made available for young women in particular who are at risk in that area?

Ms Vardon: One of the reasons why we established the Adolescents at Risk program was that when I joined the department it was clear that most of the dollars were going to young male adolescents who were locked up or were in trouble before the courts and that young women, who had had an equally disturbed life, were not getting assistance. Therefore, we carved out from the offender program a special adolescents support or at risk program targeted on young men and women who were behaviourally self-destructive, and in that category there tend to be more women.

We have a number of adolescent support teams. The staff run groups for young girls who are at risk. They get them employment, they look after them, they provide them with alternatives, they counsel them, and so on. We also have an intensive adolescent support scheme, of which we spoke earlier. We train volunteers to befriend adolescents, and often they are girls. We also support a non-government program in Murray Bridge, which is like a big sister program. A number of women there look after the girls who are at risk. That is working well. We are trying to promote those programs throughout South Australia.

Mr OSWALD: My question relates to specialist protection services. The Cooper report noted that 60 per cent of workers involved in the study of the care of children of under age parents did not have professional qualifications and that this imbalance had obvious implications for the level of service provided to clients. How many senior community welfare workers have qualifications at a level which would admit them to membership of the Australian Association of Social Workers? What is this number as a percentage of all community welfare social workers? Following on from that, what is the Government's policy on the recruitment of social workers with minimum qualifications recognised by the AASW?

Ms Vardon: It is not correct to assume that the figures in the Cooper report reflect the figures of the department. The Cooper report, which is an important report, looked at a sample of workers. The sample was taken in the country and there we have the greatest difficulty in recruiting. The percentage quoted by the honourable member relates to country workers and a few others in the city.

The qualification level for the department is different from that. I shall have to take a lot of this on notice. We have the figures, but I do not have them to hand. Membership of the AASW is not a requirement for any position in our organisation. I can actually give the figures. The number of people with no social work qualifications, and that includes many of our residential care workers, for whom social work qualifications are not required, is 247, including 94 in the field. Those with the associate diploma number 160, and those with a social work degree number 126. That is out of a total number of 533 social workers in the department, of whom 170 are in residential care. There are 363 community welfare workers. Those with a social work degree number 120 over 363. I have a table which can be incorporated into the record if required.

SWO-1 QUALIFICATIONS

	No SW Quals.	(% of total RCW)	Ass. Dip.	(% of total RCW)	SW Degree	(% of total RCW)	Total
Resi Care Workers	153	(90)	11	(6.5)	6	(3.5)	170
	No SW Quals.	(% of total CWW)	Ass. dip.	(% of total CWW)	SW Degree	(% of total CWW)	Total
Community Welfare Workers and group Workers	94	(25.9)	149	(41)	120	(33.1)	363
Total	247		160		126		533

With regard to specialist child protection services, I note that under the heading 'Issues Trends' the child protection notification levels have levelled off, as predicted but that demands on services have increased due to matters in court becoming more complex and demanding more worker time. In the light of the reference to demand on services increasing, will the Minister explain: first, why actual employment in terms of full-time equivalent in 1988-89 was 125.9 or 6.2 less than the proposed complement of 132.1 and remains at 125.9 in the current year. Secondly, why the Government appears to have cut funds to this program this year by failing to make real adjustment for a 7 per cent CPI increase with funds increasing by only 2.7 per cent over actual expenditure last year, but only 0.97 per cent over the proposed expenditure of last year?

The Hon. D.J. Hopgood: Again, I am afraid I will have to sing a song I have sung on a number of occasions today, and that is, of course, that DCW is in exactly the same position as the Health Commission is in that the inflation of salary and wage costs is taken from the round sum allowances. So, it is hardly surprising that it is not reflected in these figures.

Mr Boxhall: In response, I indicate the delight of all the financial and accounting people that over four FTEs last financial year were incorrectly debited to the child protection program. So, in fact, the reduction is only a minor one of 1.4, I think FTEs, which is just a reflection of the way that programs have been reapportioned over the new program from this year. There is only a very minor reduction in child protection; the other was that particular workers were designated for accounting purposes as doing child protection work only in field locations, when in fact they were spread over a range of field services.

Mr OSWALD: In relation to page 81, under 'Offenders services': following the Cabinet's decision in May to overturn an earlier approval to establish a secure care unit at Gilles Plains to accommodate 36 juvenile offenders, what alternative sites are being considered? Is Northfield the preferred site, as I note that Northfield Secure Centre is the name given to the proposed project for in the capital works program 1989-90. Flowing from this, to enable commencement in March 1990 and the completion within the current estimated total cost of $10.7 million, when will Cabinet make a decision and what other new secure centres are proposed, in which locations, and at what cost?

The Hon. D.J. Hopgood: The reference to a Northfield centre is historic. Obviously it was necessary to designate it in some way and that is the way it has always been designated. It is still so designated, notwithstanding that it has been made perfectly clear by me and the Premier that the site originally favoured has been abandoned. A large number of possibilities are now being canvassed. I do not have specific information for the honourable member or the Committee, because all this would have to be seen as tentative in the extreme. Nor can I at this stage anticipate or forecast when it will be possible to sift through the many possibilities and come to a short list. However, I am personally committed to as early a start on this project as possible.

Having had a chance to examine the secure facilities we have at present, having been concerned about some aspects of those facilities (although, of course, everything is done to try to ensure that the work of the staff can be made as effective as possible), and having considered the ideas that the member for Hanson and I have been bandying around in relation to the cost of maintaining such facilities, I am keen to proceed as soon as possible. However, the experience of the past two years has indicated that the identification of a site or sites for such facilities is a complex matter and I would rather get it right, even though it may take a little longer, than to again rush into a decision which may be overturned at a later time.

Mr HAMILTON: I refer to page 63 under the heading 'Welfare Services for Specific Groups'. I notice services to people with disabilities. For 1988-89, the proposed full-time equivalents was 41.4 but actual was 27.5. Will the Minister explain? It seems a dramatic drop. There must be an obvious reason for such a dramatic reduction in full-time equivalents.

The Hon. D.J. Hopgood: That almost certainly means that the program has been split between two areas at this time. Mr Boxhall will provide an answer.

Mr Boxhall: The bulk of that line has been included under the community residential care subprogram of support to adolescents and their families, because it is predominantly a residential care service. It has been grouped with like functions. The remaining component is under support services, which represents grants for disability advocacy groups.

Mr HAMILTON: On page 76, I note under 'Issues/Trends' that the number of incoming telephone calls for Crisis Care increased by 17 per cent in 1988-89 whilst there was a small drop in the number of callouts. Will the Minister give some details on the number of calls to the Crisis Care service? How effective is it in handling this very important service?

The Hon. D.J. Hopgood: In 1988-89, the Crisis Care Unit received approximately 61 200 telephone calls—an increase of some 9 per cent over the 1987-88 figure. In addition, Crisis Care workers attended 2 373 crises within the community. Whilst this is a decrease of 4 per cent when compared with the 1987-88 figure, quarterly data figures indicate the decrease in call-outs occurred in the July-December months and that the January-March quarter was one of the busiest three month periods in the unit's history. Staff from the unit have continued to work very closely with a broad range of Government and non-government agencies, to ensure there is an excellent after-hours service for callers. It has coordination with the Ethnic Affairs Commission. Volunteers from the Vietnam Veterans are available to cowork with Crisic Care staff when appropriate.

Unit staff with police at a variety of levels. Unit staff have almost daily contact with metropolitan shelters with regards to vacancies, referrals, after-hours contact and Crisis Care provides the only after-hours social work service for people with psychiatric problems. Unit staff provide the major input into training for the new Upper Spencer Gulf Crisis Response Teams in Port Augusta. A number of their volunteer staff have done observation shifts at Crisis Care. Quite obviously, this is meeting a need in the community and it will continue to do so.

Mr HAMILTON: It is stated in the Program Estimates that crisis services for the aged and people with psychiatric illnesses will be reviewed and upgraded. Can the Minister elaborate on this point?

The Hon. D.J. Hopgood: In view of the time, I will take that question on notice.

Mr OSWALD: I refer to page 72 of the Program Estimates—'Building community support'. One of the broad objectives or goals of this program is to promote the services of the Department for Community Welfare. I trust therefore, that Mr Jeremy Cordeaux's media consultancy is funded from this program. Did the department, earlier this year, advertise for tenders for departmental public relations work? If so, how many responses were received? Did the department make any decisions to appoint any public relations

company following these tenders calls and, if so, which company did it appoint; and, if not, why not? Did Mr Cordeaux submit a proposal to the original tender call, and was the decision to appoint Mr Cordeaux made by the department or on recommendation from the Premier's Department?

Ms Vardon: Some time ago, when Rosemary Wighton was leaving, a request was made throughout the public relations industry for people to present propositions to the department. It was clear that the estimates coming in were far outside any funds available to the department. As a result, we discarded the notion of an external public relations firm working on behalf of the department, and we decided to concentrate on primary tasks; that is, how we could advise people in the community of our services. We were concerned, as are all welfare agencies, that we are often in the position of having our hands tied behind our back when any public debate or issue is raised on radio or television, because we cannot present the other side of the story in a particular case.

We did a number of things: we decided that we would improve our publications. Our publications were many and varied in their themes and we thought that we should bring them together. We advertised and let a contract to an agency that does a lot of work for the Government. It was a fairly small contract and we were able to get a consultant provided by the Government Management Board—Professor David Corkingdale and his offsider, Mr Tony Sporton, both senior teachers of marketing at the Elton Mayo School of Management—to help us with our internal strategy to improve our public communications. Both Professor Corkingdale and Mr Sporton are still working with us. Our weakest area was in the understanding of the media, particularly radio and television.

I spoke with Mr Jeremy Cordeaux—as I spoke to a number of people—as he had a private consultancy firm that provided media advice. We were very clear that we wanted him and his advice because of his knowledge and contacts in the radio and television fields. I then consulted Commissioner's Circular No. 9 and I spoke with a number of important people in Government—those who make the decisions in these matters—and it was clear that to hire someone for a short-term contract—someone specifically identified as a talk-back radio host—it would be inappropriate to go to public tender; that this was not within the requirements of the Commissioner's Circular; and that I was able to put Mr Cordeaux on, so long as the Government was satisfied (and I found this to be so).

He was hired as himself, for his knowledge and talk back experience. We had heard earlier that many customers of DCW were listeners of 5DN, so we particularly targeted that radio station on the best advice we had. We hired him as part of a 10 point strategy across an area, and it was perfectly proper and within the appropriate guidelines of the Government.

Mr OSWALD: As a supplementary question, on 4 August in the *News*, a spokesman for the Minister is quoted as saying that Mr Cordeaux's appointment was 'all above board and in line with normal practice'. In the same article, Mr Cordeaux states that he had no formal written contract with the department, only a verbal agreement that he would receive $12 500 per year. Is it normal practice for the Department for Community Welfare to engage consultants such as Mr Cordeaux without entering into a written contract; and what are the terms and conditions, if any, of Mr Cordeaux's appointment, including the fee to be paid?

Ms Vardon: Mr Cordeaux received a letter from the department very clearly outlining our expectations of the appointment. I do not have the letter with me but some of the specific things included in that letter were that we wanted advice on how better to present our services to the public through the media; how to improve the presentation of information to key journalists in their understanding of the department's services and programs; how to ensure that the language and style of the department in the media would be appropriate to the messages it wished to convey; and we required him to provide media skills training to our staff, most of which he has now done.

Mr OSWALD: Why was there not a contract?

Ms Vardon: There was a letter of agreement.

Mr OSWALD: Relating to individual and family protection under SAAP and superannuation, I understand that the department has issued an instruction to all recipients of SAAP funds that provision must be made for the 30 per cent productivity contribution to superannuation by all shelter workers. Is this correct? If so, has provision been made in SAAP funding allocations to each shelter for funding to cover the 3 per cent contribution, or must the 3 per cent be found from within existing funds, thereby requiring the shelter to curtail existing programs?

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

Mr Bicknell: If it is appropriate, I will provide a detailed written response to that question.

Mr HAMILTON: The Minister can take this question on notice. Referring to Home and Community Care funding, has the State matched all available Commonwealth funds for 1989-90, and in which areas will those funds be directed?

The Hon. D.J. Hopgood: I will ask Mr Bob Leahy to briefly respond to that question.

Mr Leahy: The answer is 'Yes'. We are one of the few States picking up the full 20 per cent increase for which the HACC agreement provides. Most other States have a maximum of 15 per cent. The 20 per cent will give us a shade over $5 million of expansion funds for 1989-90. The $3 million which will be available on top of the indexation of existing projects will be provided to three basic areas which are currently being negotiated with the Commonwealth, the first of which is the Ageline about which questions have been asked in this place earlier.

The other two areas include the proposal to strengthen the domiciliary care services which have been under quite considerable pressure in the past two years. Members may know that the review, carried out by Dr Anna Yateman, has just about been completed. That review has indicated a number of areas where additional funding was required and the new HACC funds will involve the provision of additional services in that area.

The third initiative will be in the home maintenance and support area. The Commonwealth and State Governments are currently looking at a proposal to develop a package of services to assist the older people who are living at home and who are rather anxious about living alone or are fearful or anxious about their security. That program is currently being developed in conjunction with the State Government's crime prevention strategy and HACC funds.

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

ADJOURNMENT

At 10.1 p.m. the Committee adjourned until Thursday 14 September at 11 a.m.