HOUSE OF ASSEMBLY

Wednesday 12 September 1990

ESTIMATES COMMITTEE A

Chairman:
Mr M.J. Evans

Members:
Dr M.H. Armitage
Mr D.M. Ferguson
Mr P. Holloway
Mrs C.F. Hutchison
Mrs D.C. Kotz
Mr J.K.G. Oswald

The Committee met at 11 a.m.

The CHAIRMAN: Any changes to the composition of the Committee will be notified as and when they occur. Members should submit that documentation to the table. If the Minister wishes to present any written information to *Hansard* it should be provided, if at all possible, no later than Friday 28 September to enable it to be incorporated in the normal timetable, of which I know the Minister is personally well aware. I will allow the Minister and the lead speaker for the Opposition to make an opening statement of about 10 minutes, if either or both of them should desire. The approach on questions will be flexible; it will normally be three questions per member looking from right to left. Brief supplementaries which follow the line of questioning will be allowed at the discretion of the Chair, but I ask members to keep them as brief as possible.

Standing Orders have been amended to allow members of the Estimates Committees to ask for explanations on matters relating to the Estimates of Receipts as well as the Estimates of Payments, and it is my intention to draw members' attention, each time we come to a new line, to the relevant pages in both documents. I ask members to draw attention to the actual program or the relevant document when they begin their questioning so that it can be referred to by the Minister and his advisers and by the Chair and other members. I now invite the Minister to make his statement and introduce his advisers.

The Hon. D.J. Hopgood: We are here to be inspirational and erudite, but also to provide to the Parliament and this Committee as much information as we can. Therefore, we will endeavour to keep our answers as brief as possible to maximise the number of questions that can be asked. I draw members' attention to the blue covered book 'Information Supporting 1990-91 Estimates', which I think all members received about a week ago. I point out that from the figures in that book the Government has allocated $1.152 billion as the gross expenditure budget of the commission for this financial year. This represents an increase of $41 million or 3.7 per cent on the 1989-90 actual expenditure of $1.111 billion. However, this $41 million will be increased during the next 12 months to take account of salary and wage increases during the year. This is something that is sometimes misunderstood.

The recently departed Mr Martin Cameron never seemed to quite understand that it was not altogether legitimate to compare the expenditure in one year with the budgeted expenditure in the following year. Of course, that is to put the budget in the worst possible light, just as doing the opposite would be to put it in the best possible light. That does not take into account the amount put into the round sum allowances to allow for movements for CPI, and so on, in wages and salaries during the year. We do not know what they will be in this coming year, but, by way of comparison, the additional increases during last year, which were fully funded, accounted for an extra $51 million. If such increases were to occur this year, the final gross expenditure level would represent an 8.3 per cent increase, which is modestly ahead of inflation. Despite the relative generosity with which I and my instrumentality have been treated by the Treasury in what otherwise has been a fairly grim budgetary situation, we have nonetheless had to fund new initiatives almost overwhelmingly by reallocation, and no doubt some of that will be canvassed during the progress of the Committee.

Turning to capital works, the commission has program works valued at $58.5 million for 1990-91. That is considerably less than the $71.3 million expended last year, but it is still significantly higher than any year in the past decade. Details of the program are provided in the papers. I should like to place before the Committee an outline of the commission's plans for practical and achievable responses for the foreseeable health needs of the people of this State, and that is in the form of a document entitled 'Planning for the Health of South Australians'. It is the commission's initial statement of goal strategies and targets in four main areas. These are available. It covers improved service delivery, increased effort in the prevention of illness, improved management of the health services and increased effort in research. I have arranged for members to get early copies of the document today, although they will not be available to the health system for a couple of weeks. The commission changes its strategies as circumstances change and as it receives feedback from health units and other agencies. In the meantime, individual health units will be asked to prepare and review their own strategic plans in the light of the commission's plan.

South Australian Health Commission, $1 009 042 000

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

Departmental Advisers:

Dr W.T. McCoy, Chairman, South Australian Health Commission.

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

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

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

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

Ms C. Gaston, Director, Nursing Branch.

Ms C. Johnson, Executive Director, Community Health Services.

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

Mr P. Case, Executive Director, Human Resources.

The CHAIRMAN: I declare the proposed payments open for examination and refer members to pages 29 to 34 in the Estimates of Payment, page 27 in the Estimates of Receipts and pages 32 to 52 in the Program Estimates. This

is a large single line because of the nature of the commission. While this line is open, any member may direct a question to any point in the whole ambit of that coverage. I am sure it would assist everyone if members could group their questions according to the programs or function of the persons who are advising the Minister, but naturally the Chair would not disallow any other question at any other time. It is for the convenience of the Committee that I make that suggestion.

Dr ARMITAGE: In relation to line 2, Central Office, on page 19 of the blue book, what justification is there for the continued expenditure on rental payments for floors 1 to 7 at 160 Rundle Mall, which is the site of the previous Central Office of the South Australian Health Commission which has been completely vacant for one year and on which the SAHC has been paying full rental from that time with still 2 ½ years of the lease to run?

What annual rental is the South Australian Health Commission paying for the seven storeys in prime central business district accommodation which it is not using? Does the Minister believe this is optimal use of Health Commission funds, and at what cost to the taxpayers might arrangements be made to get out of this lease?

Mr Davidge: The Health Commission has, during the past six months of this financial year, concluded an arrangement with Sacon with regard to paying out our residual obligations under that lease. An amount of $640 000 was paid in 1989-90, and from that point onwards the Health Commission has no further rental obligations under that lease for the State Bank building. The amount that would be saved on the annual rentals of that property was about $330 000 per annum.

Dr ARMITAGE: When was the payment of $640 000 made?

Mr Davidge: The payment of $640 000 was made to Sacon by the Health Commission in May or June of 1990.

Dr ARMITAGE: That was one year after the Health Commission had moved out.

Mr Davidge: That is correct.

Dr ARMITAGE: In fact, rental was paid for a year, and then $640 000, which is two years' rental, was paid, to take the commission through to the end of the lease. In other words, the Health Commission paid rental on the building for three years without using it; is that correct?

Mr Davidge: Yes, that would be correct. The $640 000 was a calculation based on present value of the remaining obligations under the lease.

Dr ARMITAGE: In other words, the lease was paid out. At the time the lease was paid out, I understand there were approximately 2½ years of the lease to run, and about two years' rental was paid out. That means that three years' rental was paid whilst the building has been completely vacant; is that correct?

Mr Davidge: Yes.

Dr ARMITAGE: What are the specific components of the AIDS program, page 17 of the blue book, and will those components be affected by a 20 per cent decrease in the preliminary budget allocation? What money has been allocated to the sharps disposal scheme in hospitals or health agencies under the control of the South Australian Health Commission, and in what hospitals or health agencies do these schemes run? It is indicated on page 24 that the administrative expenses for the AIDS program are $614 952, being 58 per cent of the total gross payments for the AIDS program. Can the Minister supply a breakdown of those administrative expenses?

The Hon. D.J. Hopgood: I will ask Dr Blaikie and Dr Kirke to address themselves to the detail.

Dr Kirke: I will address the first question, that is, the distribution of the AIDS moneys proposed. It should be made clear at the outset that $260 000 is provided through the Education budget and $210 000 through the Correctional Services budget for HIV measures in prisons, leaving a total of just over $2 million, which is divided up into treatment, counselling and education services. That is broken up as follows: STD clinic at North Terrace, $500 000; IMVS for HIV testing, $570 000; hospice care of terminal AIDS patients, $60 000; community support for the Royal District Nursing Society, $75 000; harm minimisation needle exchange programs, run by the Drug and Alcohol Services Council, $100 000; and the AIDS Council of South Australia, $430 000. That $430 000 is divided up according to a Commonwealth Government formula between the secretariat, education programs for gay and bisexual men, sex industry workers and IV drug users, and community support and counselling for HIV positive persons.

The Aboriginal Health Organisation and the Aboriginal Medical Service are allocated $70 000 for Aboriginal education programs and AIDS prevention. The Port Adelaide Community Health Service receives $40 000 for AIDS work among recently arrived migrants. The Family Planning Association gets $40 000, and the Youth Sector Training Council receives $50 000. The Haemophiliac Society receives $27 000, and $100 000 is allocated for HIV study grants. That is the matched funding. There are two other lots of funding coming to the State for AIDS matters, namely, the Medicare incentive payments and the Red Cross Blood Transfusion Service funding.

Dr Blaikie: Dr Kirke outlined some of the details of the AIDS matched funding program. I remind the Committee that the AIDS funds to South Australia come in three categories. There is the national AIDS program, which is primarily a Commonwealth responsibility, and the matched funding program, which Dr Kirke has just outlined. In addition, we have the AIDS Medicare funding, which is provided to the State under the Medicare agreement. Those funds are specifically for, and all other funds preclude, the treatment of AIDS patients in hospitals.

I inform the Committee that South Australia's share under the AIDS Medicare funding is $1.417 million. The division has not settled totally the allocation of AIDS funding to the hospitals this year because it is dependent on two things: the number of AIDS cases at particular hospitals and the testing of AIDS cases at hospitals by the IMVS. In notional terms, a figure of $524 000 has been allocated to the four major hospitals, that is the Flinders Medical Centre, the Royal Adelaide Hospital, the Queen Elizabeth Hospital and the Adelaide Children's Hospital, for AZT for the treatment of AIDS patients and, in addition to that, a further $893 000 has been allocated to those three hospitals for the general treatment of AIDS patients.

The Commonwealth, when allocating these funds, makes it very clear that it is not an allocation to cover the full cost of treatment of AIDS patients in hospitals, but a contribution towards those costs. That money can, of course, be used for the disposal of sharps, but the disposal of sharps is just one of many occupational health issues in the hospital system. Funds have in the past been allocated under occupational, health and safety provisions and they have also been allocated under waste management provisions. Hospitals have global budgets. They have funds from different sources which they allocate towards the disposal of sharps, according to the needs of particular hospitals.

Dr ARMITAGE: I also asked in what hospitals or health agencies under the control of the South Australian Health Commission do recognised sharps disposal schemes operate.

Dr Blaikie: In every hospital in the State, it is of course a requirement under the Occupational Health, Safety and Welfare Act, under which chief executive officers are held responsible, that a safe system of work be provided, so the answer is that it applies in all recognised hospitals in this State, to my knowledge.

Dr ARMITAGE: I further asked what was the exact breakdown of administrative expenses for the AIDS program, as indicated on page 24, involving $614 952, or 58 per cent of the total payments under that program.

The Hon. D.J. Hopgood: I understand that we will have to get that information for the Committee. If we can do that before the close of business today, we will do so.

Dr ARMITAGE: I now have a question which the Minister may wish to take on notice. On page 93 of 'The Budget and its Impact on Women' it is indicated that the South Australian Health Commission has nine central line office management committees and 52 advisory or consultative interdepartmental committees. I would like to ascertain the title of each committee; the names of committee members; the function of the committee; the date on which it was formed; the amount of membership fees, if any, and where they are paid; the budgeted cost of servicing the committee; and how often the committee meets.

The Hon. D.J. Hopgood: I am advised that we have a good deal of that information here, but it would probably be better for the Committee's functioning if we took it on notice.

Mrs HUTCHISON: My first question relates to page 39 of the Program Estimates, involving 1989-90 target/objectives and the training of community based workers in drug and alcohol related issues. How much of that training has been done for workers outside the metropolitan area, that is in country communities; if such training has been carried out, where; and how successful has that been to date? Given the 1990-91 specific objectives to provide 'increased emphasis on prevention/early intervention', what is planned as training for country community providers of this service in the coming year?

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

Membership:

Mr Quirke substituted for Mr Ferguson.

Mrs HUTCHISON: My second question also relates to page 39 of the Program Estimates concerning specific targets and objectives. What evaluation, if any, has been done on the success or otherwise of the sobering-up centre in Port Augusta? I am aware that it has been operating for only approximately ten months, but I would appreciate any advice which the Minister can give on its performance to date.

The Hon. D.J. Hopgood: I will ask Ray Blight to respond to that. I can understand the honourable member's interest in that matter; I recall the day when I officially declared it open and it has been interesting to see how it has gone.

Mr Blight: I cannot provide formal results of the evaluation of this service; the best I can do is to give the Committee some anecdotal feedback about not only the centre at Port Augusta but also the other sobering-up centres at Ceduna. They are generally regarded by the health service, which is responsible for their operation, as very successful. There has been a high level of utilisation in terms of basic care such as food, shelter and clothing that is provided.

At this stage—and we should recognise that the program is in its very early days—there is a high level of 'repeat business'. We hope that as time goes by the counselling services will be more effective and that therefore there will be some changes in the pattern of drinking behaviour of the current clients. The centres seem to be fulfilling very well the purpose for which they were set up. In due course I expect them to provide a more detailed evaluation of their operations.

Mrs HUTCHISON: I refer to page 44 of the Program Estimates, concerning services for women: what is the current status of the South Australian mammography screening program conducted by the South Australian Breast X-Ray Service?

The Hon. D.J. Hopgood: This survey was formally commenced in 1989, and since that time over 11 000 South Australian women between the ages of 50 and 64 have been screened with nearly 100 breast cancers being detected in the early stages of development. That detection rate of nine per 1 000 women screened is roughly on a par with overseas screening programs. Over three-quarters of these cancers have been found at a very early stage when there is a fair chance of a complete cure with simple treatment.

I am advised that overseas trials have shown that, provided mammography screening is of the highest possible standard and properly controlled, it can cut deaths of elderly women by at least 30 per cent. I know that the honourable member is particularly interested in access to this service by country women. A mobile service is currently being developed which will have the capacity to conduct 10 000 screenings annually, and that service should be commissioned by April of next year.

Mr OSWALD: Page 44 of the Program Estimates under the heading '1990-91 Specific Targets/Objectives' provides for the 'Establishment of Conjoint Gynaecological Service at RAH and Adelaide Medical Centre for Women and Children'. Will the Minister provide a specific explanation of this line and say when approval for an amalgamation budget will be forthcoming?

Dr Blaikie: The first part of the honourable member's question related to the formation of a conjoint gynaecological service: the amalgamation of the Queen Victoria and Adelaide Children's Hospitals has already occurred in a legal sense, the two hospitals of course being situated on different sites. Once the Queen Victoria Hospital shifts to the Adelaide Children's Hospital site, the commission, the clinicians and the representatives of both hospitals are keen, of course, to ensure that the most effective gynaecological service is provided.

At present, gynaecology services are split between the Queen Victoria Hospital and the Royal Adelaide Hospital and, in keeping with our desire to have coordination and cooperation, we commissioned Professor Rodney Shearman to review the most appropriate way of providing comprehensive gynaecological services for women in South Australia. Professor Shearman, who is Professor of Obstetrics and Gynaecology at the University of Sydney, has submitted a report which is still being discussed by both hospitals and the South Australian Health Commission.

In his report Professor Shearman recommends an expansion of inpatient gynaecological beds at the Royal Adelaide Hospital to meet the needs of women with cancers and complicated gynaecological procedures. Those procedures are currently carried out at the Royal Adelaide Hospital. Professor Shearman also recommends that outpatient services at the Royal Adelaide Hospital be limited only to multidisciplinary gynaecological procedure, that is, the more complex gynaecological procedures that require the full range of specialists at the Royal Adelaide Hospital. He further recommends that outpatient services, by and large, be met at the new Queen Victoria Hospital building at the Adelaide

Children's Hospital site and that almost all day surgery services occur there.

So that is what we are talking about: resolution of these issues and further examination of Professor Shearman's recommendations with regard to a conjoint gynaecological service. The second question related to the budget for amalgamation. Does the honourable member mean the capital budget? The two hospitals have budgets now in a recurrent sense. The capital budget for amalgamation I presume will be decided once a full brief has been submitted to Cabinet but perhaps the Minister might like to answer that.

The Hon. D.J. Hopgood: That is my understanding as well. We are not quite into the capital lines yet so, if I can crave your indulgence, Mr Chairman, I will simply say that we must accept that it is a process that will be staged over a number of financial years. We would obviously be keen to get the two campuses together as soon as possible. However, I would not want to set aside other, often urgently required, capital projects in order to get this together quicker than the budget can sustain. It will depend a little on how our capital budget goes in the next couple of financial years.

Mr OSWALD: As a supplementary question, are there any plans for terminations at both hospitals?

Dr Blaikie: The Queen Victoria Hospital, of course, currently performs terminations.

Mr OSWALD: And at the Royal Adelaide Hospital?

Dr Blaikie: Terminations currently occur at the Royal Adelaide Hospital. The matter of terminations at the new medical centre will really be a matter for its board of directors.

Mr OSWALD: I refer to 'Major Resource Variations—1989-90 to 1990-91' on page 46 of the white book under the program title 'Specialist and General Hospital and Associated Services'. One of the main components of this variation is the Red Cross Blood Transfusion Service (hepatitis C) and hospital initiatives. Can the Minister explain how this is a main component of the variation given that on page 11 of the blue book a preliminary budget allocation for the Red Cross Blood Transfusion Service indicated an increase of 10 per cent last year, which is $600 000 out of a total of $71 million for associated services?

The Hon. D.J. Hopgood: The actual increase is $527 000. If there is some inconsistency between the figures we will double-check it, but I can say that that is the actual amount of money.

Mr OSWALD: What specific plans have been undertaken to prevent the spread of hepatitis C? What hospital initiatives for treating hepatitis C are referred to in this line on page 46 of the Program Estimates?

The Hon. D.J. Hopgood: The South Australian branch of the Red Cross Society introduced hepatitis C screening in February of this calendar year. From February to August the screening costs amounted to $598 520 (and I use round figures; if the honourable member wants specific figures they are available). This is made up of $110 000 for capital, $469 000 for goods and services and $19 000 for salaries and wages. As at August 1990, 49 584 blood samples had been tested, and 327 (that is, 0.5 per cent) of those reacted positively on repeat testing. I will have to seek advice as to any procedures in public hospitals. That information is not immediately available.

Mr QUIRKE: Will the Minister provide details of the 1990-91 medical equipment program for South Australian hospitals? I understand that since the completion of the Commonwealth teaching hospital equipment program in 1988 the South Australian Health Commission has included a significant provision for the replacement of medical equipment items in its annual capital works program.

The Hon. D.J. Hopgood: The Adelaide Medical Centre for Women and Children will receive $720 000 which will be divided into two components: at the Adelaide campus $600 000 will be for X-ray equipment and at the Queen Victoria campus $120 000 will be for a biochemical analyser. That will replace 12-year-old equipment and provide a diagnostic service in a reliable and efficient manner. The biochemical analyser will allow efficient processing of urgent specimens in the hospital's intensive care unit.

The Flinders Medical Centre will spend $400 000 on a gamma camera and $353 000 on a urodynamics system, making a total of $753 000 in all. The gamma camera is used in the Nuclear Medicine Department for producing diagnostic images for whole of body examinations as well as the functional analysis of the heart, kidneys, lungs and brain. The urodynamics system will enable the Flinders Medical Centre to provide patients in the Urology Unit with a complete investigational and treatment facility.

At the Royal Adelaide Hospital there will be what is called an 'equipment package' for the intensive care unit which will cost $600 000 and which will equip four new intensive care beds. It will enable the Department of Anaesthesia and Intensive Care to upgrade its facilities and provide life support and clinical care to critically ill patients.

The Queen Elizabeth Hospital will benefit from new equipment totalling $885 000. The gamma camera system will cost $560 000 and will supplement two older existing gamma cameras. The QEH will also spend $175 000 on an image intensifier and television chain which will form part of the total equipment producing the diagnostic images required from fluoroscopic examinations. A mobile image intensifier required for emergency operative and orthopaedic procedures will also be purchased at a cost of $150 000.

The Institute of Medical and Veterinary Science will benefit from a new flow cytometer/cell sorter at a cost of $450 000. That performs diagnostic analysis and monitoring of numerous cell types. The equipment is used in the monitoring of AIDS progression, the detection of surface antigens, the detection of DNA and chromosome abnormalities, bone marrow analysis and the detection of malignancy.

Ultrasound/doppler equipment totalling $415 000 will be purchased for both the Lyell McEwin Health Service and the Modbury Hospital. In country hospitals a total of $478 000 will be spent on the following: dialysis equipment for Port Augusta; ultrasound equipment for Port Pirie; X-ray equipment and theatre lights at Whyalla; and steriliser equipment at Millicent.

In addition to this $4.3 million, equipment will be purchased through hospital operating budgets and through the commission's capital works program. That will amount to $7 million in metropolitan hospitals alone and $3.2 million for a linear accelerator at the Royal Adelaide Hospital.

Mr QUIRKE: I have a supplementary question. The Minister mentioned that the number of intensive care beds at the Royal Adelaide Hospital had been increased by four. How many intensive care beds are available at the Royal Adelaide Hospital and how many were used last year in respect of motor vehicle and motor cycle accidents?

The Hon. D.J. Hopgood: We are fairly close to being able to say exactly how many intensive care beds there are, and we know that generally they are flat out during the year. However, as to their specific use, to which the honourable member referred, we will obtain that information.

Mr QUIRKE: On page 33 of the Program Estimates under 'Services for the Aged and Physically Disabled', I note that the Health Commission will continue to expand services provided by Alfreda Rehabilitation and McWork Rehabil-

itation at the Lyell McEwin Health Service under the commercialisation programs. Will the Minister inform the Committee of the progress to date?

The Hon. D.J. Hopgood: Alfreda, of course, is an annexe of the Queen Elizabeth Hospital and it has provided occupational rehabilitation for over 10 years. With the introduction of the current Act in 1986, Alfreda became a contracted provider with WorkCover, the only Government agency to be so contracted. Alfreda continues to provide services to non-compensable patients at no charge. The Alfreda service also gained a contract with Comcare in 1988-90 to provide rehabilitation services for Commonwealth Government employees.

In 1989-90 it generated additional revenue of $628 000 which was used to appoint rehabilitation counsellors and extra allied health staff and to purchase additional equipment. Further revenue, including a surplus of some $200 000 in the past two years, will be used to provide purpose-designed facilities for assessment and fitness functions as well as upgraded reception and administration areas.

WorkCover has recently supplied data which indicates that Alfreda is a very efficient rehabilitation provider and that 93 per cent of its closed cases have returned to work—an outcome which far exceeds that achieved by any other contracted rehabilitation provider.

McWork Rehabilitation is a much more modest venture by the Lyell McEwin Health Service, which provides physical and medical rehabilitation for injured workers on a commercial basis. Prior to Cabinet approval in July 1989 to establish McWork, Lyell McEwin provided essential medical treatment for persons with work-related injuries but referred compensable patients requiring physical rehabilitation to the private sector because allied health staff were fully occupied with the treatment of non-compensable public patients.

The establishment of McWork has generated revenue which has enabled the appointment of additional physiotherapists and occupational therapists. There were profits of $63 000 in 1989-90. I am not sure that that is the complete profit, but profits of that order have been retained by the Lyell McEwin Health Service to be used at the discretion of the board of directors for the purchase of equipment or the expansion of services in high priority areas. With your indulgence, Mr Chairman, Mr Blight can tell us about the country outreach and how that operates.

Mr Blight: While on the subject of Alfreda, it is worth mentioning that we are planning to set up an outreach unit of Alfreda in Whyalla to run a rehabilitation service there. A feasibility study some years ago recommended that a multi-disciplinary occupational rehabilitation treatment facility be established in Whyalla. That would be a community-based service with a health and fitness philosophy, located in the Whyalla recreation and leisure centre. Because of Alfreda's excellent results in this area, it was decided to build on that expertise. The proposal now is that Alfreda will manage and operate this centre in Whyalla. It will be staffed and managed as a discrete entity within the Alfreda organisation. We would plan for this service to be cost neutral and to generate sufficient revenue to cover its operating costs. We are looking at servicing about 20 clients at any one time.

Mr QUIRKE: My next question refers to specialist services which are available in our hospitals (page 46 of the document, under the heading 'Orthopaedic Services'). On Friday 17 August 1990, the *Hinch* program reported that there were 7 000 South Australians on booking lists for elective surgery, compared with 27 000 in New South Wales, 26 500 in Victoria and 9 000 in Western Australia. No figures were available for Queensland or Tasmania. Despite the relatively favourable position in South Australia, I am aware that there are particular problems relating to the provision of orthopaedic surgical services in major metropolitan public hospitals. What action has been taken to ensure that orthopaedic services are available in the public hospital system?

The Hon. D.J. Hopgood: Despite that fact the South Australia has the highest number of orthopaedic surgeons per population of any State, we have had difficulties in attracting sufficient orthopaedic surgeons into the public hospital systems. In order to improve the situation and provide a focus for orthopaedic excellence, the Health Commission funded the State's first Chair in Orthopaedic Surgery and Trauma at the Royal Adelaide Hospital in early 1989. Professor Don Howie was appointed to the position, and his unit has received $1.494 million in the past three years under the Medicare incentive program to develop an early discharge orthopaedic service for people undergoing joint replacement. Obviously, with an ageing population, more and more people will be affected by degenerative diseases, and the demand for expensive joint replacements will rise. It is important that people receiving this surgery get the best possible and appropriate treatment and that they are discharged from high-cost acute hospital beds at the earliest opportunity.

The problem, in part, has been the Lyell McEwin service, where there have been no orthopaedic surgical services since June 1988. That has nothing to do with the lack of money; it is the fact that we had not been able to attract a surgeon to the hospital at that time. I initiated a meeting with representatives of the Australian Orthopaedic Association to discuss the problems facing the public hospital system in the provision of these services. I will quote from a letter received from Dr David Marsh, Chairman of the South Australian branch of the Australian Orthopaedic Association. He says that it was agreed:

> . . . to review the waiting list and, in particular, patients who have been waiting longer than 12 months; to look more closely at the establishment of an orthopaedic service at the Lyell McEwin Hospital; and to discuss the possibility of an increased number of operating sessions and become involved in a review of services at the Royal Adelaide Hospital.

It is pleasing to be able to inform the Committee and the people of Elizabeth and surrounding districts that since that meeting the Lyell McEwin has recruited a full-time orthopaedic surgeon who will commence on 1 January 1991. He is a Mr Darby, who is currently Director of Orthopaedic Services in the Northern Territory. Negotiations are also going on with another orthopaedic surgeon who is likely to commence at Lyell McEwin for four sessions per week in April 1991 or thereabouts. I should have liked to be able to announce that these dates were a little earlier than they are, but there is every prospect of those services now being heated up, whereas we have been through a period when they have not been available at all.

Mr QUIRKE: As a supplementary question, can the Minister outline the waiting time for this type of surgery currently on the booking list?

The Hon. D.J. Hopgood: If we focus on the five metropolitan general hospitals, we see that the numbers on the booking list at June 1990 stood at 7 040. These numbers fluctuated from a low of 6 593 in October 1989 to a high of 7 120 in January 1990. There was a marginal decline in July 1990 to 6 980. The booking list numbers at the Adelaide Children's Hospital increased during 1989-90 from 544 in June 1989 to 783 in June 1990, but fell to 680 in July 1990. I will not give the breakdown for each hospital, because it would take some time. There was an increase of

1 733 procedures during that 12-month period. That compares favourably with the Premier's announcement, jointly made with me, in June 1989 that 1 300 additional operations would be performed with the $3 million allocated under the metropolitan funding package for that purpose. That target was exceeded by 433.

It is important to realise that over 55 per cent of people who had elective surgery at Adelaide's major metropolitan public hospitals in the past 12 months received their surgery within a month of being added to the booking list. More than two-thirds of all people on the booking lists at the five major general hospitals in June 1990 had been waiting for six months or less.

I can confirm the honourable member's figures relating to New South Wales and Victoria. I do not know whether he mentioned Western Australia, but the booking list there is about 9 000. The longer lists tend largely to refer to ear, nose and throat surgery, plastic surgery and orthopaedic surgery, upon which the honourable member focused in his earlier question. We have already canvassed some of the reasons for that.

I will finish by talking about the median waiting times in weeks for orthopaedics in the major hospitals: Royal Adelaide Hospital, seven weeks; Queen Elizabeth Hospital, 13 weeks; Flinders Medical Centre, eight weeks; Modbury Hospital, 11 weeks; AMCWC, five weeks; and, for reasons that brought on the question, the Lyell McEwin Hospital is not applicable.

Mrs KOTZ: I note from the white book (page 44), that the expansion of mammographic screening programs was a specific target for 1989-90. What funds have been allocated for the existing program in this budget year? Is the allocation, if any, an increase in funding to enable an expansion of the existing program, and will the expansion, if any, open up the program to include women 40 years of age and over and classed as part of the high risk category? With reference to the introduction of mobile mammography screening programs in the rural areas, to which the member for Stuart referred, I am aware that a Federal commitment of $400 000 capital funding has already been received and held in Treasury. What is the State's funding commitment to this program?

Dr McCoy: We are negotiating with the Commonwealth about what new funds will be applied to the program in 1990-91. We have been advised that nationally the Commonwealth, as part of the Prime Minister's $64 million five-year program, will allocate $14 million nationally. We would expect about 8 per cent to 9 per cent of that, and we are negotiating with an officer of the Commonwealth Department of Community Services and Health but have not yet received a definite allocation. That is the new money. The State funding of the mammography program has been maintained at the current level in 1990-91.

Mrs KOTZ: There has been no actual increase or expansion of the program; is that correct?

Dr McCoy: There has been no increase under the State budget, but there will be a substantial increase from Commonwealth funds when the amount is finally negotiated.

Mrs KOTZ: In regard to negotiations with the Commonwealth, I presume that that answer referred to the rural mobile screening scheme?

Dr McCoy: No, it would include that, but it was part of the new Commonwealth funds that are available as part of that $64 million, there is $14 million in 1990-91 nationally, and South Australia is negotiating for its part of that national allocation. That allocation could be about $1 million, give or take, which would represent a substantial increase in the mammography funding at the present time.

The Hon. D.J. Hopgood: In the meantime we are maintaining our effort.

Mrs KOTZ: I refer to the blue book (page 17), and the allocation for 'South Australian Breast X-ray Service'. Regarding the release of the report by the Breast Cancer Screening Evaluation Committee for the Australian Health Ministers Advisory Council, has the Minister, or any officer of the commission, held discussions on the implementation of the 29 recommendations of that report? What is the proposed contribution required from South Australia, and has the Government agreed to the allocation of this share?

Dr McCoy: That report has been received, but in essence it has been overtaken by the events of the Prime Minister's announcement of the $64 million national breast mammography screening program. It is that new Commonwealth mammography program that we are now negotiating with the Department of Community Services and Health to establish the State contribution and the exact Commonwealth contribution to the program.

There are three breast mammography screening units at present: one at the Flinders Medical Centre, one at the Queen Elizabeth Hospital and one at the Royal Adelaide Hospital. We currently have a central unit, and we are planning to add another screening unit associated with that. As the honourable member has said, at this stage we are planning one mobile unit for country work. However, the details have not yet been finalised with the Commonwealth. I am advised that the cost-sharing—that is, the further State contribution—does not apply until the 1991-92 financial year, so for 1990-91 the program is fully Commonwealth funded.

Mrs KOTZ: Regarding the reference in the blue book (page 9) to 'South Australian Health Commission Central Office', have any of the computers in hospitals or health agencies under the control of the South Australian Health Commission in general, and within the central office organisation in particular, been affected by computer viruses? If so, what are the specific effects of these viruses, and what will be the expenditure of eliminating them from the South Australian Health Commission computer systems?

The Hon. D.J. Hopgood: I think the simple answer is, 'To our kowledge, no.' We are not unused to viruses, but fortunately not in our computing equipment. However, I will check on that matter.

Mrs KOTZ: I have some information on that that might help jog the memory of someone in the commission. Apparently, one of the viruses that is quite effective tells the operator, 'Your computer is stoned; legalise marijuana', and then effectively writes off a program.

The Hon. D.J. Hopgood: I find that fascinating. We will check, but we have no knowledge of any of our computers being so affected.

Mr HOLLOWAY: I congratulate the Minister on the efficient way in which he manages his portfolio and on some new initiatives that were announced in the budget. The Budget and the Social Justice Strategy 1990-91 (page 27) states:

> The social justice strategy has given increasing priority to disability issues in successive budgets and in 1990-91 a $2.8 million package of initiatives will be implemented with a full-year effect of $5.7 million.

Can the Minister provide more details of those schemes and how they will operate?

The Hon. D.J. Hopgood: The important aspect of the initiatives is that they have been largely directed to people with disabilities. Under the Homecare support program $1 million has been allocated, and under the disabled persons equipment scheme $300 000 has been allocated. There are programs to be cost-shared with the Commonwealth, includ-

ing the national better health program, $168 000; the women's health program, $240 000; and the innovative health services for homeless youth, $320 000.

In general terms, if one wanted to put a theme into all of this, I would say that we are particularly concerned about the needs of people with family responsibilities who are likely to be most affected by social and economic hardships, and about the health needs of the Aboriginal people. In putting together our strategy, we have tried to take account of that. I have a good deal of information about some of these initiatives, such as the Homecare Support Program and the Disabled Persons Equipment Scheme but, if members want more detail, they can ask for it.

Mr HOLLOWAY: I refer to program 13 on public and environmental health. Recent publicity has been given to a program to assist elderly people in making their homes safer to prevent falls. What are the objectives of that program? Does the Minister have any statistics on the problem relating to falls? How does this particular program relate to the existing work undertaken by domiciliary care agencies, which do an excellent job in modifying homes?

The Hon. D.J. Hopgood: The actual project is an activity of the Injury Prevention Forum of South Australia, which is a private body working with Foundation South Australia. Our role has been to provide technical training of staff and administrative functions. The target group of the program is not the same as that of the domiciliary agencies, and I note the second part of the honourable member's question. Whereas domiciliary care concentrates on people who have a significant disability, the program in question is for elderly people generally before they become disabled.

Hopefully, if falls at home can be prevented, fewer people will require hospitalisation and domiciliary care services. In time, this will help to reduce the waiting times commonly experienced by people requiring domiciliary care services. We think that it is a very promising initiative and one into which, with time, some more resources can be put, once the existing program has been monitored.

Mr HOLLOWAY: I refer to program 9 and medical research. I am aware that South Australia has been very successful in gaining the submarine contract and in being selected as the site of the MFP as part of the Bannon Government's commitment to becoming a clever State in a clever country. Will the Minister provide the Committee with evidence of the Government's support for medical research initiatives, which are likely to enhance the State's reputation as a leader in this important area?

The Hon. D.J. Hopgood: Over the past two years, the Government has provided capital grants of nearly $3 million to establish research institutes in association with our teaching hospitals. This is a boost to construction and related industries. It also advances medical knowledge and improves the standards of health care. It provides additional scientific and technical positions and, of course, there is further potential for the commercialisation of intellectual property skills in medical research and development.

The major initiatives in this area have been the Australian Centre for Medical Laser Technology, the Child Health Research Institute, the Flinders Medical Centre Research Foundation and the Hanson Centre for Cancer Research. The Centre for Medical Laser Technology is located at the Royal Adelaide Hospital and provides a focus for medical laser activities, including basic physical and biological research, development and evaluation of laser products, clinical assessment and training in the use of lasers, and scientific, medical and technical support for industry in the development of medical laser products.

The centre was established with 'seeding' funds from the Department of State Development and Technology and the Health Commission, with the aim of becoming financially self-sufficient after two years. The Health Commission contributed $60 000 in 1988-89 and a further $60 000 in 1989-90. The Commonwealth provided a total of $250 000 to the centre in 1989-90 and 1990-91—over two years—from the Hospital Enhancement Program.

The Child Health Research Institute was approved in April 1987. It was then known as the Paediatric Research Institute and was a major health project in the 1988 bicentenary year. The Variety Club of Australia agreed to contribute $750 000 towards the capital cost of the project to be met on a one for one basis by the State Government. Construction of the institute on level 9 of the Adelaide Children's Hospital Rieger Building commenced in mid February 1989 and was completed in August 1989 at an approximate cost of $1.3 million. Recurrent funding for the institute is provided by the Health Commission ($100 000 for five years), the Adelaide Medical Centre for Women and Children Foundation, various research grants and corporate and public fundraising.

In July 1989, Cabinet approved capital grants of $500 000 to the Flinders Medical Centre Research Foundation in each of the financial years 1989-90 and 1990-91. It provided a CPI indexed loan to the foundation up to a maximum of $2 million under conditions to be negotiated between Treasury and the Health Commission. The project, estimated to cost $5.5 million, involves an addition to the existing animal house and the construction of a block of 22 laboratories on the north-eastern corner of the existing FMC building to provide increased capacity for medical research. A fund raising program in existence since 1987 has raised in excess of $2.4 million to date.

In July 1989, Cabinet approved a capital grant of $500 000 to the Hanson Centre for Cancer Research in each of the financial years 1989-90 and 1990-91. The project, estimated to cost $3.5 million, is a joint Royal Adelaide Hospital/IMVS/Anti-Cancer Foundation project involving the construction of a four-storey building at the IMVS campus, two floors of which are to be dedicated exclusively to cancer research. In addition to the Government grant of $1 million, $500 000 is to be provided by the Anti-Cancer Foundation, $900 000 from RAH research funds and $100 000 from IMVS research funds. The balance is to be met through a public fundraising campaign.

The Division of Human Immunology at the IMVS has been granted funds from the National Cancer Institute of the National Institute of Health, USA—a first for this State. Two large American biomedical companies and the Australian Medical Research and Development Corporation have also supported research into new agents for cancer therapy at the IMVS. We have a pretty good story to tell in the area of medical research.

Dr ARMITAGE: I refer to page 17 of the blue book under the line 'Health Industry Development Centre' which, the footnote informs us, was previously known as the Joint Staff Development Unit. Will the Minister explain what is the exact function of the Health Industry Development Centre and for whom it operates its program? How many people are employed at that centre and what are their titles? What is the justification for a preliminary budget allocation of an increase of $80 000, despite the fact that last year it came in $25 000 under budget?

Mr Case: The Health Industry Development Centre is an arm of the Health Industry Development Council. It employs six full-time staff. The council is headed by a manager

(training) and there are four training personnel and one clerical support person.

The main aim of the centre is to provide a comprehensive training program for both central office and health unit employees. The main programs conducted by the centre fall into several different categories. There is a short course program run by the centre which includes courses such as report writing and courses relating to the performance appraisal area. Any specific courses requested by health units for particular employee groups which need training are developed by the centre and put on specifically for those particular health units. A considerable amount of work is being undertaken at the present time relating to the development of an integrated management development program aimed at providing for a more skilled and productive work force. There will be an emphasis on increased quality of client service delivery.

We are looking to improve our ability to target and respond to changing economic, social and political priorities within the health system and to providing training for our managers to be able to give the Minister quality economic and policy advice. That is the main thrust of the centre. Under the umbrella of that centre, we also have a program aimed at management skill development to assist in identifying people within the health system for further management training. This year four people have been seconded from health units for a 12-month middle management program to expose them to a wide range of health unit management areas and to enable them to develop into future senior managers within the health system.

The other major area of responsibility for the centre is to provide internal consultancy arrangements for the Health Commission. In that area, they are currently developing occupational health, safety and welfare training programs for managers across the system. They are assisting in the development of recruitment and selection and training programs for the health system, and they are also assisting in the development of senior nurse executives. The other area which they are currently looking at is equal employment opportunity and sexual harassment training, and those courses are currently being provided.

The Hon. D.J. Hopgood: The honourable member was interested to know why there is an increase in allocation. There is a new operating theatres attendants course and an increase in scholarship funds which I am advised should largely account for the increase. I have just been doing another of my back-of-the-envelope calculations, and I have worked out that, in an overall budget of $1.151 billion, if we spend $761 000 on training, that is about .07 per cent of the budget. I think members would agree that that is pretty modest.

Dr ARMITAGE: Can the Minister detail the scholarship funds to which he just referred?

The Hon. D.J. Hopgood: We will have to take that on notice and get that information for the honourable member.

Dr ARMITAGE: I refer to page 9 of the blue book. Given the Minister's recent statement to the House that 40 out of the total of 120 beds will open in late April 1991, why do the estimated receipts from the Noarlunga Hospital in 1990-91 equal zero dollars? That seems to indicate no patients being treated in the hospital in 1990-91.

The Hon. D.J. Hopgood: The answer is that at this stage we have not factored it in, because it is a little difficult to judge exactly what it might be. I am advised that the hospital is quite confident of being able, within its budget, to open the beds to which the honourable member has referred. However, that will be late in the financial year, and in those circumstances it is a little difficult to judge just what income there would be. Obviously any income will be some addition to this budget.

Dr ARMITAGE: Given that the process is a budget estimate and given the experience of the Health Commission, it would be quite reasonable for them to estimate the income from a hospital the equivalent of Noarlunga with 40 beds over a two-month period. Surely you could have factored that in as an estimate.

The Hon. D.J. Hopgood: The honourable member is absolutely right and I guess that we can do it on the spot. Dr McCoy might like to do it for the honourable member.

Dr McCOY: First of all, only 20 of the beds will be private and, therefore, receipts will come from only 20 beds. The receipt of income is at least six weeks after the issue of the account so the actual receipts in the 1990-91 financial year will be very small. We have a bill of $165 a day and if I had a moment I could estimate that. It will be very small in 1990-91, but rapidly escalating after that.

Dr ARMITAGE: On page 26 of the blue book, referring to 'Post-Medicare', can the Minister explain exactly what are compensable patient accounts? Can he also explain why, out of net raisings for the five major hospitals during 1989-90, of $12.5 million a total of about $3.2 million has been what is termed remitted or discounted? Why was the outstanding balance at 30 June 1990 a total of 59 per cent of the net raisings during 1989-90?

The Hon. D.J. Hopgood: I will ask Dr Filby to address that question.

Dr FILBY: Compensable patients are patients defined in the Medicare agreement, which the State has signed with the Commonwealth, as those people who have entitlements under a variety of motor vehicle, workers compensation or similar arrangements. In most cases we are talking about patients who do not have any individual responsibility for the account but expect to have it paid by some third party other than a private health insurance fund. We are not talking about a private patient who is insured with a fund but, rather, about someone who has a compensation entitlement, the details of which are laid down in the agreement.

One of the side effects of that is that many of these accounts are settled a considerable time after the account is raised, in some cases because of a need for legal proceedings to have ensued before the insurance fund accepts responsibility for payment of the account. We have traditionally had very significant carry-over figures or outstanding balances at the end of a financial year for accounts raised in that year. On some occasions accounts are paid three, four or five years after they are raised.

In respect of the $3.2 million referred to in that list as remissions and discounts, the commission provides a remission on accounts paid by SGIC in circumstances where SGIC admits liability and pays the account within 28 days of receipt. I do not have with me the exact proportion of accounts to which that relates, but it relates to a significant number of them.

Secondly, there are circumstances in which accounts are raised by hospitals where the patient believes they may have an entitlement to workers or motor vehicle compensation, but which is subsequently proved to be inaccurate. In those circumstances, the accounts are remitted, particularly where those patients do not have private insurance.

Dr ARMITAGE: I presume that that is an explanation of why, under this line, $5.3 million of a total of $12.6 million net raisings are greater than 60 days. Can a breakdown be provided of which of those compensable patients' bills that are greater than 60 days are due to matters such as compulsory third party insurance and so on and which are due to workers compensation?

Dr Filby: I am not sure of the ease with which that information can be obtained. It would have to be obtained from individual hospitals, and it will be necessary to determine whether they maintain records in a form that can readily be made available to the Committee.

Dr ARMITAGE: I am happy for that to occur, but given that $5.3 million out of total net raisings of $12.6 million is greater than 60 days, I would have thought that that information would be of interest to the Committee.

Mrs HUTCHISON: Page 39 of the Program Estimates refers to the 1989-90 targets and objectives. One of those targets was to identify needs and develop appropriate services for special target groups such as women, Aborigines, non-English speaking people and youth. What work has been done this year and what will continue to be done in the coming financial year?

The Hon. D.J. Hopgood: That is a very broad question, but I will take it on notice and provide the information to the honourable member.

Mrs HUTCHISON: I note that the sale of the Ingle Farm site of the Salisbury Community Health Service was listed in the Program Estimates as a 1990-91 target under the program entitled 'Community Based Primary Health Care Services'. Will the department advise the reason for the proposed sale and indicate recent developments pertaining to community health services in the City of Salisbury?

The Hon. D.J. Hopgood: Because of the need to extend community health services throughout Salisbury and the relative concentration of resources in the Ingle Farm catchment area, the Health Commission supported the reorganisation of the service into a regional service for the whole of the city. This has required a new constitution to be approved for the Salisbury Community Health Service, which came into effect in December last year; the transfer of the community health centre at Burton from the Lyell McEwin Health Service to the Salisbury Community Health Service, as newly constituted; the renegotiation of the agreement between the Health Commission and the Salisbury council to transfer responsibility for the 'Shopfront Youth Health and Information Service' to the Salisbury Community Health Service from September 1989; the relocation of the administrative headquarters and a multi-disciplinary team from the Roopena Street, Ingle Farm site to a new building in the centre of Salisbury in January this year; and the development of an outreach service in a community health house on the grounds of the Settlers Farm Primary School.

The Health Commission is investigating the feasibility of selling the existing Ingle Farm Community Health Centre premises at Roopena Street and constructing purpose-built premises in Salisbury West at the Hollywood Plaza District Centre and Ingle Farm. The Ingle Farm Community Health Centre was one of the original centres built under the Whitlam Government's community health program, but it is both too large and inappropriately sited to be the base for the Salisbury Community Health Service.

Mrs HUTCHISON: The Health Commission objectives for 1990-91 in relation to community-based primary health care include the completion of a primary health care complex at Campbelltown. If my memory serves me correctly, the development at Campbelltown is part of the Health Commission's northern and eastern property rationalisation program which involves the sale of a number of mansions and the provision of improved accommodation for health services. Will the Minister provide details of the northern and eastern property rationalisation program including the capital gains which have been made thus far?

The Hon. D.J. Hopgood: The Campbelltown development consists of a major refurbishment of a building previously belonging to the Campbelltown Primary School in order to accommodate the Eastern Community Health Service and the Domestic Violence Service currently located at St Corantyn's in East Terrace, Adelaide; the Child and Adolescent Mental Health Service, previously located at Mitchell House, Fitzroy; the Campbelltown Community Health Centre, currently located in unsatisfactory rental accommodation; and the Family Planning Association.

Mitchell House at Fitzroy has been sold and I understand that negotiations for the sale of St Corantyn's and the adjoining Moorcroft House in East Terrace are about to be finalised by the Department of Lands. In addition to the Campbelltown relocation, progress to date on the northern and eastern property rationalisation program has involved the sale of Marden Hill, with proceeds being used to purchase community based accommodation for IDSC; the relocation of the Mental Health Accommodation Program from Moorcroft House to the Payneham Rehabilitation Centre; and the establishment of a head injuries service for outpatients and a day centre for the South Australian Head Injuries Service at the Payneham Rehabilitation Centre. They are all very laudable objectives. There is also the sale of surplus land and buildings at the Payneham Rehabilitation Centre and the identification of surplus land and buildings at the Hampstead Centre which will become available once the spinal injuries unit has been relocated from the Morris Hospital to the main Hampstead site.

I think the honourable member asked also about the results of the program. It has yielded a surplus of over $3 million to date and has provided improved accommodation for a number of health units. A further surplus of at least $3 million is anticipated once Moorcroft House and St Corantyn's are sold.

Mr OSWALD: I refer to services for Mental Health on page 40 of the Program Estimates. Has the South Australian Health Commission produced statistics to show the incidence of different types of disability in the population and, if so, can they be provided to the community?

Ms Johnson: The Health Commission recently established a disability services unit within the Community Services Division. That unit has been operational for only a few months. One of the priority tasks is the development of a database of various groups of people with a disability, and the obvious starting point is to develop statistics of the incidence of disabilities. Commonwealth organisations collect similar information which will be utilised in our database. Amongst those is the ABS, which includes such questions in its surveys.

We have been addressing the needs of disabled people, particularly with recent initiative funds which were discussed earlier today. I have some figures for some disability groups. For example, we estimate that there are 4 000 people in South Australia with brain injury. A very recent initiative taken in the past fortnight is to pilot a head injury register within South Australia which will be administered through the metropolitan hospitals. The primary aim, of course, is to get a firmer figure on the number of people in this State suffering from brain injury. We know, for example, that about 15 000 people in this State have a serious mental illness. Approximately 7 000 people in this State have an intellectual disability. However, we will certainly firm up those figures as the development of our database proceeds in the disability area.

Mr OSWALD: Given that the strategic planning authority for Mental Health Services submitted a budget of $2.5 million, which it felt was the minimum required to begin restructuring services and developing new services for the chronically mentally ill living in the community, does the

Minister believe that the allocation under new initiatives in his press release of 23 August this year, which I understood to be $200 000, will be sufficient for this work?

The Hon. D.J. Hopgood: There are one or two points of detail I will ask Ms Johnson to explain to the Committee.

Ms Johnson: The statistics that I have just talked about were certainly taken into account in determining the amounts of money to be made available to each group in the split-up of the initiative money. This initiative money was provided for home support. It is an area of service industry delivery that needs further development. Many people with a psychiatric illness have a long-term disability and require day-to-day support in the tasks of daily living. However, it is also true that that support is required by other disability groups, namely people with a brain injury, intellectual disability, severe behaviour disorder, autism and so on.

In determining the amount of money that would go to each disability group we attempted to estimate the number of people in the community requiring support with daily living. That, of course, is not everyone with a serious mental illness, but it is a sizeable proportion of the number of people with serious mental illness. Beyond that, we then attempted to estimate the degree of support that those people require. For example, we estimated the number of people within each disability group requiring intensive levels of support, high levels of support, moderate levels of support and so on. It is true to say that on average people with a serious mental illness, while they require support with daily living, tend to require less intensive support than people with other disabilities.

We costed each level of support, multiplied that by the number of people we estimated within each group and came up with a total allocation required to satisfy their service needs and then worked on proportions. In that way we determined the allocation of the $1 million to various groups. Therefore, I believe that the allocation of $210 000 to people with a serious mental illness, while inadequate in terms of meeting their total needs, is a fair and equitable proportion of the $1 million made available this financial year.

Mr OSWALD: I refer to page 38 of the white book. What are the budget implications in respect of implementing the domiciliary care services review recommendations? In other words, there has been a review of domiciliary care services and, while the white book refers to the review, it does not go any further. Can the Minister give me some broad knowledge as to where we are going with the review, and what it means to the State over the coming financial year?

The Hon. D.J. Hopgood: We do not know the budgetary implications at this stage, but I can do hardly better than to refer the honourable member to the Chairman of the implementation team, Dr Filby. He may like to answer the rest of the honourable member's question.

Dr Filby: The review of domiciliary care services was presented jointly to the Minister of Health in South Australia and the Commonwealth Minister, and it has been referred to a group that I convene to prepare a plan for the implementation of its recommendations. That group has been meeting over the past few months and anticipates being in a position to report to Ministers before the end of October. The group has identified certain recommendations in the original review that we believe will require some additional resources. We have not yet sifted through those to the extent that we can identify the priorities for those additional resources.

We still have to negotiate with our counterparts in the Commonwealth about the sorts of resources it might be able to provide under the Home and Community Care arrangements to help us implement the recommendations. As a result, we are not yet able to identify the actual implications of either all of Dr Yeatman's recommendations or those which we might put to Ministers which need to be implemented as a matter of priority.

Mr OSWALD: On page 46 of the white book there is reference to the 1990-91 specific targets for the St John Ambulance Service and the use of fully paid personnel. The concluding sentence states:

> . . . implement new aerial medical service arrangements.

Can the Minister tell the Committee what is meant by that?

Ms Johnson: As from 1 July 1990 the Royal Flying Doctor Service, the central section of which is our local branch, has assumed responsibility for management of the air ambulance fleet of St John's. The air ambulance fleet was previously managed by the St John Ambulance Service and consisted of two Piper Chieftain aircraft and the use of a RFDS Kingair for up to 450 hours per annum. Under the arrangements introduced on 1 July this year, the St John Ambulance Service will still be responsible for tasking air ambulances and providing air attendants to crew them. The Royal Flying Doctor Service is responsible for maintaining the aircraft in a serviceable condition and employing the pilots to fly them.

It is anticipated that these new arrangements will provide a more comprehensive and efficient air ambulance service to the South Australian public, and savings in capital costs have already been achieved. Further savings will be derived from improved aircraft maintenance arrangements developed by the Royal Flying Doctor Service.

Mr QUIRKE: Will the Minister provide the Committee with details of the ante-natal shared care program in the western suburbs of Adelaide?

The Hon. D.J. Hopgood: The ante-natal shared care program is a joint venture between the Parks Community Health Service, the Queen Elizabeth Hospital and other agencies which provides ante-natal care and education for women intending to have their babies at the Queen Elizabeth Hospital. It particularly seeks to service the catchment area of the Parks Community Health Service. It consists of a part-time community health nurse and medical officer to arrange visits to the Queen Elizabeth Hospital ante-natal clinic at 20 weeks and 36 weeks gestation and ensures referrals for postnatal services such as CAFHS, family planning and paediatric care.

The program caters for about 35 women each year or about 10 per cent of pregnancies in the Park catchment area. The model is being extended to other primary care agencies in the western suburbs and represents a simple and effective approach to improving the effectiveness of care during pregnancy for women who may otherwise enjoy less than ideal access to care.

The inner western and north-western suburbs of Adelaide are noted for a higher than average number of neonatal deaths and illnesses, high rates of teenage pregnancy, lower numbers of ante-natal visits and a range of other risk factors such as single parenthood, more than four previous births and a low birth rate, which is why this program has been targeted to that specific area.

Mr QUIRKE: Under the program 'Services for the Terminally Ill' reference is made to the Health Commission's intention to commission hospice beds at the Lyell McEwin Health Service and to appoint a medical director to the Northern Hospice Care Service in 1990-91. Will the Minister provide the Committee with details of services for the terminally ill which have been established in recent years?

The Hon. D.J. Hopgood: If we go back to 1982, when this Government came to power, the Southern Hospice Association was the only palliative care service funded by

the Health Commission, and at the time that funding was $20 000 per year. Of course, we now have a very comprehensive and efficiently coordinated hospice service, which is possibly the best in the country. One of the breakthroughs was the appointment of Professor Ian Maddocks to the Chair in Palliative Care at the Flinders University. This was the first such appointment in this country. In addition to the funds spent on palliative care from individual hospital budgets, which, of course, are very difficult to dissect, an additional $2.83 million has been specifically allocated for hospice care services in 1990-91, and this is a 24 per cent increase on last year's expenditure.

The programs include the establishment of a six bed dedicated hospice unit at the Lyell McEwin Health Service; the establishment of a six bed dedicated hospice unit at the Modbury Hospital; continued funding of the 15 bed Daw House Hospice (which, of course, is a joint venture of the Health Commission and the Repatriation General Hospital); Medicare incentive funding of palliative care teams in the north, south, east and west; an annual grant to Southern Cross Homes as a contribution towards the 10 bed hospice unit at the Phillip Kennedy Centre; an annual grant to Calvary Hospital as a contribution towards the care of nonfee paying patients of the 17 bed Mary Potter Hospice; and continued funding of the Chair in Palliative Care at the Flinders Medical Centre.

A capital grant of $200 000 was also provided to the Mary Potter Foundation in 1989-90 for the new Mary Potter Hospice Unit. With the establishment of dedicated hospice units at the Lyell McEwin Health Service and the Modbury Hospital, a Medical Director (Hospice Care Services) is being recruited to coordinate the programs at both hospitals.

In the country areas of South Australia the palliative care program is to enable persons with a terminal illness to remain at home in familiar surroundings if they so desire by providing improved education and support to the family of the patient, existing community services and coordination of any additional services. Palliative care services are currently operating in the country areas of the Murray-Mallee, Mount Gambier, the South Coast, the Barossa Valley, the Riverland, the Mid North, the Upper North and Whyalla. The level of Commonwealth funding in 1989-90 provided for the service was $410 900.

Mr QUIRKE: The Minister did not mention the Julia Farr Centre. My understanding was that it played a central role in terms of hospice beds, particularly with the transfer of hospice facilities from Kalyra.

The Hon. D.J. Hopgood: The unit to which the honourable member refers is a nursing home—of course, our biggest nursing home. I understand that it has no specific hospice service. The Chairman of the Health Commission will explain exactly what happened in relation to Kalyra and where those services are now located.

Dr McCoy: During the discussions about the change of role of Kalyra Hospital, two basic things eventuated: first, the creation of the Daw Park Hospice at the Repatriation General Hospital at Daw Park and, secondly, the establishment of the convalescent hospital part of Kalyra in a vacant ward at the Julia Farr Centre. Those two new units have been established and, as a consequence, operating savings of the order of $1 million per year have been achieved. The Daw Park Hospice, under the direction of Professor Ian Maddocks, has been very successful in providing for the needs of the people in the southern suburbs.

Mr OSWALD: I refer to page 38 of the Program Estimates. The Government has increased expenditure in the budgets of both the Health Commission and the Department for Family and Community Services for respite care for dementia sufferers, but it is still only scratching the surface. The Program Estimates (page 38) refers to 'expanded support from community-based services' in addition to the current numbers of institutional beds. What does the Minister mean by this? What budget provisions are made to assist community-based services to provide the necessary care options that are not otherwise available because of the lack of institutional beds?

The Hon. D.J. Hopgood: The alternatives would be domiciliary care and the Royal District Nursing Society. I do not know whether or not the honourable member wants the specifics of the funding in those areas. In some cases it may be difficult to isolate funding for specific services for people with dementia as opposed to people who are well on into other forms of degenerative disease. Some of these programs are supported by the HACC program and, therefore, have an element of Commonwealth funding. I will take the specifics of that question on notice and provide that information.

Mr OSWALD: I refer to page 43 of the white book, the program entitled 'Services for Aborigines'. Given the much vaunted social justice strategy and the frightening increase in the number of Aboriginal suicides, will the Minister indicate specific reasons why the initiative proposal submitted by the Department of Psychiatry of the Adelaide Children's Hospital to establish an Aboriginal youth community mental health team within the division of CAMHS, following extensive consultation with Aboriginal organisations and individuals, has not been funded?

The Hon. D.J. Hopgood: I will try to get a comment on the specifics to which the honourable member refers. Of course, we are not able to fund everything. We may have a higher priority for a particular target group. That does not necessarily mean that we are in a position to fund every service that is suggested, but Colleen Johnson may have more specific detail.

Ms Johnson: The Northern Child and Adolescent Mental Health Service, Northern CAMHS, has sought an initiative for funding a three-person team specialising in Aboriginal adolescent mental health issues. The service has identified Aboriginal issues as a major priority, given the significant rate of suicidal behaviour, family breakdown and offending amongst Aboriginal youths. Similar concerns have been expressed by the Health Commission Strategic Planning Authority for Mental Health Services.

Additional specific funding for this initiative could not be provided in this financial year. However, Northern CAMHS has been requested by the commission to examine its program priorities for the 1990-91 financial year in an attempt to redirect existing resources to meet this need. Successful submissions were made to the Department of Personnel and Industrial Relations by the Health Commission to fund six training positions for Aboriginal health workers. Experienced Aboriginal health workers will be selected and provided with 12 months full-time training in all aspects of mental health, including the identification and coordination of assistance for people with a serious mental illness. It is anticipated that these six workers will then return to a variety of health services with greatly increased skills in the area of mental health and will help to alleviate this difficulty that has been specifically identified with Aboriginal adolescents.

Mr OSWALD: As a supplementary question, I note from reading the papers that the Government has recognised the need for Aboriginal health to be given priority and it has even established the Aboriginal Health Council, which I guess has the same motives and objectives. With the increasing problems that we have in Aboriginal health, I cannot

understand why the Government has decided to reduce the overall expenditure on Aboriginal health by 7.8 per cent. Will the Minister explain why that decrease has taken place? If I am wrong, I should be happy to have that 7.8 per cent decrease explained.

The Hon. D.J. Hopgood: Funding for Aboriginal health is being maintained in real terms, but there were a number of one-off expenditures which we had to meet in our accounts last year and which we do not have to meet this year. In particular, I draw attention to the completion of the hepatitis B screening program, which was $234 000. There was also a motor vehicle replacement funded in 1989-90, which does not have to be met this year. If we exclude those one-off items, I am assured that in real terms the actual expenditure has been maintained.

Mr OSWALD: My final question relates to page 38 of the Program Estimates. What is the perceived role of the Health Commission in the integration of disabled children into schools; what is the budget allocation; and what is the full-time equivalent staff component that will be set aside to work with the Education Department in the integration of disabled children into schools?

Ms Johnson: The Health Commission has been involved in discussion with the Education Department for several months in an attempt to assist the Education Department in implementing its new policy regarding the integration of children with disabilities into schools. As of January 1991, all students with a disability can attend school with appropriate curriculum and school supports. Arrangements are subject to agreement between the Health and Education Departments. As I said, discussions have been taking place and we are near to agreement on a policy.

The principal of the child's local school will be responsible for ensuring the availability of educational and special educational programs. School therapy services—that is, those therapy services required by a child during school hours to enable it to remain within a school environment—will be the responsibility of those Government and non-government agencies which are funded by the South Australian Health Commission and those which have traditionally been involved in the care of children with disabilities. Hence, the Education Department will be responsible for the educational components of the integration of a child and the South Australian Health Commission funded agencies will take responsibility for providing special therapy and nursing services that a child may require during school hours. It is not envisaged at this stage that additional resources will be required by Health Commission agencies. Those agencies have indicated to me that they are willing to take on the responsibility and they envisage that they will be able to do so as part of their normal workload.

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

The Hon. D.J. Hopgood: The member for Playford asked me a question about intensive care beds at the Royal Adelaide Hospital. The answer I have received from the Hospital Administrator is that there are 15 general intensive care beds and six coronary care intensive care beds. In addition, as a result of the new funds for medical equipment four new general intensive care beds are available, as I announced this morning, giving a total of 25 beds. There are also 20 high dependency beds for staging patients moving away from intensive care and I am advised that only a very small number of intensive care beds are actually used for victims of motor vehicle accidents.

Mr OSWALD: I refer to the responsibility of the principals of schools. As I understand it, the adviser said that the principal would have responsibility for the integration of the scheme involving the integration into schools of disabled children and, therefore, the welfare of the children concerned flows on. What professional assistance will the Health Commission give to these principals? I would have thought it would be difficult for a trained teacher to have to come to grips with disabled children being placed in the classroom. My question was also prompted by my recent attendance at the AGM of the Downs Syndrome Association, at which this area of concern was evident. It is all very well to say that they will be provided with additional teacher aides, but we are talking of a medical problem as much as a physical problem. Where does the Health Commission sit in providing backup support? Does this mean that personnel from the Commission would be available to these schools to go around and help? How does the department see its role *vis-a-vis* the role of officers of the Education Department in making it work?

Ms Johnson: I can address that question, but these matters are still subject to final agreement between the Education Department and the South Australian Health Commission. Nevertheless, it has been agreed that for each child integrated into a school two plans will be developed: one a curriculum plan and the other an access plan. Curriculum plan development will largely be the responsibility of the principal and school staff, as that will be around the content of the educational program that the child will receive. That clearly is an Education Department responsibility. However, it is acknowledged that it may be appropriate for staff of Health Commission funded agencies to be involved in the development of that plan since special consideration may need to be taken into account.

The access plan, on the other hand, covers a range of issues. It may cover, for example, transport, equipment, therapy, nursing or medical requirements. It will refer to the general daily supports that a child will require to be in that school. It is seen as a responsibility of both the school principal and health agency staff to jointly develop that access plan with the parents. Within the access plan several areas may need to talk about services provided by health agencies so that such agencies can agree to assist with transport or equipment, provided that it is daily living or access equipment rather than educational program equipment. Certainly those health funded agencies will be responsible for providing therapy and nursing supports required by the child.

The agencies to which I refer in speaking of health agencies include the Intellectually Disabled Services Council for children with an identifiable intellectual disability; the Spastic Centre for children with multiple disabilities; the Crippled Children's Association for children who are physically disabled; and the Royal District Nursing Society if nursing supports are required. Those disability agencies I have mentioned have been involved with the Health Commission in developing its views on the commission's responsibilities in this area, and they are willing to assist in those ways.

Mr OSWALD: I applaud what you are doing, but I am trying to get a handle on what it will cost. I will be asking the same question of the education portfolio. The total ticket will be a very large cost in the budget. From your viewpoint in the Health Commission, do you have an estimate of what the whole integration program will cost at the end of the day?

Ms Johnson: I have no idea of what the cost will be within the education system—that is a matter for the Education Department. If there are additional costs I expect that that is where it will be as the Education Department

will employ additional teacher aides within the school for the full school day to assist the child with daily living issues. From the viewpoint of the health funded agencies, we do not anticipate a cost as those agencies are supporting most of these children now. They are supporting them largely outside the school environment, as their service delivery staff will go into the school, where necessary, rather than provide the service outside the school as they are doing at the moment. Our agencies do not envisage a resource problem for them but there will be a cost from the Education Department side.

The Hon. D.J. Hopgood: I see this as a subset of a broader question, namely, the relative cost of institutionalisation on the one hand and community living, on the other. I do not think there is a simple answer to the question of which is the cheaper way to go. You have to come down to cases before you can answer that. I also do not believe that there is a simple answer on the best way to approach the problem as, again, one has to come down to cases. Either way we are involved with costs. The only way to avoid those costs is to withdraw those services, which I am sure no one here would want us to do.

Mr HOLLOWAY: My question concerns general and specialist hospitals and associated services. The Minister will be aware that I am one member keenly awaiting the selection of the teaching hospital to house the coronary surgery unit associated with Ashford Community Hospital's privately run heart unit. Will the Minister indicate what progress has been made in the selection of the hospital to house this facility and can he provide any information relating to the cost of such a unit?

The Hon. D.J. Hopgood: I will answer generally. The honourable member indicates by the nature of his question that he is aware of the way in which the decision was arrived at, namely, to provide that Ashford could undertake the service but effectively as the private wing of a teaching hospital. Since two teaching hospitals were interested in taking it on—the Queen Elizabeth Hospital and Flinders Medical Centre—the commission has called for submissions, and two very good ones were received from those units on why they should be the ones to get the nod.

Dr McCoy: As the Minister has said, those applications have been received. Dr Blaikie and Dr Filby within the commission are principally responsible for working them through. They have had discussions with staff at Royal Adelaide Hospital, Ashford Hospital, Queen Elizabeth Hospital, and, I think next week or the week after, they will have conversations with staff at the Flinders Medical Centre. As a result of those discussions and investigations, they will make a recommendation to the commission. I cannot indicate what that recommendation will be because they have not completed the work on it.

Mr HOLLOWAY: I refer to the Estimates of Payments, program 10 (page 32), concerning community-based primary health care services and the establishment of a Marion community services accommodation facility in 1989-90, and also a planning study into the future of the Clovelly Park community service in 1990-91. Will the Minister inform the Committee of progress with the Marion community health service development?

The Hon. D.J. Hopgood: A formal agreement has been reached with Marion City Council whereby it would acquire one hectare of land on the Sturt Road Site, owned by the Department of Family and Community Services, to enable construction of a new administrative centre, and the Health Commission would purchase the existing Marion council administrative centre on Marion Road as the site for stage 1 of the Marion community services development. Stage 1 of the development commenced in December 1989, and was completed in July of this year at a total cost of $2.412 million, including $850 000 for purchase of the land. This provides accommodation for Southern Domiciliary Care, the Royal District Nursing Service, Southern Hospice Care Association and the Glenside Hospital Psychogeriatric Centre.

With the completion of stage 1, planning has commenced to colocate a number of human services on the Sturt Road-Diagonal Road site adjacent to the Marion Shopping Centre. Health Commission units likely to be involved in stage 2 include CAFHS and CAMHS, currently located in the old Oaklands Primary School site, and the Clovelly Park community health service. The honourable member asked for further specific information on the Clovelly Park community service, concerning which planning is still under way.

Mr HOLLOWAY: Referring to the Program Estimates (page 50) I note that one of the items listed as a specific target for 1990-91, under the public and environmental health services program, is the introduction of immunisation records at school entry, and also a proposal to facilitate greater preschool immunisation coverage. Can the Minister provide some more information about that, and say whether he has any statistics which indicate the need for such measures?

Dr Kirke: We are proposing to conduct a pilot study of recording immunisation status at school entry in a series of schools later this year and next year, with the intention of eventually introducing it Statewide. We are quite proud of our immunisation record. The immunisation status of children in South Australia is as high as any in Australia, and we want to retain that. We believe one way of doing that, without there being any coercion or specific legal requirement, is to make it a condition that children's immunisation status be recorded at school entry.

Mrs KOTZ: The blue book (page 11) indicates the subtotal of country hospitals. Will the Minister explain the significance of the change this year to the allocation of fee-for-service payments and patient transport payments which previously have been picked up by the South Australian Health Commission outside the global budget of the organisation which provided the service but which this year have been included in the organisation's global budget? Given that commitments in country hospitals for fee-for-service payments and for patient transport requirements are utterly unpredictable, will the Minister indicate what would happen where the allocation within a global budget for these items of fee-for-service and patient transport services are exceeded?

The Hon. D.J. Hopgood: In general terms the answer to the last part of the honourable member's question is that it would be viewed sympathetically. It would depend on the capacity of that unit to absorb the cost depending on what had happened elsewhere in the unit. It may have overrun that aspect of its budget, or it may have underrun other aspects of the budget which, of course, would be able to support it.

Mr Blight: It has been past practice to exclude fee-for-service and patient transport funding from the global budget, which has had an undesirable effect. Both of those expenditure lines have tended to be viewed as being tied lines. In other words, whatever was expended by a unit, there was an expectation that that level of expenditure would be automatically funded by the Health Commission and Treasury.

Our view is that there is some ability on the part of boards of directors to control both fee-for-service and patient transport costs. By shifting both those lines into the global budget, we are signalling to boards of directors that we do want those lines of expenditure to be monitored. However,

as in past years, we would expect that the actual funding for those lines would be adjusted as real needs emerge; for example, in past years in the fee-for-service funding there has been automatic adjustment of the allocations to take account of changes in the Commonwealth medical benefits schedule, so any price changes for those services have been funded.

In past years demonstrated activity increases—increases in services provided by units which have flowed on into increased fee-for-service costs—have been met. Again in this financial year, we would expect to be mounting those sorts of arguments to Treasury and receiving supplementary funding. We are also signalling that it is a responsibility of boards of directors, if they are going to expand services or introduce new services, to be aware of the fee-for-service impact, and to budget and plan for that in a responsible way.

Mrs KOTZ: Referring to the Program Estimates (page 39) under 'Services for Persons with Drug and Alcohol Problems', can the Minister explain why the number of methadone collections is given the specific annotation of 'approximate figure only'?

The Hon. D.J. Hopgood: I think we will have to get that information. I would agree with the honourable member: it does seem a strange way in which to present it. One would have thought the exact numbers would be available. We will get the exact number for the honourable member if at all possible.

Mrs KOTZ: The Minister may wish to take this question on notice. What are the numbers of staff employed at metropolitan hospitals and associated services, both teaching and non-teaching, in the purchasing and supply departments over the past 10 years, and the total bed numbers over the same period in the same establishments?

The Hon. D.J. Hopgood: The honourable member is correct in her assumption. We will take the question on notice.

The CHAIRMAN: My question relates to the Lyell McEwin Domiciliary Care Services. I understand that a report was prepared by Des McCullough Consulting Pty Ltd entitled 'An Analysis of Funding Provided to the South Australian Metropolitan Domiciliary Care Services with a Focus on the Northern Domiciliary Care Service'. That report, presented to the Lyell McEwin Hospital Board, drew the conclusion that domiciliary care services in the northern region were under-resourced relative to the other services in the metropolitan area by the average of the methods amounting to an annual sum of $690 000. The under-resourcing indicated by the preferred model was something of the order of $230 000 to $480 000. The report came to the conclusion, presumably by averaging all the averages, that the health unit at the Lyell McEwin Domiciliary Care Service is under-funded by an amount of approximately $400 000 a year. That is relative to the other services.

If the total budget is limited, as it must be in the State normally, the northern region must bear its share of the overall limitation. However, the matter raised in this report is not so much with the absolute level of total funding but with the relative allocation to the northern region. I ask whether the Minister or his officers are familiar with that consultant's report and whether any steps are being taken to address the issues it raises.

Dr Blaikie: I am familiar with the report. However, it arrived too late for serious consideration during this current budget cycle. Members will see from the blue book that the allocation to metropolitan domiciliary care services is approximate $17.4 million in this current year, of which the Lyell McEwin Domiciliary Care Services receives $2.874 million. The study was conducted by Mr Des McCullough, a former employee of the South Australian Health Commission. There is some debate about which of the indices it is best to use but, if one were to use the most sensitive of the indices, the so-called Warhola model, one finds that there might be a case for an additional allocation of $230 000 to the Lyell McEwin Domiciliary Care Services.

Domiciliary care services are funded from direct State funds and from Commonwealth Home and Community Care funding, so one of the things that the Health Commission will be doing this year is to pass that report on to the Commonwealth Government and the HACC unit and discuss the possibility that additional funds be made available. As raised in the question, if there were no additional funds in total, some funds would have to come from the two services, both in the east and the west, which are shown to be relatively over-funded. Both the north and the south fared not so well in Mr McCullough's report. The report will be taken into account and I can give some guarantee that there will be a shift of funds in the next budget.

The CHAIRMAN: Is the Minister able to comment on the bed capacity at the Lyell McEwin hospital? It is currently established at a level of 185 beds, but demand is growing locally and I understand that some planning might be under way to extend that in future years. Is planning being undertaken and, if so, what are the indications for the future?

Dr Blaikie: Some planning is going on in the north and the south, the two areas it might be argued are the least well supplied with beds. The activity increase at the Lyell McEwin hospital since the new stage 2 redevelopment opened has been quite amazing. In 1989-90, there was an increase of 12.2 per cent in total admissions to the Lyell McEwin. That is very pleasing in some respects because we have some anecdotal evidence that the leakage from the north to the Royal Adelaide Hospital is not occurring. We think it appropriate that people are voting with their feet and going to their lovely new hospital. The planning study will look into the future requirements for beds in the north in cooperation with the proposed new hospital at Gawler.

Mrs HUTCHISON: I refer to 'Issues/Trends' on page 44 of the Program Estimates as the Minister is aware, I have a continuing interest in the Papsmear campaign which has been operating in the northern area. Will the Minister indicate what impact that program has had on screening levels in the Upper Spencer Gulf cities of Whyalla and Port Augusta?

The Hon. D.J. Hopgood: Prior to the introduction of the active promotion of screening in those cities in late 1987, about 35 per cent of women in the age cohort 20 to 69 years were being screened in a three-year period. By October 1989, that figure had increased to 71 per cent, and I am told that further increases have occurred since that time, although I do not have the detailed figures. Screening levels in those cities equate with screening coverages in Scandinavian countries, where they are reported to be the best in the world. In particular, Aboriginal women, who were seldom screened before, are now being screened to the same extent as other women. That is the impact on the screening levels. I do not have immediately available the indications that have been picked up as a result of that program.

Mrs HUTCHISON: I refer to program 12, page 49 of the Program Estimates, 'Client Benefit Schemes' the pensioner denture scheme and the South Australian spectacle scheme. What is the total funding available under these schemes? Is an allocation made for the cities of Port Augusta and Port Pirie under that scheme? If so, what is that amount?

Ms Johnson: The allocation for the pensioner denture scheme in the 1990-91 financial year is $2.223 million. The

allocation for the spectacle scheme for this financial year is $1.338 million. The spectacle scheme is a State-wide allocation. There is no allocation to any specific area and, as far as I am aware, that is also the arrangement under the pensioner denture scheme. Because the schemes are Statewide, they are available for take-up by anyone within the State, and quite a few country people access both schemes. There is no predetermined allocation for a specific locality or region. It is provided on an as comes basis.

Mrs HUTCHISON: I refer to page 51 of the Program Estimates, 'Development and Control of Health Services'. In the 1989-90 targets and objectives, it was revealed that the cost benefit analysis of selected nurse rostering systems had been completed. Will the Minister explain that? What has been the result of the analysis to the health system in terms of efficiency and cost effectiveness?

Ms Gaston: We completed two studies in the 1989-90 period, one at Modbury and the other at the Adelaide Children's Hospital. The Modbury trial, on completion, indicated no cost benefit and as a consequence that system was not introduced. The system trialled at the Children's Hospital indicated a benefit as a consequence of improved information systems and it was kept in place at the Children's Hospital for that purpose. However, as a rostering system, again there was no cost advantage and therefore it is not being used for its rostering capacity.

During this last financial year and this new financial year, we are trialling a third system at the Lyell McEwin Hospital and at the Royal Adelaide Hospital. The evaluation to date indicates that there will be significant cost savings as a consequence of the use of that system. Already there has been an indication of some 10 per cent saving in nurse manager time spent on rostering.

Dr ARMITAGE: I refer to page 12 of the blue book and the line 'mental health hospitals'. Given the recent difficulties with doctors leaving the psychiatric training scheme at Glenside, what is being done to address the potentially serious shortfall in psychiatrists which will eventuate from the hiatus in the training program?

The Hon. D.J. Hopgood: I have some information about medical staffing at the Glenside Hospital. In August 1990 junior medical staff at Glenside Hospital took industrial action placing bans on the admission of patients not previously known to Glenside Hospital. This arose from a temporary shortage of medical staff caused by some recent resignations, a number of people being on leave and training rotations of trainee psychiatrists.

The Royal Australia and New Zealand College of Psychiatrists and the South Australian Health Commission are working closely to rectify the problems associated with training rotation for psychiatrists and recruitment procedures are under way to fill vacancies for trainees who have resigned. In the interim, temporary medical staff have been engaged on a casual basis—which admittedly increases costs—to ensure that patient care is not compromised. Limited bans not including admission restrictions have been imposed by SASMOA until permanent arrangements are in place, but all industrial action ceased at Glenside on 20 August this year.

Dr ARMITAGE: With respect, that industrial action occurred because, as I understand it, four or five trainees left the training program. In two or three years those four or five psychiatrists will not be at a level to graduate in psychiatry. What are we going to do about the serious shortfall that will cause?

The Hon. D.J. Hopgood: I may have to ask Colleen Johnson to give a few more details if she has them. I indicated that recruitment procedures are under way to fill vacancies for trainees who have resigned. It may be possible to recruit people at the requisite level of training and experience but, if Ms Johnson has anything further to add to that, I invite her to do so.

Ms Johnson: Most parties involved in this area—the psychiatric hospitals and the College of Psychiatrists—believe that this is largely a temporary problem and one which is just one of those things. I do not believe that they particularly see any long-standing inherent problems within the structure of the training programs. However, there have been discussions between the mental health unit of the South Australian Health Commission and the College of Psychiatrists to ensure that, if there are any ongoing problems, action is taken to alleviate them. We have had discussions with the college about its taking responsibility for training in the future. It is keen to do so and I am sure that our difficulties in this area will subside. I doubt that there is an ongoing problem.

The Hon. D.J. Hopgood: Dr Blaikie indicates that he has a little more information, if the Committee wishes it.

Dr Blaikie: There are problems arising in at least three areas of medical training: psychiatry, obstetrics and gynaecology and physician training. To a large extent, of course, the Health Commission is powerless because this decision has been taken by doctors—as I am sure the honourable member for Adelaide knows—going into the training program. Under the structural efficiency principles, a survey is about to occur to determine satisfaction of trainee medical officers in the system, and we hope that that might give us some indication of the steps that we should take.

Dr ARMITAGE: On page 13 of the blue book under the line 'Medical Student Rural Placement', can the Minister explain why preliminary budget allocations indicate an amount which, although slightly increased from last year's allocation, is still less than 1988-89? Taken in concert with the item on page 16 of the blue book under the entry 'SAPMEA (Country)', which indicates that there is no allocation this year for post-graduate medical education in the country, will the Minister explain the exact measures that are being taken to encourage doctors who are already in the country to remain there and to encourage medical students to go to the country?

The Hon. D.J. Hopgood: I might ask the Chairman to explain to the Committee our reasons for getting Dr Livingstone to come to South Australia. As the honourable member may well know, he has been around our country units recently. Dr Blight might also want to add something.

Dr McCoy: The Commission has been aware for many years of the difficulty of persuading medical graduates to go into country practice, of retaining those medical graduates in country towns and of persuading medical students to take up rural practice after graduation. There have been many attempts to overcome the problem and, in my time in the Commission, the situation has gone from one of crisis to one of reasonable stability. In the 1970s and 1980s there were always long periods when small hospitals, especially those on the West Coast, were without medical practitioner attendance.

It is a constant battle and we have recently been very interested in the emergence of the Rural Doctors Association, which is apart from the AMA and the Royal Australian College of General Practitioners. It has recently been established with special promotion by Dr Peter Livingstone, who is the Director of postgraduate education in Queensland. We invited Peter Livingstone to Adelaide and he met the Minister and many people. He visited a number of centres on the West Coast, on Eyre Peninsula. We are now considering how the Rural Doctors Association and the special

training program which has been developed at Toowoomba may be modified and accessed perhaps by the Whyalla hospital in South Australia and by rural practitioners in general and better training for rural practitioners and better satisfaction for rural practitioners can be achieved, so that we can maintain and build up again a strong cohort of medical practitioners in the country.

The pathfinding change in policy in relation to this is that throughout the 1970s and the 1980s there has been movement away from procedural general practitioners because of the strong dominance of specialists in the medical field. What is currently being considered is a rebirth of general practitioners who intend to practise in rural and remote country districts and who are skilled and able to undertake procedures, especially obstetrics.

Mr Blight: We place a very high priority on improving the training of rural GPs and we are looking forward to receiving a formal report from Dr Livingstone on how we might best approach this matter in South Australia. Two years ago Cabinet approved funding of about $200 000 per annum for a continuing medical education scheme for country practitioners. Country practitioners, of course, are private practitioners; there are no salaried staff in the country providing clinical services. So this scheme was made available to these practitioners to enable them to attend courses to either expand their education or engage in skills maintenance by having practical experience in a metropolitan teaching hospital. The priority for that funding was, first, to sole country practitioners; once their needs were met it was made available to small practices and, after their needs were satisfied, to the larger country practices.

A key component of this scheme was the provision of a rural registrar, a trained and experienced country practitioner available on a locum relief basis to any practitioner who participated in the scheme. This means that sole practitioners, in particular, could get away from their practices with the assurance that their patients would be looked after by an appropriately skilled doctor. A small amount of funding from that scheme was made available to SAPMEA to review the education and training needs of country doctors and also for some course delivery in the country.

Dr ARMITAGE: Why has no allocation been made to SAPMEA (Country) this year?

Dr McCoy: About $15 000 has been allocated to SAPMEA.

Dr ARMITAGE: The blue book (page 16) shows that the 1990 preliminary budget allocation for SAPMEA (Country) is nil.

Dr McCoy: SAPMEA is one organisation, and a grant is provided to it. We do not direct SAPMEA or where it should spend its funds.

Dr ARMITAGE: Why then is it designated under 'Grants to Health Agencies' as country and metropolitan?

Dr McCoy: I will need time to access the reason for that difference.

Dr ARMITAGE: I refer to page 10 of the blue book, in relation to the Elliston Hospital. Can the Minister inform the Committee of the planned future for that hospital, given that the preliminary budget allocation for the Elliston Hospital for this year of $719 700 is only $6 000 less than the total allocation for last year?

The Hon. D.J. Hopgood: I am a bit bemused by the use of the word 'only'. Was the honourable member suggesting that the amount would be drastically less than what was allocated last year? The Elliston Hospital has received its budget for this year, and that should be some sort of indication that it will not suddenly have its foundation stone pulled out from under it. The Elliston debate arose from the very simple fact that in this hospital, as in a number of other circumstances, a number of funded beds are grossly under-utilised. In a sense, that is the source of some solace for that country community, because people are sufficiently healthy not to have to fill all the beds in their local hospital. It is also the cause of some concern that we are funding a service which is not being used to the full. However, the problem is that, given the necessity to staff each shift at a particular level, if we simply marginally reduce the number of beds we are not necessarily reducing funding at all.

On the one hand, it would appear to be fiscally responsible to reduce the number of funded beds at the Elliston Hospital, but for industrial and other reasons, in a sense, that reduction is meaningless. So, the Commission is looking at regional planning as to what can be done on the basis of service delivery from a region using a number of health units. We are looking at this across the State, and not necessarily singling out the West Coast, although I understand that some work in that area is to be done in the very near future.

Mr Blight: We are planning to develop regional plans for each of the 14 country regions, including the West Coast. As we develop those regional plans we will accelerate the country health strategy, which is essentially one of improving the range and scope of health services available in the country for country people. There are two areas of priority: one is in the area of specialist medical and surgical services, which we believe should be expanded in each of our regions at appropriate regional and subregional hospitals, and the second is in the area of primary care services, the backbone of which is the general practitioner network which we have in the country and which includes also a range of allied health professional services for women, mental health services, and so on.

Within that general strategic framework we plan to look at each one of our regions and to identify opportunities where we think resources can be reallocated or restructured to meet that strategy. So, it is not principally a plan to make savings *per se*; but a plan to use more effectively the resources that we have available for the provision of comprehensive health services. Eyre Peninsula and the West Coast will be part of that process.

In relation to the poor level of utilisation of the Elliston Hospital, last year the acute daily bed average at that hospital was 2.2 patients, and the nursing home daily bed average was 3.5 patients. If those services were provided at any other hospital on the West Coast, they would have been valued at approximately $350 000, very much less than the actual 1989-90 expenditure on the Elliston Hospital.

As the Minister has explained, that is to do with the fact that a certain minimum level of staffing has to be provided and the patient load is way below the actual capacity of the staff. The number of funded beds would be of the order of 12 if they were all occupied by acute patients. If they were all occupied by nursing home-type patients, it would be slightly more than that.

Mrs HUTCHISON: I note, from page 51 of the Program Estimates under 'Broad Objectives', that the Health Commission has been involved in consultancy in the interests of more efficient management of certain services and I am aware of two of these—the review of psychiatric nursing in Hillcrest and Glenside, and the review of the organisation arrangements for operational management of air ambulance and aero-medical services in South Australia. That was referred to earlier. What has been the value of these consultancies in terms of increased efficiency and cost effectiveness to the Health Commission?

Ms Johnson: In early 1990 Ms Marie-Louise Evans, Principal Nursing Consultant from the Victorian Office of Psychiatric Services, was engaged to review psychiatric nursing arrangements in Hillcrest and Glenside Hospitals. This review resulted from industrial action late in 1989 involving a campaign by the Federated Miscellaneous Workers Union to increase staffing at Hillcrest Hospital. The review was completed in April 1990 and reported very high standards of care in both hospitals. It also determined that both organisations were generally well resourced with nurses.

However, several inefficient work practices were identified, including rostering arrangements for senior nurses, acting-up arrangements when senior staff were absent and management techniques for reducing absenteeism. The review identified the need for additional ward helpers at Hillcrest and night shift staff at Glenside. The South Australian Health Commission is working closely with both hospitals to implement the review's recommendations. Any additional ward helper and night shift staffing are contingent upon reducing sufficient savings from the review's identified work practice inefficiencies.

In relation to the review of the aero-medical services, we talked about that earlier in the day. Certainly, there is an expectation that there will be more efficient allocation of aeroplanes as a result of all the aircraft being managed by one organisation, namely, the Royal Flying Doctor Service. In addition, there have been capital savings in that, at the time of transfer of aero-medical services to the RFDS on 1 July, another Piper Chieftain aircraft was added to the air ambulance fleet. This third aircraft was donated by the Royal Flying Doctor Service at no cost to the Government.

Provision was also made at that time for increased access by the air ambulance service to the Kingair aircraft. It is anticipated that these streamlined arrangements will result in savings in capital costs in the future. We are also expecting to see savings from improved aircraft maintenance arrangements as those aircraft are now under the control, direction and management of the Royal Flying Doctor Service.

Mrs HUTCHISON: At page 46 of the Program Estimates some of the 1990-91 special targets and objectives relate to nursing and one in particular states:

> Consider the feasibility of establishing a system for centrally processing graduate nurse replacements.

I believe that there is a difficulty in some country areas in attracting nurses. Can the Minister advise what effect such a system could have in overcoming this problem?

Ms Gaston: Before answering the question, I will explain the nursing status in the country area. It is worth noting that there is a balance in the supply and demand of registered nurses in country areas. According to our forecasting, it is unlikely that that will change in the foreseeable future. We have calculated that there is also an oversupply of enrolled nurses in rural areas. The central processing of graduate replacements would probably not be of assistance to the grade 1 or 2 hospitals because, as has been mentioned previously, the staffing levels, although in excess of the number of beds occupied, are so small that they are not suitable for the placement of graduates.

So, in fact, such a system is seen to be perhaps advantageous to the major metropolitan hospitals where, in fact, the higher proportion of vacancies take place. Fewer vacancies occur in the rural areas than in the metropolitan areas.

Mrs HUTCHISON: I refer to program 9 of the Estimates of Payments. As the Minister is probably aware, the Port Augusta Hospital has the only dialysis unit outside the metropolitan area and has had a very high occupancy rate and, I believe, a waiting list. I also believe that there might have been a proposal to expand that service. Can the Minister say whether that is correct and, if so, what funding has been allocated to the expansion of that service and what does it involve?

The Hon. D.J. Hopgood: I am fairly certain that I made at least a passing reference to that this morning when talking about some of the expenditures. Mr Blight will be able to give the exact details.

Mr Blight: The regional dialysis centre at Port Augusta is the only major dialysis centre outside the metropolitan area, although we do have single dialysis machines in other country locations. The Port Augusta centre operates six places and it is true that in recent times the demand for those places has increased and has put us in a situation where demand has clearly exceeded supply. We are responding to that situation by introducing a second shift at the centre, so that the available machines will be more highly utilised than they have been in the past.

The Minister said earlier in response to a question about medical equipment that there is some funding for new machines at the Port Augusta Hospital, and that is part of that plan. We have introduced a free dialysis patient transport system between Port Pirie and Port Augusta. The centre needs to be expanded physically. The extra storage capacity required for the second shift means that the centre needs to be augmented. We expect to handle that through minor works allocations this year, and that is why there is no specific budget line indicating that expenditure. I would be confident that, as this financial year unfolds, we will see a significant expansion of the facilities and services that it offers, but there will be only a marginal cost increase.

Mr OSWALD: Page 4 of the blue book, under 'Supplementary State Allocations', shows an amount of $229 000 for negligence claims and legal costs during 1989-90. Will the Minister explain this line and say what are the estimates for negligence claims and legal costs for 1990-91?

The Hon. D.J. Hopgood: I ask the honourable member to ask his next question, and by the time we have answered it we will probably have this reply.

Mr OSWALD: Page 4 of the blue book indicates that in April 1989 a ministerial reshuffle cost $53 000. Will the Minister detail exactly what expenses occurred in this ministerial reshuffle?

The Hon. D.J. Hopgood: This is the charge to the Health Commission?

Mr OSWALD: Yes.

The Hon. D.J. Hopgood: I can only assume that the staffing in my office, given that I have the portfolios of health, community welfare (now family and community services) and the aged, has increased commensurate with these additional responsibilities. I assume that Mr Blevins was serviced in a different way for his prisons responsibilities and, of course, he did not have the community welfare or aged responsibilities, although he had the health responsibility. I can give the honourable member a reasonably detailed breakdown of the staffing in my office, although we would have to go back to the records to determine exactly what it was under Mr Blevins. That could be the only explanation for it. Certainly, I occupy exactly the same office as Mr Blevins occupied; the facilities available to me in terms of hardware and that sort of thing are really no different from the facilities he had. It must get back to some marginal increase in staffing.

Mr OSWALD: I have a supplementary question. I accept that when Ministers change the staff changes as well, but this is a specific charge against the Health Commission, not against Mr Blevins' portfolio. If the Minister is happy to provide that detail later I will be happy with that.

The Hon. D.J. Hopgood: I will do that. I understand that there is some arrangement between the two major instrumentalities. I think that 12 of my staff are accepted as a charge against the commission. However, we will get that information.

Mr OSWALD: I refer to page 13 of the blue book, dealing with the CAFHS line. Will the Minister explain why the estimated receipts for 1990-91 are only $33 800 when the actual receipts in 1989-90 were $878 425? Has there been a major program change?

The Hon. D.J. Hopgood: We will take that question on notice and try to get the answer as soon as we can.

Mr QUIRKE: I understand that in recent years there has been an attempt to rid structures, such as the Royal Adelaide Hospital, of asbestos and that an ongoing program of asbestos removal has been part of the budgetary process for a number of years. How is that program progressing? At what point is that program now, and are significant amounts of asbestos still to be removed?

Dr McCoy: Huge amounts of asbestos are still to be removed from Health Commission buildings, the Royal Adelaide Hospital being the major one. There is asbestos in the Queen Elizabeth Hospital and a small remaining part of the Adelaide Medical Centre for Women and Children. There may also be asbestos in other commission buildings, but these I have mentioned are the large ones. Whenever a contract at the Queen Elizabeth Hospital or the Royal Adelaide Hospital is being considered, asbestos removal is a major cost item involved.

The Hon. D.J. Hopgood: There is also asbestos in some buildings we have quit, but we are no more responsible for the removal of that asbestos than we are for the reletting of them.

Mr QUIRKE: I was under the impression that there was an ongoing program of asbestos removal. Is asbestos removed only when an asset is to be upgraded or refurbished?

Dr McCoy: That generally is the case: we remove asbestos only when major work in a ceiling is undertaken. In such a case we usually seal off the whole floor (or in the case of the Royal Adelaide Hospital it would probably be part of a floor) and completely remove the asbestos before any reparation work is undertaken.

Mr QUIRKE: Page 46 of the Program Estimates under the program title 'Specialist and General Hospital and Associated Services' states:

> Commence transition of the St John Ambulance Service to a fully-paid service in the metropolitan area, and review country St John Ambulance Services operated by a mix of paid staff and volunteers . . .

How far has that program progressed? What is the current volunteer/paid staff ratio in percentage terms?

The Hon. D.J. Hopgood: I believe that the original agreement with St John was that it would be a three-year phase-out process, but I think it would probably be true to say that at this stage the degree of professionalisation has occurred rather more quickly than was originally envisaged. I will ask the Chairman to comment on that.

Dr McCoy: The transition to a fully-paid service is confined at this stage to the metropolitan area and is planned for completion by 1 July 1991. A consultant (Dick McKay, the recently retired Manager of the National Australia Bank in Adelaide) is working with a group of people comprising St John, Treasury, the Health Commission and Government Management Board to look at the transition to a fully-paid service and at ways of increasing revenue for St John services. That is proceeding very well and is planned for completion by November 1990.

The cost of introducing a fully-paid service in the metropolitan area is estimated to be $7 million. There will be an additional cost when the major country centres (Whyalla, Port Augusta, Port Pirie and Mount Gambier) are transferred to a fully-paid service and that will proceed in the 1991-92 financial year and beyond. The first objective is to get the metropolitan area up, and recruitment, training and funding are on track for that to be completed by July next year.

Mr QUIRKE: As I understand it, in the seventh year of medical training University of Adelaide medical graduates are interns in Health Commission hospitals and under their direction. Can the Minister outline how in the past few years their hours of service have changed? I understand there has been some progress in terms of the number of hours that interns are expected to be on duty and in their general conditions of service.

The Hon. D.J. Hopgood: There have been significant improvements in the terms and conditions of employment of trainee medical officers. We are spending about $2.1 million extra in a full year in relation to the way in which this has occurred. The South Australian medical officers award was varied in January 1989 to provide the trainee medical officers with a reduction in ordinary hours of duty from 48 to 43 hours per week and a reduction in the divisor used to calculate overtime payment to 38 hours. They have been gains in the industrial sense. Despite those gains, there are still shortages of trainee medical officers, particularly in obstetrics, gynaecology, psychiatry and physician training. A survey is being undertaken as part of the structural efficiency principle to determine the satisfaction of trainee medical officers with various aspects of their employment and education.

Mr QUIRKE: What are the longest shifts that an intern would be expected to work in one of our institutions?

The Hon. D.J. Hopgood: Sixteen hours.

Mrs KOTZ: I refer the Committee to the blue book, page 9, under the line 'Teaching Hospitals'. Why is the average sick day incidence per employee so different at the Queen Elizabeth Hospital, the Royal Adelaide Hospital and the Flinders Medical Centre? I draw the Minister's attention to page 344 of the Auditor-General's Report, which indicates that the average sick day incidence per employee over the past three years has fallen consistently at the Flinders Medical Centre, is falling after a rise in year 2 at the Royal Adelaide Hospital, but continues to rise on an annual basis at the Queen Elizabeth Hospital.

Dr McCoy: Sick leave of staff is a major problem not only for the commission, but for all employers, be they in the public or the private system. This matter was first brought to light in the Auditor-General's Report two years ago. At that time an investigation revealed that the sick leave incidence in South Australia was on a par with that in private sector organisations and was in the middle of the range when looking at international comparisons for sick leave. From memory, the high sick leave users were from the north-western European countries and the low sick leave incidence occurred in the United States.

In the case of the particular hospitals, we were looking at different rates for different staff groups. It was noteworthy that, although it had been alleged that sick leave was particularly an issue with blue-collar workers, sick leave was at about the same level in most other employment groups. It was not specifically related to a particular group. It has been disappointing to us to note—and we have statistics for three years for Flinders and the Queen Elizabeth, Modbury and Lyell McEwin Hospitals—that there has not been a great improvement in sick leave incidence, despite instructions to line managers to question sick leave occurrence, to counsel sick leave people who are seen to be abusing the

sick leave privilege, and to provide training programs for line managers in the management of staff in relation to sick leave and other personnel matters. It is still relatively high. We do not believe that it is especially high in the Health Commission. It is exceedingly difficult to make a major inroad into it as there is a leave entitlement for sick leave, and it is interesting to see that the number of days is pretty near that entitlement.

The Hon. D.J. Hopgood: I should like to make two comments. If one looks at the average sick days taken per person over the past three financial years by staff group, it is difficult to draw any particular conclusions. The honourable member referred to the Queen Elizabeth Hospital. Certainly it can be demonstrated that among porters and orderlies there has been a continuing increase. On the other hand, in the catering staff group there has been a decline. The catering staff group at the Queen Elizabeth Hospital has the lowest average number of sick days taken per person—I was going to say of all the categories over the three financial years, but porters and orderlies at Modbury did marginally better in 1988-89. It is a confusing pattern with different patterns emerging for different occupational categories in the different hospitals. The other point is that a pilot study is being conducted in the cleaning department of the Royal Adelaide Hospital to determine the effects of the work environment on sick leave absenteeism.

Mrs KOTZ: It interesting that at one of the three hospitals we still have a continual rise. Accepting the explanation that has been given, were there any specific reasons why in this hospital there is such a difference from the other two?

The Hon. D.J. Hopgood: It is a little difficult: it may relate to the occupational mix in that hospital. I will see what further figures I can get for the Committee. I have the average sick days taken per person by the following staff groups: catering, clerical, domestics, nursing, and porters and orderlies for the past three financial years. That to which the honourable member refers does not show up when one dissects it down to these categories. As I said, porters and orderlies have increased from 8.13 in 1987-88, through 9.84 in 1988-89 to 12.68 in 1989-90. That in itself is only marginally above Flinders Medical Centre for porters and orderlies. On the other hand, in the catering area there has been a decline at the QEH from 10.85 in 1987-88, to 8.10 in 1988-89, to 6.98 in 1989-90. It is a confusing pattern. We will try to get some improvement for the honourable member and the Committee on the figures that we have before us.

Mrs KOTZ: My next question relates to page 9 of the blue book, under the line 'Flinders Medical Centre'. Is any specific funding allocated for the children's assessment team at Flinders Medical Centre?

Dr Blaikie: The short answer is that no specific money has been allocated for the children's assessment team at the Flinders Medical Centre. Specific money has never been allocated to that team at Flinders Medical Centre. Hospitals receive global budgets and it is up to hospital management and the board of directors to direct funds. With the children's assessment team, established in 1976, the aim was to provide a one-stop assessment and review of children with learning, behavioural, motor and speech problems rather than refer these children on different days to a range of professionals. That is a most laudable approach in the delivery of care. The team deals with about 80 children each year, about half of whom have come from referral within the Flinders Medical Centre and another third from the Education Department. In March 1990 the Flinders Medical Centre advised the Health Commission that the members of the team were too busy on other duties to be able to continue with the operation of the team and the hospital put in a bid for additional funds.

We spoke with the management of the Flinders Medical Centre and the clinicians but, more importantly, we have opened negotiations with the Education Department. As I mentioned earlier, about one-third of all clients are referred from the Education Department and we are hopeful that the Education Department will be able to assist with the provision of additional funding to enable the team to continue.

Mrs KOTZ: My third question relates to page 22 of the Financial Statement 1990-91 under the heading 'Expenditure' where it states:

> The Government's decisions have resulted in an overall reduction of $130 million in the no policy change expenditure estimates for 1990-91.

What contribution has the South Australian Health Commission made to these savings? Can the program be identified specifically and what was the saving?

The Hon. D.J. Hopgood: I will obtain details on that as soon as possible.

The CHAIRMAN: I understand that the hospice service at the Lyell McEwin is now moving into a fairly solid phase of establishment, and in fact some six beds are being set aside at the Lyell McEwin for the hospice service and dedicated to it. I read in the estimates of a director of hospice services being appointed. Will the Minister confirm when these six beds will be available, if they are not already available on a permanent basis, and fully funded and established? Where will the director and any associated staff be located?

The Hon. D.J. Hopgood: I did refer to this matter earlier this morning, Sir, possibly when you were out of the Chair. We said at that time that $383 000 would be spent in 1990-91. It was indicated that a medical director was being recruited to coordinate the programs at Modbury and Lyell McEwin, but Dr Blaikie may be able to be a little more specific.

Dr Blaikie: The hospice is to be located in one of the existing old medical wards and work is in progress. I am not certain of the precise date, but it is very close—within the next few weeks. Funds have been made available to the hospital—$390 000 for 1990-91—for the commissioning of those beds. As to the third question on when a director will be appointed, I advise that it is a cooperative arrangement between Modbury and Lyell McEwin Hospitals. I am not privy to the precise details, but it is likely that the director will be located betweeen the Modbury and Lyell McEwin Hospitals. The position has been advertised and I believe that interviews are due soon, but no appointment has yet been made.

The CHAIRMAN: I refer to a more general aspect of the Health Commission. Performance indicators have often been raised in the budget context, in particular by me on a number of occasions. The Health Commission has made some effort in that regard and a number of the programs come with some indication of performance, but probably it has not yet reached the point where one could say that performance indicators were being taken seriously in the papers presented to Parliament. I am not sure whether internally the commission has been able to develop a series of performance indicators which could be used as a time series analysis to show trends and to give some indication of what is expected in the future or whether those indicators are used at all internally. What thought has the commission given to making those indicators part of its budget presentation rather than specific verbal discussion targets? Is there some indication of health statistics and performance in

terms of productivity and health outcomes in South Australia and, if so, have they been developed internally or used externally and specifically in relation to budget material?

The Hon. D.J. Hopgood: It is a broad question that relates to health prevention as much as it does to the effectiveness of the hospitals themselves. If we look at it anecdotally, one would say that one obvious index is the rapidity with which any hospital is able to respond to accident emergency and so on. There is always a degree of controversy over the extent to which booking lists are any sort of index. Professor Coster in his report two or three years ago indicated that booking lists were a poor index of performance and gave a number of cogent reasons why that should be the case. Even more controversial are the so-called infamous DRGs used in other States and here and which are the subject of a good deal of controversy, so much so that it is probably safer for the Chairman to comment than for a mere politician.

Dr McCoy: The general question is the one that would have the highest attention in the commission. We want to move from an era of historical budgeting to one of output based budgeting. It is fair to claim that the South Australian Health Commission in the past 10 years has made considerable forward moves and is indeed now a national leader in terms of costing patient episodes and being able to allocate funds to hospitals on the basis of what they do and what they produce rather than what they want. The DRG case mix analysis, which has been developed principally by Robert Aust (the Director of the Information Branch in the commission) in conjunction with many other people, has been used over the past three years to monitor the allocation to the major teaching hospitals and to lessen the gaps between those teaching hospitals. You would know, Sir, that there was a time when Modbury Hospital was funded to a much higher level than was Lyell McEwin. Over the years with DRG costing and other measures that disparity has been reduced and in the last report the difference was some $200 000.

Ray Blight is developing a DRG-based funding system for all country hospitals, which is a giant step forward. The DRG system is used to measure that other large output of a hospital which we do not have a good measure of at the moment, that is, outpatients and casualty departments. It is being developed also in the commission, and it is hoped that in about a year we will have a useable system to indicate proper funding for outpatient services.

In relation to other specific targets, we are specifically funding hospitals to perform a certain number of operations. In the past 12 months, the special booking list funds were provided to allow 1 300 additional operations, and that target was achieved. Regarding targets for other performances, such as the average stay in hospital, earlier today the Minister issued a strategic plan which calls for a reduction in two or three years of the average stay in hospital by about a day. The commission is trying to develop an objective measure of its performance and is walking away from historical methods.

The Hon. D.J. Hopgood: Earlier on we took a question on notice about the breakdown of administrative expenses of the AIDS program. For reasons that are not clear to me these administrative expenses are grants and not expenses at all. In brief, $581 000 of the $615 000 is paid as a series of grants, $12 000 for travel and $22 000 for general administration expenses. Without taking up the time of the Committee to give the exact details of the $581 000, I can indicate that, as was perhaps expected, the largest amount was paid to the AIDS Council but other amounts were paid to groups such as the Haemophilia Society of South Australia, the Family Planning Association, Catholic Education Office, the Aboriginal Medical Service and the like.

Mrs HUTCHISON: I refer to page 32 of the Estimates of Payments. What is the funding for the Port Pirie Environmental Health Centre for 1990-91, and can the Minister outline how successful or otherwise the programs provided from that centre have been?

The Hon. D.J. Hopgood: As I understand it, this initiative was originally set up in relation to the Port Pirie lead problem. There has been an evaluation indicating that the lead decontamination program has been effective in significantly reducing the blood lead levels of Port Pirie children, although it is not possible to determine the relative effectiveness of the varying components of the program. There is a necessity for continued action to decontaminate the Port Pirie environment. In general terms I can say that the blood lead levels in Port Pirie children have reduced by 20 per cent, and the proportion of children above the so-called level of concern has halved since the establishment of the program.

Blood lead levels have decreased in all children whose home environment has been treated, but the respective effects of general environmental modification and home treatment were not able to be quantified. However, there is evidence that the home environment is subject to broader environmental influences. The strategy for decontamination will continue in 1990-91 and there will be further investigation of the way in which lead enters homes. Since the inception of the program in 1982-83, expenditure has totalled $14.8 million.

Mrs HUTCHISON: One of the specific targets in the 1990-91 objectives in the Program Estimates (page 47) states:

> Further introduction of special health programs in health promotions and illness prevention for women in country areas.

What will this involve, and what areas have been targeted in the first instance? Who will be responsible for these programs?

Mr Blight: Some initiatives are about to be taken in this area in the country under the auspices of the Commonwealth Government's national women's health program, which is a national program cost-shared between the States and territories with funding estimated at around $33 million to be available over a four-year period. The proposal is for the State's shares to be allocated on a pro rata population basis. The national program focuses on three action areas: improvements in primary health services for women; the provision of consumer health information and education; and continuing education and training of health care providers.

The commission accepted an argument that priority should be given to country women in attracting and deploying funds under this program. The funds do have to be matched dollar for dollar by the State Government and it was proposed that last year (which was the inception of the scheme), this year and next year, the matching would be provided by the Country Health Services Division within the commission so that all of the funds under that program can be deployed to program information and training for country women's services. A country women's health service advisory group has been established within the commission to advise on how those funds should be deployed. That committee has representatives on it from the CWA, the Women's Agricultural Bureau, the South Australian Rural Advisory Council, two country general practitioners (one male and one female), the Family Planning Association and so on.

At this stage, the total funding likely to be available under that program in this financial year is about $350 000. I have

yet to receive a formal recommendation from the advisory group as to how that should be deployed, but I understand that two priority projects are being considered: one for the Southern Hills region, and another for the Upper Spencer Gulf region. I think that latter program is building on the excellent Pap smear demonstration program mentioned earlier, but we will extend services beyond the current cervical smear service.

The Hon. D.J. Hopgood: We also have some information on a birthing centre at Port Augusta, which I think would be of interest to the Committee, and to the honourable member.

Dr Filby: In its 1989-90 budget, the Commonwealth Government announced a funding package to assist State and Territory Governments to establish alternative birthing centres or services for women. In essence, that program provides some contribution towards the establishment costs for such centres, the funding for meeting the salary of one midwife and a contribution, probably through the medical benefits schedule, for the cost of home, midwife-assisted births. At this stage, the commission is seeking expressions of interest for a number of proposals in relation to this money, one of which is to establish a birthing service in and around Port Augusta.

The Hon. D.J. Hopgood: The member for Newland asked a question earlier the burden of which was, in terms of the Government's overall no policy change, what is the contribution being made by the Health Commission in its budget to the savings which have to be realised by Government? The short answer is, 'None at all.' In this sort of situation where there has been a reduction in real terms in State recurrent outlays, there will be, in relative terms, winners and losers. In fact, our allocation on no policy changes increased by $488 000 and, depending on what might happen with future salary and wage increases during the year, we might finish up with recurrent outlays increasing by between 1.5 per cent and 1.6 per cent in real terms this year. So, we are a net gainer rather than a net provider to that budget task.

Mrs HUTCHISON: One of the stated objectives (page 47 of the Program Estimates) is to establish a system for the ongoing provision of nurse re-entry programs. Where will these programs be carried out? I am aware that the North West Education Centre in Whyalla could do it. Where else will the programs be run? What numbers are being looked at this financial year in terms of re-entry training?

Ms Gaston: The Health Commission is funding approximate 150 places this financial year, about 36 places being at the Royal Adelaide Hospital. The remainder are to be conducted from the Sturt campus of the South Australian College of Advanced Education. According to need, these courses are available for general nursing, psychiatric nursing and midwifery. There is no plan to provide such a service from the North West Nurse Education Centre in Whyalla. However, a significant distance learning mode is available from the Sturt campus for the 120 places that are available. As I understand it, approximately 40 per cent of those places are taken up by women, predominantly, returning to the work force from country regions.

Dr ARMITAGE: On page 50 of the white book, it is indicated that one of the objectives is to 'encourage more people at risk of HIV and STDs to undergo appropriate screening'. What does the Minister believe is 'appropriate screening' and how will the Health Commission encourage those at risk to have screening tests as this line indicates?

Dr Kirke: One particular response to that more general question could be the harm minimisation program or the needle exchange programs, which are designed to exchange needles, to provide education and to recommend screening for people who believe themselves to have been at risk of contracting HIV or other STDs. We are also promoting the notion of screening pregnant women around the State. We also—

Dr ARMITAGE interjecting:

Dr Kirke: Voluntarily, yes. We are also negotiating the prospect of making HIV positivity a notifiable disease, which will have quite marked effects on screening programs around the State.

Dr ARMITAGE: How will you encourage people to have these screening tests? What specific programs will you undertake to do that?

Dr Kirke: That will be done through the harm minimisation people, as they go around, making encouraging noises. The advent of AZT being more widely available, and the prospect of it having some beneficial effect on people who are HIV positive before they become symptomatic is, in itself, an encouragement to be tested for people who are concerned that they may be positive, because they will not be given AZT unless they are shown to be positive. Those two things and other issues that flow from them are the major factors.

Dr ARMITAGE: On page 50 of the white book, one of the 1990-91 specific targets and objectives is to 'Devise strategies to reduce the risk attributed to home birth'. What strategies are envisaged? What are the budgetary implications? How many full-time equivalents will be involved?

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

Dr ARMITAGE: Page 38 of the white book deals with services for the aged and physically disabled. One of the specific targets and objectives is the 'development of cooperative working arrangements and clear role definition for major service providers'. Will the Minister explain what budgetary allocation is put towards this item? How will the cooperative working arrangements be enforced and evaluated? Which major service providers need a clear definition of their role?

Dr McCoy: The establishment of cooperative working arrangements between the separate organisations funded by the South Australian Health Commission is a major and ongoing task. In recent years, a number of initiatives have improved that cooperation immensely. At the top of that list, I would put the creation of the Metropolitan Hospitals Coordinating Group, which comprises the administrators of the eight major hospitals in Adelaide, David Blaikie, some senior staff from the Metropolitan Health Services Division and me. That group meets every two months and is very important in establishing cooperation between the separate hospital organisation units and in communicating between those units, which is a major factor in improving the cooperation.

Reporting to the Metropolitan Hospitals Coordinating Group are a number of trans-hospital programs such as in renal services, in diabetic services, in trauma services, in neurosurgical services and in a range of other specialised services. These programs comprise the program leaders in each of the hospital units and have the task of ensuring that there is close integration of their services and, if possible, sharing of resources and information. In addition to the Metropolitan Hospitals Coordinating Group, there is a Metropolitan Community Health Services Coordinating Group, which has the same brief as the former, although it comprises those metropolitan units that are provided outside hospitals.Those are the two major coordinating efforts.

My other point is that one of the principal roles of the Community Services Division, the Country Health Services

Division and the Metropolitan Health Services Division—which are major parts of the Health Commission—is to establish good cooperation between the units that they fund. I want now briefly to refer to three units established under the Community Services Division. There is a mental health unit, a disability services unit and a general community services support unit. The first two especially have been very successful in forming cohesion between the sometimes competing interests in mental health and in disability services.

Dr ARMITAGE: I now understand what happens; however, I am not clear about what budgetary allocation is put towards this item, nor am I clear about how these cooperative working arrangements will be evaluated.

Dr McCoy: There is not a budget line as such although, as I have said, all the people on the coordinating units are paid by the commission one way or another. Therefore, there is considerable cost in all those efforts, but there is no specific budgetary line. Dr Blaikie may be able to indicate where specific funding of initiatives has been disbursed through some of the specialist programs in the metropolitan hospitals.

Dr Blaikie: Changing tack a bit, I think that that particular reference in the Program Estimates refers to clarification of the role of the Royal District Nursing Society and domiciliary care. As was mentioned earlier, a major review of domiciliary care has been initiated by the Commonwealth Government. There is currently a review of the Royal District Nursing Society. Quite clearly, our target in this current year is to take on board the results of those reviews.

The Chairman is right. There is no specific allocation for that purpose although, for instance, an accident and emergency committee has been established across the major hospitals. That committee has had responsibility for defining the allocation of $300 000 under the hospital enhancement program—in the first year for equipment and in latter years for staff. There are other examples. However, by and large we operate the system on an institutional budget basis so it is often difficult when programs then run across institutions.

Dr ARMITAGE: I would like to thank the Health Commission members for the way in which they have answered the Opposition's questions.

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

Works and Services—South Australian Health Commission, $54 615 000

The CHAIRMAN: I declare the vote open for examination.

Mr OSWALD: The Minister is the administering landlord of Seaforth House, the community centre at Somerton Park, by virtue of the carry-over when it was run by the old South Australian Hospitals Department—I think it goes back to about that time. There has been some discussion in the public arena, as the Minister will be aware, for some months now about the security of the lease of the community centre. The Minister will be aware that I wrote to him many months ago seeking clarification about the lease. As we have not heard from the Minister and as other departments have been carrying out valuations of the property, the Minister will appreciate that the users of the centre are concerned about their future. Will the Minister clarify the position as to the security of the lease? Is the Government planning to sell the real estate? If so, what security of tenure does the existing community centre have in light of the fact that the lease could be terminated and the property put on the market?

The Hon. D.J. Hopgood: We do not have that information here and I apologise for the fact that I have not responded to the honourable member. I should have done by now and I will endeavour to expedite an early response. It has been suggested to me that technically ownership is mine as Minister for Family and Community Services and not as Minister of Health. Perhaps a little later in the afternoon we can give the honourable member further clarification.

Mr OSWALD: As a supplementary question, perhaps the officers from FACS could be working on that, because I will repeat that question. It is a matter of great concern to the users of the centre and also to local residents who would like to know what is to be built on the property adjoining their existing properties.

From page 27 of the blue book, under 'RAH—Replacement Linear Accelerator', I note that, of a total cost of $3.8 million, $512 000 has been spent so far. Given the number of disturbing reports that I have received about down-time on the linear accelerator and the long waiting times for patients who are already under great stress because of the seriousness of their illness, will the Minister give an update about the exact status of the purchase of a replacement linear accelerator?

The Hon. D.J. Hopgood: The Chairman was there yesterday, so who better than he to tell us?

Dr McCoy: I understand that the equipment, which is a Siemens linear accelerator, will now arrive in March 1991. The preparatory work will be completed before its arrival, but there will then be some months before the machine is properly calibrated and able to be used. We had a discussion with the Director of the hospital and of the radiotherapy department yesterday about the provision of radiotherapy services and we are examining a number of options to overcome this interruption of service which will occur when the new linear accelerator, which is to arrive in March, is being installed.

Mr BLACKER: I seek information about the planning and likely timing of the redevelopment of the Port Lincoln Hospital.

The Hon. D.J. Hopgood: In 1991-92 the Port Lincoln Hospital is due for a new kitchen, the cash impact on the capital budget being $1.2 million, and then in the following financial year there will be a redevelopment costing $8.6 million, which will clearly be considerably more fundamental than this year's expenditure. I do not know whether the honourable member wants further details, but we can get them for him.

Mr OSWALD: Is the Clovelly Park Health Centre owned by the Health Commission? I note in the documents that there was a reference to a reappraisal of the future of the centre. It has been put to me that the Government may be planning to purchase another property at some time to replace that centre and expand it. Is that the case? Will there be some property purchased? If so, has allocation been made for it?

The Hon. D.J. Hopgood: I referred earlier to the deals made with the City of Marion. It would be ideal if these services could be accommodated in the property purchased at Marion. Not very long ago I attended a farewell for Dr Southgate at the Clovelly Park community health centre: the quarters there are very cramped and we feel we can do better at Marion. The current property will be sold.

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

Family and Community Services, $168 408 000

Chairman:
Mr M.J. Evans

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

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

Departmental Advisers:
Ms S. Vardon, Chief Executive Officer.
Ms A. Howe, Executive Director, Operations.
Mr G. Boxhall, Director, Administration and Finance.
Mr R. Bos, Manager, Financial Services.
Ms R. Ramsey, Director, South-West Metropolitan Region.
Mr P. Bicknell, Director, Family and Community Development Unit.
Mr R. Leahy, Manager, Home and Community Care Program.
Mr L. Powell, Commissioner for the Ageing.
Ms S. Castell-McGregor, Executive Officer, Children's Interests Bureau.

The CHAIRMAN: I declare the proposed expenditure open for examination. I refer to the Estimates of Payments pages 36 to 40, page 28 of the Estimates of Receipts and pages 50 to 70 of the Program Estimates.

Mr OSWALD: There is serious concern that little new money has been made available to the non-government community sector to allow for the effects of the new award increases. According to the Program Estimates, there will be a revision of the current grants funding system, but it does not appear to set out what new money has been provided. For the first time, many organisations will be required to pay overtime and other penalty rates for evening and weekend work. Whilst many are adjusting their service delivery to avoid penalty rates wherever possible, a number of services will find it most difficult to accommodate changes in service delivery hours. This will mean considerable increases in salaries which would not have been taken into account when Government funding was allocated.

Whilst the Minister is cognisant of the facts and has taken advice from various organisations, there has been no firm commitment to ensure that community organisations will be funded to cover these significant cost increases. A letter from the Department for Family and Community Services recently advised community organisations that, as the department had increased funding by 6 per cent last year, all salary commitments of the organisations could be met out of this funding increase. If this line is pursued, organisations must accept that the funding increase for the past 12 months was for salary commitments and no allowance was made for inflation in the costs of goods and services.

How much money in real terms has been made available for new award increases during 1990-91; does the State Government anticipate cutbacks to non-government services and/or staff; and does this mean in practical terms that any pay rises to staff members will mean that fewer hours will be worked and that some organisations will have to find their own on-costs?

The Hon. D.J. Hopgood: The Industrial Commission brought down the award on 13 July to commence operation on 12 August 1990. As the honourable member has indicated, it covers those workers employed in the industry of social and community services. The main exclusions from the award are State and local government employees, and workers employed under the Skillshare and Supported Accommodation Assistance Programs. Temporary exclusions are also in place for IDSC funded positions and family support homemaker services.

The principal cost implications of the award are the contributions by employers of 3 per cent of salary for superannuation, time travel for use of private cars at 40c per kilometre and the payment of shiftwork and overtime allowances where appropriate. The exact cost to organisations of the transitional payment of salaries is still unclear.

The Department of Personnel and Industrial Relations has advised that the 6 per cent increase passed to funded organisations in January 1990 covers the two 3 per cent structural efficiency adjustments and no additional funding for salaries will be paid.

A detailed costing is being prepared for consideration by Treasury and Cabinet. In our discussions with Treasury officials and the Minister of Finance we made them as aware as we possibly could, given our limited knowledge at that time, of the implications of possible interim award determinations. My understanding is that some account was taken of that in the overall Government budgetary position. However, it simply was not possible when the estimates were being prepared to provide anything close to a realistic appraisal of what might be required or what might be fundable by Government, and for that reason there is no specific allocation in these lines.

I have had discussions with some of the representatives of the agencies obviously affected by all of this and we have agreed to continue to discuss the whole matter. There is of course the matter of the community services review which the honourable member may want to ask me about quite separately later on. The genesis of that in part has been the imminence of the awards, but it will take quite some time and the problem is with us right now rather than in the immediate future. We cannot rule out the possibility that some agencies will decide to withdraw some services on the grounds that that which was an economic service delivery previously is no longer in light of the award commitments that have to be met. That also obviously is being discussed and will be picked up in the review. The honourable member referred to a letter, and perhaps Mr Bicknell will address that point before we move on.

Mr Bicknell: The issue raised involved the 6 per cent and the letter we sent to agencies. The issue was that one of the costs in the interim award was related to salaries, and at the back of the interim award was a very complicated transition arrangement to set a salary rate. Basically that salary rate was according to average wage adjustments set by the South Australian Arbitration Commission since 1986. The last two changes amounted to 6 per cent—two lots of 3 per cent structural efficiency changes. In the letter and following the advice of DPIR, we wrote to groups to say that if they passed on the 6 per cent that we paid them (just by coincidence the same amount) they would have satisfied the requirements of the interim award and there would be no further costs for straight salary with the interim award.

The issue then of whether the 6 per cent was taken from somewhere else does not apply because they had already

paid it in anticipation of the two 3 per cent changes. In the past, groups funded by the Family Community Development Fund have not been paid under an award and we have passed on to groups and they on to their agencies indexation according to a cost of living payment which has been significantly higher over the past several years than average wage adjustments. They also got 6 per cent on top of their on-cost provisions, so services using operating cost money would have got that 6 per cent. The question you asked about goods and services would have been covered by the 6 per cent which was applied both to salaries and to operating costs.

Mr OSWALD: I will need to analyse the reply. As I read the letter, organisations concerned a year ago were given an increase in their budget to account for inflation. That has now been taken away from them because of award restructuring. If that is not the case and is contained in your reply, I would analyse it. That is where the concerns lie.

Mr Bicknell: One of the difficulties is that the interim award does not set a salary rate as do most awards. It does not say that if you are a group worker you will get a certain salary. That is still to be discussed as there was an agreement on it. It will be part of the full award that will come in within six or nine months and they have more significant costs, particularly for salaries. Here, they have sought to ensure that workers have had the changes announced since 1 July 1986. For groups funded by the Family Community Development Fund it has been increased with the CPI and they are significantly ahead of changes they would have made had they had average wage changes. We are saying that if they passed on the 6 per cent that we gave them as at 1 January they would have satisfied that transition arrangement and there should not be significant increases.

Mr OSWALD: At the end of the day some organisations will reduce services and that is a concern to us all, as was expressed by the Minister also.

Mr Bicknell: Other issues with more significant impact than the 6 per cent in terms of the interim award also prevail.

Mr OSWALD: My next question relates to page 35 of the Estimates of Payments. The 'Budget and its Impact on Women' at page 85 states:

> The department has 20 committees with a total of 105 female and 119 male members.

What is the title of each committee, the names of the members, the function of the committees, the date on which each was formed, the membership fees and where they were paid, budget costs of servicing each committee and how often each committee meets?

The Hon. D.J. Hopgood: I will take that question on notice. We can have it in tabular form for the Committee immediately after the dinner adjournment.

Mr OSWALD: What were the names of any consultants employed by the department in 1989-90? What was the cost of the consultancies and their purpose? Will the Minister release any reports by those consultants? Has the Minister budgeted for any consultants during 1990-91, at what cost and for what purpose?

The Hon. D.J. Hopgood: I have the details immediately in front of me. It is reasonably lengthy and it may be better if we send it around. To give an idea of the range about which we are talking, we had a monitoring project on household surveys (a joint project with the South Australian Urban Lands Trust); two consultants who worked for us on the Aboriginal Family Care program; the Family Information Service; Crisis Care; Courts Services; Program Planning; Family and Community Development; Project Manager, Justice Information Systems; Review of Fire Safety and Security Procedures and Shelters; a valuation of the mandated notifiers package; and an evaluation after four years of YSAAP (Youth Support Accommodation Assistance Program) in the State. Several others included a domestic violence referral service; outreach source; an evaluation of the women's emergency service project; Adelaide Housing Outreach Centre; and Riverland accommodation forum and media relations. All of that information is immediately available. We will have it copied and made available to members of the Committee.

Mr OSWALD: Does that include the costs of the consultancies?

The Hon. D.J. Hopgood: Yes.

Mr OSWALD: Are the consultants named and information given on who was involved and the recommendations that were made?

The Hon. D.J. Hopgood: The recommendations are not available in all cases as some are still not available to us. Where that information can be released it will be released, but in some cases work is proceeding or we are in the process of digesting the recommendation.

Mrs HUTCHISON: I refer to 'Strengthening individuals and families' on page 54 of the Program Estimates and the estimated expenditure on family and community development grants. Is it intended that this amount will be increased with revenue from Club Keno to compensate community groups for their expected decline in revenue?

The Hon. D.J. Hopgood: The Premier met with representatives of the Institute of Fundraising and wrote to at least two major charities late in 1989. He made it clear that it was not the Government's intention to deprive charities of funds and invited them to monitor the impact of Keno and advise the Government of any adverse consequences of its introduction. It was suggested, in turn, that I might invite welfare organisations to brief me so that if necessary I can intercede on their behalf. However, it was made clear that such intercession would be unlikely to succeed unless it was accompanied by well documented facts demonstrating that revenues raised by the organisations from gambling activities had actually declined. So that is proceeding. There is no actual specific outcome as yet.

Mrs HUTCHISON: My second question relates to something that I have not been able to find in the papers. I have had some approaches from groups in my electorate and I wonder why there is no allocation in the documents for the Marriage Guidance Council of South Australia.

The Hon. D.J. Hopgood: This has been raised directly with me. The Government funds the organisation known as COPE, community health centres and many other family supports in the community. Obviously the Marriage Guidance Council does very valuable work, but it is only part of a larger picture of services. In terms of the broad spectrum of services with which the Marriage Guidance Council is associated, we fund as generously per capita as any other State. It just happens that we fund in a slightly different way.

Mrs HUTCHISON: My third question relates to staff sick leave. What was the total number of days taken during 1989-90? Was that total higher or lower than 1988-89?

The Hon. D.J. Hopgood: We will take that question on notice and provide a specific answer after the break. However, in general terms it is the same.

Dr ARMITAGE: I refer to page 55 of the white book. How is the allocation for domestic violence spent? Is South Australia tending to move towards the Queensland situation where the male abuser is forced to move out of the house if he abuses a female, rather than the wife and children moving out?

The Hon. D.J. Hopgood: As I understand it, the figure to which the honourable member refers is an amalgam of funding made available through the Crisis Care Service, the funding of women's shelters and the migrant women's emergency support service, the establishment of an Aboriginal shelter (which is well advanced), the provision of emergency financial assistance to assist victims of domestic violence to re-establish themselves in a safe and secure environment, individual referral and counselling services from district and branch offices, and the designation of domestic violence contact workers in each district and branch office. As to the actual proposition to which the honourable member refers, and that is the Queensland position, certain changes in statute law may have to occur. I will seek advice as to whether it has been discussed at an inter-agency level. These are what are called 'ouster' orders, apparently. It has been discussed but no specific recommendation has been placed before me. In view of the honourable member's interest, I will take an interest in the outcome. I certainly would not rule it out as a real possibility.

Dr ARMITAGE: As a supplementary question, can the Minister explain whether there is an increased allocation for domestic violence in cases of ethnic families?

Ms Ramsey: Specific funding goes to the western areas shelter through women's shelter funding. There are migrant women representatives on the State committee and those particular issues are being pursued by subcommittees of the State committee. It is certainly seen as something that needs to be pursued, and it is one of the areas that the national campaign picked up on. The national campaign is really directing what has been addressed at State level.

Dr ARMITAGE: Program 2—'Strengthening Individuals and Families', at page 36 of the Estimates of Payments indicates that welfare activities will receive no increased funding when inflation is taken into account. Why is this and in what areas does the Government propose to cut services and programs given that there is no increase for inflation?

The Hon. D.J. Hopgood: Is the honourable member talking about departmental programs or programs generally, given that many of these welfare programs are delivered by non-government agencies which, in turn, are funded by Government? Increasingly, of course, our strategy has been to fund these organisations to provide these services rather than doing it ourselves.

Dr ARMITAGE: I draw the Minister's attention to the fact that the actual amount in 1989 was slightly less than the voted amount but the proposed amount in 1990-91 for welfare activities under Program 2 is the same. In other words, there has been no increase for inflation. I wonder where programs will be pruned.

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

Ms Vardon: It is not so much a reduction in real terms as it is a transfer from some payments into another place. Mr Boxhall has some information on this.

Mr Boxhall: If I take the honourable member's bottom line, most of those areas, such as salaries, are affected by several programs dealing with Aboriginal family care. That was spent last year in that program but, in fact, it has been taken out of the salaries and wages line and put into the administration line. So administration, in fact, has increased this year as compared with the salaries component last year. There are major impacts on the $37 million at the bottom because of HACC funding, and all the money that is likely to be spent on HACC this year is not yet shown in the budget. There may be follow-up questions that the Manager of the HACC unit could answer.

For example, last year $27 million was voted and $32 million was spent. This year $32 million is proposed. I understand that when these figures are prepared more money is likely to come from the Commonwealth, which is not reflected in those proposed amounts. There has been no deliberate cut or any failure to allow for inflation. It is just not reflected in the amounts we knew about when these papers were prepared.

Dr ARMITAGE: In 1989-90 the Estimates Committee was given a commitment by the Minister as follows:

> To develop quality assurance procedures in the department in accordance with the recommendations of the Cooper report.

Why is the unit not up and running, despite the fact that a manager was appointed to carry out this important function? Is it a fact that, in many cases, junior and relatively inexperienced staff are the first point of contact to make difficult and complex decisions about the needs of children and families and that, because of staff shortages, these decisions are not being overseen adequately and the rationale for judgments is not always clearly stated?

The Hon. D.J. Hopgood: I would take issue with several of the assumptions in the question, but I will leave it to Ms Vardon to respond.

Ms Vardon: Most of the recommendations of the Cooper report have been implemented. We have set up the Service Quality Unit. In fact, last week we appointed the senior planner. It has been in operation for some time and had three staff, but that unit now has an additional staff person, and that has been a great relief to us. The unit is responsible for upgrading our procedures and our procedure manuals, which is one of the recommendations of the Cooper report. In fact, I have examples with me so that the Committee can see that our organisation is now producing a very clear set of standard procedures and manuals which are widely distributed amongst our people. Cooper says that you should have them and that they are important, although one should not slavishly adhere to them. However, we are getting them on deck.

We are the first human service agency to have a proper service quality plan throughout our organisation (and I can also show this to the Committee). It is so good that the person in charge of our Service Quality Unit has been asked to talk to Professor Corkingdale (of the Elton Mayo Summer School) about human service and service quality planning. We have taken the whole service quality notion very seriously in our organisation. We have had people from the State Bank and other organisations starting a cascade of service oriented projects through the organisation.

I refer to the honourable member's question about supervision and decision-making. It is a myth to think that we do not have supervisors in our organisations or that we do not have enough supervision. In fact, we have a good ratio of supervisors to staff: we have one supervisor to 3.5 staff. I will quickly reflect on the Cooper report, because sometimes too much is read into it. The Cooper report identified a small number of cases of a particular group of people, of whom about 25 were Aboriginal children and about 57 were country children. Aboriginal children and country children have some special problems, and they have had them with our organisation.

One of the things that Cooper recommended was that the way to solve some of these problems is to put on more AASW trained social workers. Inevitably, those social workers will be Anglo-Saxon because the tertiary sector has not yet worked out how to get Aborigines through to graduation, particularly in relation to social work. In fact, I think there has been only one Aboriginal AASW graduate in the whole of South Australia's history. So, it is clear that the white

Anglo-Saxon highly qualified professional approach to Aboriginal poverty and issues in the country is not the answer.

In the past year and a half we have introduced Aboriginal family care committees throughout the country, and they have made a dramatic impact on the care of children of under-aged parents (and I will be happy to talk about that later in greater detail rather than waste time now). One of our problems has been getting quality education to the country. I will incorporate in *Hansard* the qualification levels of our staff for this year.

SOCIAL WORKER OFFICER 1—QUALIFICATIONS

	Aboriginal	No. S.W. Quals.	Ass. Dip.	S.W. Degree	Total
Social Workers District Offices Crisis Care Assessment S.W.	16 (4.5%)	47 (13.4%)	150 (42.6%)	139 (39.5%)	352 (100%)
Group Workers MAYT Adol. Support Teams Youth Project Centres	9 (15.8%)	28 (49.1%)	14 (24.6%)	6 (10.5%)	57 (100%)
Resi Care Workers	5 (2.7%)	160 (86.3%)	10 (15.5%)	10 (5.5%)	185 (100%)
TOTAL					594

Note: Total figures in comparison with 88-89 affected by:
- — snapshot
- — 7 MAYT workers (new funds)
- — 19 base grade S.W. on block recruitment orientation

Ms Vardon: Apart from 13 per cent of our social workers and all of our Aboriginal social workers, all of our social workers have some qualifications. We now have a decent analysis of the qualifications of social workers on the front line doing child protection work, and it is much higher than people think. However, we have not been able to get quality tertiary education to the country. The South Australian tertiary sector has yet to deliver for us, but we have been able to get help from Victoria, Queensland and some other places. We are presently negotiating with the University of New England to do an analysis of the social work qualities required of a country worker. We are negotiating with Monash to get training to our country people. Also, we are negotiating with the country distance education centre of the new university to get the whole of the four-year social work course out to the country, and we have been excited by a new peak of technology called Optel which will do it.

It is important to see the Cooper report in context, because some of the conclusions about the quality of decision-making are assumed throughout our organisation when in fact they were made on the basis of decisions at one end of the spectrum of the work that we do. Last year we instituted extensive supervision training for our senior social workers, and nearly all of them have been to a two-week training program. Next year we will introduce the position of a principal practitioner or a social worker of excellence who will be available to do some of the tasks already identified, that is, to be an arbitrator when professional practice decisions need to be made. We are doing competency analyses of every single social work task and will be training to those in the future. It is not right to say that we have not implemented some of these things. In fact, we have done them and I think we are now well down the track to providing good quality social work in this State.

Mr QUIRKE: Will the Minister advise how the estimated expenditure of the family and community development grants program is allocated and for what purposes?

The Hon. D.J. Hopgood: The grants funds are provided to assist non-government agencies, community groups and local government to develop and provide welfare services to disadvantaged groups and to people with special needs. For 1990, 207 projects have been funded with a total allocation of $5.1 million. Of these, 56 per cent receive funding on a triennial-funded basis, representing 68 per cent of all funds allocated. A family and community development advisory committee advises me on areas of community need, appropriate responses to those needs and recommends allocations to specific services based on the needs-based priorities as agreed to by me and the performance of the service.

I will not take up the time of this Committee by going through the membership of that advisory committee, but it is chaired by Barbara Garrett. I can make the list of members available to the Committee, if necessary. All funded projects are reviewed regularly by the advisory committee with the assistance of project staff from the Family and Community Development Unit. It looks at social justice principles of targeting the most disadvantaged; the extent to which the service is viable and meets mutually agreed upon goals and objectives; and the accountability for the use of Government funds.

Its terms of reference were expanded in 1989 to give particular emphasis to policies and practices affecting families. The advisory committee is currently working with the department to develop a comprehensive policy on ways of supporting the family. This will provide a framework for the provision of family support services and will be based on the research and understanding of the Institute of Family Studies in Melbourne. The family support policy will be the basis of the Family and Community Development State Plan, which will set out the committee's policies, funding priorities, guidelines and accountability requirements each year, and will be developed by the end of April 1991. I can make the terms of reference available if the Committee so desires.

Mr QUIRKE: In terms of workers compensation, how many claims were there in the 1989-90 financial year; what was the total cost of workers compensation in that financial year; of the total number of claims, how many were stress related; of the total number of claims, how many were rehabilitated; and, finally, was the number of claims higher or lower than for the financial year 1988-89?

The Hon. D.J. Hopgood: The total number of claims was 176, and the total cost, according to the Department of Labour figure, was $766 952. Our departmental figure, which includes carry-over costs and other amounts not occurring in the overall financial year, is just over $1 million. Of the total number of 176 claims, 29 were stress claims. The number of claims (176) was lower in 1989-90, as opposed to 196 in 1989-90. I will ask the Chief Executive Officer to

explain the rehabilitation position. It is a little more complex than just a single figure.

Ms Vardon: In 20 of the rehabilitation stress claim cases, the person was back in the position within the year. Three of the claims led to no-one actually leaving work at all. Eight of those people still continue to have help in this year. We are talking of 29 claims. Only four of the 29 stress claim workers in the 1989-90 period are still away from work. Regarding the old claims, seven people are still away from work. Generally, 15 employees in the Department for Family and Community Services are away from work following stress claims. I will have to take the whole of the question on notice, because there are some back injury claims which I cannot detail just now. We are collecting information and will have it available very quickly.

Mrs KOTZ: I refer to the Program Estimates (page 68) and the Estimates of Payments (page 35). My questions refer to the placement of children with foster parents. Country areas with a low level of employment statistically seem to be taking a higher percentage of children being placed in foster care. How many children from the city have been placed in foster care in the country over the past 12 months, and in what country towns or districts were they placed?

The Hon. D.J. Hopgood: We have not got the figures here. We will have to take that on notice.

Mrs KOTZ: I continue along the same line with my next questions. The Minister might also wish to take these on notice. How many children have had multiple placements over the past 12 months; in which towns and suburbs, and for how long each time; what are the rates of payment for the care of foster children; and what was the total amount reimbursed to foster parents for the use of their motor vehicles during the past 12 months? It is alleged that foster families in towns near Adelaide, such as Murray Bridge and the like, bring their children to Adelaide and claim mileage allowance on their private cars in order to make money out of the trip rather than use the school or the local private dental service. What procedures does the department have in place to prevent these alleged abuses of the system, which have been reported to the Opposition on a relatively frequent basis?

Ms Vardon: The question is very broad. We have details of all the rates which are paid, but I think that the honourable member wants to know the total of all the moneys paid.

Mrs KOTZ: That is right.

Ms Vardon: Many foster parent payments, in our organisation, are called incidental payments. Overall, we believe that it costs foster parents more to have a child than the money that we reimburse to them. Exploitation of us or of the Government dollar by foster parents would be in a rare category. 'Exploitation' is not the right word, but foster parents are caring and generous in their own right and it costs them. We will take the question on notice. It will not be easy to get all the information on all the placements. We have just introduced a substitute care A computer register as part of the Justice Information System, and we are going to introduce substitute care B in the next few months, or perhaps next year. That computer record will be able to give us the answers that the honourable member requires. I am not sure that we have the capacity to give details in relation to every child, because there are about 1 200 children, and I think the honourable member is talking about those who came in during the last year. I am not sure that we can detail every placement, but we will do our best to get the exact figures. In one year's time, we will be able to push a button and give the information.

Mr OSWALD: You will be able to give the placements and the time that they stay in a house before moving on; in other words, you will be able to pick out the multiple placements?

Ms Vardon: Yes. There are different sorts of placements. There are some short-term respite placements: a child does not necessarily go into care, but has emergency care through foster care. I assume the honourable member is talking about children who come into the care of the Minister or come in under a guardianship order. If we are to pick out every child in South Australia we shall be in trouble. If we can limit it to those for whom we have formal responsibility, that will be a lot easier.

The Hon. D.J. Hopgood: It is worth saying, in relation to the honourable member's earlier question, that there is a certain culture associated with fostering. This was brought home to me the first time I met foster parents *en masse* on an occasion at Kuitpo. There were no Volvos parked out the front. When I walked in, I got the impression that there were no doctors, lawyers or captains of industry there who represent the various income groups which could perhaps best afford to undertake this responsibility. It is very much a working class and country phenomenon. People are often induced to go into fostering because they were fostered during their childhood. As for the phenomenon of a city child being fostered in the country, that may relate in part to who is available and capable of fostering, though in former days it might have related to certain romantic notions of getting kids out of the busy, bustling cities and into the purity of the open air of the countryside.

Mrs KOTZ: Supplementary to that, it is not my intention to impugn the character of people who foster. I think we all agree that they are very special persons and I certainly credit them in that area. However, I think it should be obvious to the department that there are areas of abuse. The specific area to which I referred relates to trips being made so that car money can be saved instead of children going to the School Dental Service, and so on. I would like to think that that will be taken into consideration and that I will be given an answer on that point.

During 1989-90 a grant of $90 000 was made to SACOSS to provide training to the non-government sector, and a training officer was appointed to the non-government welfare unit. Whilst the Opposition supported the grant being made, what accountability exists for the way in which the money was actually spent? What was reported back to the department on this expenditure?

Mr Bicknell: That $90 000 was available because there was a one-off funding at the end of the financial year, and the Family and Development Community Advisory Committee decided to negotiate with SACOSS against its having this $90 000 to be spent over three years, as it is now seeking to give a higher priority to staff training and staff development. Receivers of all Family and Community Development Committee grants are expected to report annually to the advisory committee on their expenditure and progress. Although it was a three-year grant, it was paid in a one-off sum. This grant will be supervised in exactly the same way, in that SACOSS will provide at the end of each year an account of how it has used the money, what programs have been run and, in this case, what staff development activities it has conducted. The committee will then consider that.

It was a fairly unusual grant in that at the end of that year we could have, for example, bought furniture or equipment because it was a one-off grant: it was not money that was recurrently available. The grant came about because the Commonwealth Government pulled out a family sup-

port program and we were late in knowing that, and we had to fund services for six months. We decided to turn those six months savings into a training grant for three years. There were discussions with SACOSS, which was already doing some training, and we increased that for three years.

Mr HOLLOWAY: In relation to the United Nations Convention on the Rights of the Child and the Australian Government's decision to ratify that convention, will this decision have any budgetary impact on the State? Is the adoption of this convention consistent with support for the family unit and the policies of the department?

The Hon. D.J. Hopgood: It is certainly consistent with the overall aims of the department and the Government. I think it is important to say that there has been some degree of disinformation around that the convention somehow undermines the importance of parents and the family in the development of the child. That is not so: the convention clearly supports the family. It defines more clearly what children's rights are, and is a useful and, I think, long overdue starting point for parents, politicians, judges, and the many others who make decisions about children, including Government departments. I can quote chapter and verse on this.

It is useful in relation to the ongoing debate as to the point at which the State intervenes. I do not think there are too many people who would deny that there are certain circumstances in which the State has a perfect right to intervene in the interests of the child. Of course, at that very point the rights of the parents are set aside, though the ongoing consideration of family reunion is one which continues to be uppermost in our minds. However, once one has conceded that there are circumstances in which intervention can be justified, it seems that the convention is a very useful contribution to that debate.

Ms Castell-McGregor: It is very hard to state details as to cost. Generally, South Australia measures up remarkably well in terms of the conventions, basic philosophy and intent. I could foresee more money being needed for such things as legal representation, the number of lawyers acting for children and costs involved in training the separate representatives. However, I believe there would be an obligation on the part of agencies such as the Legal Services Commission to undertake that, and not just the Department of Family and Community Services. I also believe that Federal Government money should be involved here as well as State money.

I would prefer the CEO of the department to address the issue of the separation of children who are on remand from children who are actually incarcerated for detention. I am not sure whether there would be a cost in relation to this.

Ms Vardon: We anticipate that, in our new centre, we will need to ensure that children on remand and children who are detained will be separated. At the moment there is no such separation, and I think that is probably the only challenge lying before us which we need to deal with as a result of that convention. So, there will be some costs to us immediately to honour the convention.

The Hon. D.J. Hopgood: I think it is important to understand that the convention limits the powers not so much of parents but of Governments. That is what the convention is all about. It is about what Governments can and cannot do; it secures to children rights such as the freedom of religion. One is aware that within the bosom of the family the parents tend to be very powerful determinants of that, and there is a sense in which this secures that capacity of the parents to have a considerable hand in that determination as against intervention by the States, say, in cases of a totalitarian regime or something like that. I think there has been a good deal of misunderstanding, because the essential point is that it is about what Governments can and cannot do as opposed to what parents can and cannot do. I think it is important that that be kept in mind.

Mr HOLLOWAY: In relation to privacy and access to personal records, I am aware, from some of my constituents' cases, of the difficult decisions that officers of the department must face, particularly when they are protecting the interests of children. I am certainly glad it is they rather than I who have to make those decisions. It does raise the question of the rights of the individuals. How many applications for access to records have been received since the introduction of the Government's new program? What type of people have made the majority of applications and, finally, do any charges apply to cover the cost of access to personal records?

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

Mr HOLLOWAY: Will the Minister provide information about the assistance this year for the Meals on Wheels program?

Mr Leahy: Meals on Wheels receives part of its funding through the Home and Community Care program, which is a joint Commonwealth/State initiative. The program provides its funding in a couple of forms. The main one is a per meal subsidy which the Government is proposing to increase by the indexation provision of 6 per cent. That per meal subsidy will increase from 85c, which has been its level for the past couple of years, to $1.04.

We have recently negotiated with Meals on Wheels to rationalise its funding arrangements and to include some other subsidies that we have given over the years in the one figure. We have included the full year cost of salaries for welfare officers and some funds made available for volunteer expenses and rolled those over into one per meal subsidy. This year, the number of meals will peak at slightly over one million. The demand for meals from the organisation has increased. At this stage, additional funding in the program is not sufficient to expand the number of meals delivered, so 1 044 000 meals or subsidy equivalent to that at the dollar mark will be provided this year.

However, in the past, we have been able to provide Meals on Wheels with additional funding in the form of one-off costs for assistance for its maintenance and building program. Since 1985-86, through the HACC program, we have provided over $500 000 in one-off grants for new kitchens and for the maintenance of existing kitchens. Currently, Meals on Wheels has been negotiating with the program to obtain additional funds for more kitchens over the next five years to meet the perceived demand in services from older people, in particular.

Under the HACC program, there has been a recent review of all food services in this State and the report of that review has been released. We are in the process of setting up negotiations with Meals on Wheels to look at the recommendations of that review and the services it currently provides. Once that process is finished, we will look at the issue of providing additional funding for the building program.

Mr OSWALD: When the Minister replied to a question from the member for Stuart about Club Keno, did he imply that compensation would be paid to those charities and welfare organisations which now find curtailed their fundraising capacity in clubs and hotels?

The Hon. D.J. Hopgood: No, that is not strictly true. What I said was that the Premier had met with representatives of some of these organisations, and asked the Treasury to look very closely at the issue. Treasury officials

suggested that I might canvass opinion in my area, because it is particularly my area that is potentially affected, and that, in turn, my department might ask organisations to give us chapter and verse. We have made clear that there would have to be a very close accounting of revenue forgone before we would be in a position to put any particular point of view back to the Premier and Treasurer.

Mr OSWALD: Is it fair to say that it is unlikely that organisations will be compensated?

The Hon. D.J. Hopgood: It is in the balance at this stage. We have no funding for that. We would have to go to my colleagues to get any funding in the circumstances where it could be shown that certain fundraising activities were out of pocket because of Club Keno. At this stage, we have had no specific submissions, but that is not to say that we will not have some.

Mr OSWALD: I turn to page 37 of the Estimates of Payments, program 4, 'Strengthening Community Agencies'. Will the Minister give the committee a detailed explanation of the discrepancy between the vote of $300 000 in 1989-90 and the vote of $12.664 million in 1990-91 for the Supported Accommodation Assistance Program (SAAP)? There must be a reason for shifting such large sums of money. I have read the explanation in the Program Estimates but, quite frankly, it does not quite answer the question. The Opposition wants more information so that it can understand the composition of that $12.664 million and why it is sitting in that line.

Mr Boxhall: The major impact is bringing together under this program all the supported accommodation assisted programs, so $5.7 million is transferred from individual and family protection and $3.7 million from programs for support to adolescents and their families. We now have the provision for women's SAAP, general SAAP and youth SAAP. So, $9.4 million out of the discrepancy brings those budget lines together. There is also some money from a carryover or full-year effect of new initiative funds from the Government for supported accommodation last year, together with new initiatives funding for supported accommodation assistance programs this year, both the general SAAP program and the special Burdekin money. In summary, $9.4 million has been transferred from the two other programs to bring all the SAAP money together and $2.87 million accounts for the inflation carryover or full-year effect of last year's initiatives and the new initiative money this year.

Mr OSWALD: Will the officer give the Committee some indication as to why there is such concern in the welfare industry about that figure of $12.664 million?

Mr Bicknell: Because the new SAAP agreement we have with the Commonwealth takes away from the supported accommodation assistance program its subprograms—this appears in this budget line—when in previous years it has appeared in other budget lines. In the previous SAAP agreement, there was youth SAAP, women's SAAP and general SAAP, and we had to account to the Commonwealth separately for those three subprograms. In the new Commonwealth SAAP legislation, those subprograms are completely out and we are encouraging supported accommodation services to link together and not see themselves completely separately. A number of joint programs, such as the one at Gawler, service young people and families together in the same range of supported houses. Those distinctions are not in this budget. Whereas in the past women's funding may have been allocated in the budget against women's services, and youth against youth, etc., they are now all put together.

I am not sure what their concerns are. The funding here honours the undertaking which the State Government has for a three-year expansion fund in SAAP. This is the second year of a three-year agreement and there is $810 000 in that, which is the second year of the expansion. I would be pleased to answer the point more carefully, although I am not sure what the concern can be apart from the fact that we have put them together in one line.

Mr OSWALD: As a supplementary, I was actually asking the officer. Quite often departmental officers are aware of what the industry is 'talking' about. The industry is telling me to ask questions about this $12 million, saying that there is concern about it and the question must be asked. Officers in the department are the best people to know where there is concern. I was in fact seeking as an exercise in the estimates to ask the officer what is the concern that is worrying everyone about the $12.664 million.

Mr Bicknell: I am not sure.

The CHAIRMAN: Order! The question is directed to the Minister of Health, of course.

The Hon. D.J. Hopgood: I am happy at this stage to hand the ball to Mr Bicknell.

Mr Bicknell: It honours the undertakings that were given. The expectation is that the State Government would match with indexation the Commonwealth offer, which we did, and that we would match the $405 000 which the Commonwealth offered in expansion, and we did that. All those are included. I am not sure about what other concerns people can have. They certainly have not brought those concerns to our attention.

Mr OSWALD: The Minister might find that the concern might surface after people have read the *Hansard* reply. I would be happy to come back to the Minister with further questions at a later date.

Under the Estimates of Payments there is reference to '35 staffing'. The total global increase to family community services is marginally over inflation, although not very much. However, if we bear that in mind, what increases in real terms have been made available to family community services to deal with the high turnover rate of social workers, the fact that there are not enough workers or that workers are not adequately trained, the alleged low morale, poor support structures for country officers and the 400-odd unallocated cases to which the Minister admits of reported child abuse? (The PSA tells me that the figure is up to 1 000 although, for the sake of this afternoon's discussion, I will use the Minister's figure of 400.)

There are allegations through the PSA and other organisations of real concern which need injections of funds and staff and also changes of direction. However, the budget does not pick up the concerns voiced by the PSA and others about where we are going. Would the Minister like to use this opportunity to justify the increase as it stands against these allegations and also the allegations from other parties that perhaps the department should be re-examined, reviewed or whatever?

The Hon. D.J. Hopgood: To the extent that any problem in morale might relate to too few people trying to do too many jobs, I guess that I can say what I said to the Committee earlier in relation to my health budget, namely, that within the context of a fairly difficult budget overall, we have been able to get some resources to enable additional people to be employed to do those tasks. The number is not enormous—I think that the overall increase would be in the order of 10 this year, but with a full year effect of 20 additional people. That will go some way towards addressing the problems which our people in the field have been experiencing.

It is important that I place on the record that a so-called unallocated case is not one that is ignored any more than

the person on a booking list for ear, nose and throat surgery at a public hospital is ignored in the sense that they will, in the fullness of time and possibly before that, be admitted to hospital and undergo their elective surgery.

Cases cannot always be dealt with immediately and there is obviously a program on hand to try to ensure that the most urgent cases are dealt with. It is also true enough to say that our people develop some degree of skill in being able to determine the more difficult cases and those which need to be dealt with very quickly as opposed to those which can be dealt with in a longer space of time.

We have put into place the so-called workload management system which was introduced into the department in May 1989. It has been devised to allow the proper management of case work and related client programs. It reinforces its value as a workload management rather than measurement tool for the social worker, supervisor or manager. It provides better information in relation to the nature of the work being undertaken in an office, particularly about urgency, it allows better reference to non-case work methodologies and it focuses on client work.

The workload management system allows for the use of professional judgment and expertise in the assessment of risk factors to the client. It has four broad divisions: children and adolescents in immediate danger or possibly in immediate danger; children and adolescents subject to court orders, guardianship, direction and correction; children and adolescents for whom specific concerns are held and families needing protection, for example, domestic violence; and families of individuals seeking other assistance.

An urgency rating is attached to those based on the following risk factors:

High: dangerous or critical situation with a high risk of serious harm or where otherwise directed.

Medium: meeting statutory requirements or situations not immediately critical or dangerous.

Low: situations which do not fit the above categories.

That is basically our position. The assistance that we have put in place has been, as I said earlier, the allocation of additional resources to the field through the budget process; the freeing up of positions through the amalgamation in August of this year of two regions and a new resource allocation model which redirected additional resources to those regions. A follow-up study will occur in October this year to ascertain the effect of those changes and we hope that the effect will have been beneficial.

However, I must return to the basic point which is that, in circumstances in which from time to time we hear voices raised against the proposition that the Government should spend more money, we can hardly be surprised if the level of resources that I have allocated to me to attack those problems, although it is an increase, is a modest one.

The resignation rate has some bearing on this matter because, with all the money in the world, if people are resigning quickly enough, we cannot replace them as quickly as we should. The resignation rate at present is running at about 8 per cent, which is higher than we would prefer, but nonetheless is not disastrous and certainly not abnormally high in historic terms.

Mr OSWALD: I was interested in your 20 additional staff, and you led on to resignations. It is fine to have 20 additional staff and to say that we have reorganised two regions and are now in a position to begin to address the problems alleged to exist in the department. If at the same time you have had transfers, and staff out on WorkCover or stress-related causes, one could equate with the other, and we could end up no better off. I believe that the department, as we are moving into hard times in this country, is under-resourced. I would not blame the Minister if he or the Government had increased his budget considerably.

However, I hope that the Minister, to allow me to carry out further research, will provide me with the figures over the past 12 months of how many employees have transferred to another department, resigned or been absent on WorkCover or because of stress-related causes. The Minister might wish to take that on notice, but I am very interested to know the figures.

How many new members of staff have been employed during the past 12 months; for what purposes were they employed; what are the individual academic qualifications under which they were employed; and how many no longer work with the department? It is all very well to say that the department has employed 20 additional staff and done some reorganisation, but the social workers to whom I have talked are very conscientious people who are becoming burnt out. I do not think they are getting the resources or that this budget reflects the need to increase their resources. If the department continues to survive by closing branches, shifting staff and putting up with small additional increases to staff while at the same time the base is being eroded, it will continue to mark time and still be subject to allegations which I, on a bipartisan basis, would like to share with the Minister and resolve quickly.

The Hon. D.J. Hopgood: I thank the honourable member for his support in this matter and I will provide those details to him, but the information that would really enable him to gauge the efficacy of this budget is not immediately available. The number of staff who went off on stress, resigned or were transferred to other departments last year is half the picture, but, if the number of departures in this financial year is no greater than last year, we will have had a real increase by the amount I have indicated. If a person transfers to another department or resigns, it does not mean that position is lost because usually the department is in a position to fill it. However, if the number of resignations and departures, particularly those people who go off on workers compensation, is significantly higher than last year or the year before, that will eat into the growth that this budget tries to make actual. However, as a result of the additional resources we have been given, we will be better off than if we had not received those resources.

Mr OSWALD: The department is not losing people underneath; it is adding on top all the time. It takes a while to gain experience in the department. I have this great fear that the department is adding at the top in all good faith, but it may be losing personnel from the existing ranks. Under those arrangements, the department is not going forward.

The Hon. D.J. Hopgood: It depends on how many we lose as to whether the department is going forward or dropping back.

Mr OSWALD: What about the qualifications and experience of the people the department is losing?

The Hon. D.J. Hopgood: That is a slightly different question. The honourable member is homing in on two problems: one is the total number of bodies available to do a task and the other is the skill mix or the degree of excellence determined by qualification and experience which is reflected within that total number of bodies.

Mr OSWALD: There is a third body, and that is the almost non-growth budget with which the Minister must contend to try to come to grips with this problem.

The Hon. D.J. Hopgood: I can tell the honourable member what that is, and I have. We cannot predict exactly what the department's performance will be in terms of

departures, for whatever reason, in the coming financial year. That, in itself, will determine the extent to which the department is going forward or back or whether it is treading water. In any event, I will provide whatever information I can for the honourable member and the Committee.

Earlier, the member for Mitchell asked three questions about privacy and access to personal records. Approximately 120 people have applied for access to records since the introduction of the program. The department is still in the process of setting up a statistical system which will provide cross-department information. These applications have been made by parents of children who have been taken into care or who have been the subject of child protection notification. As to the amount of revenue received as a result of this program, the answer is 'Nil'. If an inquiry is made in circumstances where a guardianship order is in place—where people are placed under the guardianship of the Minister—it is philosophically and possibly ethically wrong to charge these people. In other circumstances, a charge would apply, but those other circumstances have yet to obtain.

Mrs HUTCHISON: Many people in my electorate have questioned the qualifications of social workers in the FACS. How many social workers have a social work qualification, that is, an associate diploma or a degree in social work?

The Hon. D.J. Hopgood: That information has already been provided.

Mrs HUTCHISON: My electorate office has received a number of inquiries or complaints about financial hardship because of the imposition of the child support formula. Will the Minister comment?

The Hon. D.J. Hopgood: The Commonwealth Government introduced reforms to the child support system because of the fact that, on a national basis, less than 30 per cent of sole parents were receiving regular cash payments from non-custodial parents; an unfair burden was being placed on the taxpayer; research has established that many non-custodial parents who were not paying child maintenance had a capacity to do so. No doubt all members have experienced this as a result of queries through their electorate offices. In South Australia, about 75 per cent of the total amount due to be paid by non-custodial parents was being collected. The Government was concerned that expenditure on social security payments to class A widows and sole parent beneficiaries had increased substantially from $160 million in 1973-74 to $157 million in 1985-86.

The Commonwealth Government noted further that some 85 per cent of Australia's sole parent beneficiaries received social security benefits and many were living in poverty.

A child support consultative group recommended that the level of maintenance be set by means of a legislative formula. The amount to be paid is calculated by taking the non-custodial parent's taxable income, allowing a self-support component and then applying the child support percentage payment as follows: 18 per cent for one child; 27 per cent for two children; 32 per cent for three children; 34 per cent for four children; and 35 per cent for five or more children. A person may apply to the Family Court for a review of the amount assessed under the formula.

There remains the intractable problem of what happens where, even in the face of such an order and under threat of a prison term, a non-custodial parent is not prepared to pay. Some sort of sequestration order can be placed on his or her salary, but there may still be ways in which the individual can get around that. If they go to prison, they lose their job and no income is available to support the family. I understand that, in the majority of cases where it is applicable, this system is found to work and that it would be a fairly rare sort of bird who would be prepared to run the risk of serving a prison sentence for not paying under a court order.

Mrs HUTCHISON: I refer to 'Specialist Child Protection Services' on page 55 of the Program Estimates. The comment is often made to me that it appears that departmental staff have child protection investigative powers far exceeding those given to people such as the police. Why is it so?

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

Ms Vardon: We have some powers under the Community Welfare Act and the Child Protection and Young Offenders Act to make assessments and investigations when it is alleged that a child is at risk. The coercive powers we have for the potential to take children from families or to require medical orders are used rarely where possible. However, in terms of investigation, particularly in the area of child sexual abuse, we like to rely on the police to do that investigation and the interviewing of children. The powers that we have in South Australia are less than those of social workers in other States. It is part of the proposition that the Minister has put to Parliament that we should consider these investigative powers.

Mrs HUTCHISON: As a supplementary question, when will that legislation be introduced?

The Hon. D.J. Hopgood: I think anyone who has been a Minister would be well aware of the fact that one gets a reasonably limited crack of the legislative whip, and whenever a Bill is before the House everyone wants to have a bit of a go at it. On the last occasion, we were not able to proceed with the legislation, because Parliament rose, and that is obviously an invitation for more people to ask, 'Have you quite got it all together?' There has been a further round of consultation based on the previous Bill. A number of changes have been made to deal with concerns that have been raised as a result of that and a new Bill will be introduced as soon as it is ready. The latest information I have is that the Bill should certainly be available for examination by Parliament before it rises for Christmas.

Mr OSWALD: Are there any problems?

The Hon. D.J. Hopgood: No, there are no major problems at all, if I can respond to the interjection. People are concerned not so much for any matters in it which might draw outrage, but rather that there may be means whereby a few extra things thrown in will improve the situation somewhat.

Mrs HUTCHISON: I refer to 'Building Community Support' on page 54 of the Program Estimates. What are the operational aims of the public communications program, and why is it considered appropriate to allocate the resources that have been allocated to that program?

The Hon. D.J. Hopgood: The program aims to achieve more regular and positive coverage of the departmental policy programs and services and of the department's views on social issues through the media to try to ensure that people who present news items have a solid understanding of exactly what the department does, who it does things for and why, and also to equip our staff with skills to inform the media in a constructive manner and also to provide the public with information on the broad range of services which the department provides.

We believe that the public has a right to know about the full range of services that are available. We obviously need public support in certain instances for delicate programs such as recruitment of foster parents and volunteer activities, for example, Crisis Care, telephone counselling and support for young offenders from skills training to rehabilitation activities. It would be very difficult for us to be able to attract these sorts of people and this sort of support if

there was not some degree of media presentation of them (and one would hope media presentation in a reasonably favourable light). That, in part, relates of course to the skills of our people in making those presentations.

Mr OSWALD: Will the Minister tell the Committee how many staff have been in acting positions for more than six months over the past 12 months without the vacancy being advertised under the DPIR and PSA requirements?

The Hon. D.J. Hopgood: It would be a fairly small number. We will get that information.

Mr OSWALD: How many members of staff in the department at CO classification are acting in AO roles?

The Hon. D.J. Hopgood: Again, we would have to get that information.

Mr OSWALD: In the Family and Community Services Department over the past six months how many members of staff have used their own private motor vehicle for official use and claimed mileage allowance because a departmental pooled motor vehicle has not been available? That would be difficult to answer, and no doubt it will require the cooperation of the Government Car Pool. I would like the Minister to look at that exercise because it has been put to me that officers of his department, and indeed other departments, have to use private vehicles and claim mileage allowance because at times Government Car Pool vehicles are out on one month block bookings. This is a budget session and this is an allegation that increases costs. Certainly, there is a requirement for the use of a private motor vehicle for Government purposes and the necessity to claim mileage under certain circumstances, but the allegation that is coming to us is that departmental officers do not have access to Government vehicles in the car pool because some of them are out on a one month booking. It is something that I think should be raised and may require some homework on the part of the department.

The Hon. D.J. Hopgood: For the most part, of course, car pooling arrangements would not be used. They would in certain circumstances. Mr Boxhall may be able to address himself to this.

Mr Boxhall: We have a total vehicle fleet of 224, 172 of which are four cylinder sedans. There are a number of specialist vehicles as well. Most of our staff would have access through their local office to a number of those vehicles. I understand that car pools are operating in several locations in the city and at Murray Bridge, Noarlunga and Elizabeth. I have not heard that people are having particular difficulties. Certainly, those car pools also have short-term hire arrangements, and that, I think, would be the norm for most of our requirements: people would hire a vehicle for the length of their day trip.

Very few vehicles would be out on long-term hire arrangements and it has not come to my attention that our officers are having difficulty with the lack of vehicles because they are out on long-term hire. It would be true from time to time that there would be pressures in getting vehicles, even within our own stock at a local office. We cannot have enough vehicles so that they are sitting there every minute of the day when someone might want one; we have to have vehicles to meet most of the requirements most of the time. We can take that question on notice and obtain more information on where there might be some problems.

Mr OSWALD: I will ask the Education Department officers the same question. Obviously, we do not make up these questions; they are drafted because of allegations that have been made by people in the departments. It may be that the Department for Family and Community Services staff are not as involved as others. However, the loss of access to a pooled vehicle because it is out for a month on a long-term booking and having the departmental officer use his own vehicle and claim mileage should be stopped.

I refer to page 35 of the Estimates of Payments. What is the minimum academic qualification for social workers who are permitted to be involved in assessments of reported child abuse cases? Although we touched on this matter earlier, I would like to formalise the question so that we have a clear understanding of the academic qualifications of a 'social worker' in the department who is involved in assessments of reported child abuse cases.

Ms Vardon: In South Australia at the moment some people in the position of social worker have no qualifications, but the number is very small. I think it is about 13 per cent according to the table that was inserted in *Hansard* earlier. Some Aboriginal staff are also not qualified in the sense of having a degree but have come to us with an enormous range of information and skills as to how to do assessments in their own communities. They are much more appropriate than even the most qualified of perhaps the white Anglo-Saxon social workers. So, the question of qualifications is always difficult, because a university does not necessarily teach someone how to do the assessments that we require. In fact, the Flinders University social work course has had very little content on assessment or investigation; one could almost do that whole two-year degree without bumping into a social work notion. However, that course has recently been reviewed and that deficiency has been pointed out.

At present some people who do not have a qualification are doing that task. However, the present recruitment policy of the department is that, with the exception of Aborigines, a person must have a degree or qualification in a social work-type course. This year that includes the Associate Diploma in Social Work, which will become extinct at the end of the year or may just follow over into the next year. From the beginning of next year we will accept a social worker who has a degree in social work from the South Australian Institute (which will become the new university), a degree in social administration from Flinders or a three-year degree from SAIT. We will exempt Aborigines because, as I said earlier, the universities have failed to get them through.

Mr OSWALD: It has been put to me that the Commonwealth has different criteria: that social workers who are acceptable to the State department are not acceptable to the Commonwealth because of qualification levels. Is that a fact?

Ms Vardon: It depends on how tight the classification is. There are some Commonwealth jobs with the criterion 'social worker AASW only need apply'. There are other rehabilitation counsellors jobs in the Commonwealth and jobs to which the words 'social worker', do not apply but for which the people whom we call social workers would be perfectly eligible to apply. However, the Australian Association of Social Workers has some jobs sewn up, some in hospitals and some in the Commonwealth and, for that job, only those people in our organisation who are AASW accredited would be able to apply.

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

Mr OSWALD: It has been alleged that the ongoing management of children in care has not been a success when compared with handling reports of child abuse cases. What ratio of staff is involved in this work of ongoing management of children in care, and what are their academic qualifications?

Ms Vardon: The children under the Minister's guardianship are equal at the top of our priority list. It has been

said that the management of a State welfare organisation will be measured by the way that it looks after the Minister's children. That is the test that we set for ourselves. Over the last four or five years we have given a lot of attention to children in substitute care or in forms of care other than their family.

If we do an apportionment of the district officers or community welfare workers as a resource in our organisation, we see that of all the work of the department at local office level foster care takes up close to 5 per cent of the resources. If we take into account the fact that we put aside special substitute care workers—at least half a position in every office—we start to look at specially identified staff to do the work. We have introduced regional substitute care workers. We work very closely with the non-Government sector in substitute care. We put a lot of money, through our Substitute Care Advisory Committee, into the non-Government sector. We do not try to do it all ourselves. I could find the millions that we set aside for that in the non-Government sector. We work closely with the Anglicans, the Lutherans, the Catholics and others who have many specialist resources in substitute care. Emergency foster care has taken many of our resources, and we work closely with it in substitute care. It is an absolute priority for us. I have personally put in a lot of time going around talking to foster parents' organisations, and I use that as a check to see the quality of the service. I have been impressed by the number of positive comments that we have had about our work in that area. We are not perfect. There are some children who get a visit only once a year, but in those placements we are usually happy if the placement is a long-term stable one.

Mr OSWALD: As a supplementary question, what are the qualifications of the staff members involved in that area; what are the minimum requirements?

Ms Vardon: It is the same as for those who work in child protection. They are the social workers at the district office. They would be in the same three tiers about which I spoke earlier.

Mr OSWALD: So you have a mix of highly qualified and less qualified?

Ms Vardon: Yes, with the moves that we have been making over the past few years of having everybody qualified, with the exception of Aborigines, because we work very closely with the Aboriginal Child Care Agency in substitute care. The same staff do the two sets of work.

The Hon. D.J. Hopgood: Perhaps I might explain about the question that was asked earlier. I have a very comprehensive answer about the committees. I will explain by referring to one of the shorter aspects of the answer so that members can indicate whether it is in line with what they require. For example, the Medical Guidelines Committee's function is writing medical guidelines and protocol for interviewing children suspected of being abused. The members are Dr George Blake of Flinders Medical Centre, Dr Margaret Moody of the Queen Elizabeth Hospital, Dr Terry Donald of the Adelaide Children's Hospital and Dr Di Hetzel of this department. It was formed in July 1988, there are no fees provided, the budget is absorbed within other budgets and the committee meets monthly. I have similar information on all the committees with which the department is involved. I seek leave to have that incorporated in *Hansard.*

The CHAIRMAN: We also have a document relating to consultancies. Is that in the same category?

The Hon. D.J. Hopgood: That was the subject of a separate question or part of the question. I am happy for this to be incorporated in the record.

The CHAIRMAN: The point that I would make in relation to both documents is that they comprehensively address the matters raised, but they are quite long. Incorporation of them in *Hansard* would be quite an undertaking. Would it meet the requirements of the Committee if those documents were available for duplication and access by individual members, or is there a requirement that they should be incorporated in the record?

The Hon. D.J. Hopgood: We are in the Committee's hands. We do not mind either way.

The CHAIRMAN: I ask the member for Morphett whether it is satisfactory that these quite long answers be made available or does the honourable member require them to be incorporated in the record, which would be quite an undertaking?

Mr OSWALD: I am quite happy, so long as members of the Committee have access to them.

The CHAIRMAN: They will be public documents on the basis that they are available as part of these deliberations but not incorporated in the record because of their size. If that meets the convenience of the Committee, that is what I propose.

Mr OSWALD: If there is one document floating around, to whom do I go for a copy?

The CHAIRMAN: The Clerks will provide it.

Mrs HUTCHISON: I refer to page 55—'Program/Subprogram Resources'. Is the department doing anything at this stage to help small businesses and low income earners in the area of financial counselling; if so, what is it doing; and, if it is doing something, is the facility well used?

The Hon. D.J. Hopgood: The service responds to all people seeking financial counselling, including people with small businesses, farmers, who are all in small business one way or the other, as well as wage and salary earners and social security recipients. The counsellors are trained to assess the financial difficulty and assist in the areas in which they have expertise. Those clients who may be more appropriately helped by other specialist agencies, for example, the Small Business Corporation or rural counsellors, will be referred to those agencies. In complex cases, the counsellor will involve other specialists, depending on the client's need.

Currently, approximately 27 per cent of clients who seek face-to-face counselling are either wage/salary earners or small business people or farmers. The Debt Line—the telephone financial counselling service—has a higher proportion of callers in these various categories. Although the service is available to all, obviously once one gets into the area of more substantial small business people, perhaps it would be more appropriate that they seek advice elsewhere, because that is where the training of our people would tend to run out somewhat.

Mrs HUTCHISON: What effort is the financial counselling service making to better inform the community about money management and credit practices?

The Hon. D.J. Hopgood: There is a community interface program. About 200 community education talks per year have been launched through the program over the past three years. The service is currently developing a money management course which will soon be offered to communities and to which credit providers can refer clients where they have concerns about money management skills. I guess that an applicant in the HomeStart scheme might fall into that category. The service is represented on a Credit Education Consultative Committee, along with key representatives of credit organisations. The aim of the committee is to develop opportunities for young people to learn about credit management. The service has recently been approached by representatives of banks, finance companies and building

societies interested in learning how we assess and help people in financial difficulty. That is probably as a result of a rising number of bad debts due to the ready availability of credit during the 1980s. This opens up an opportunity to educate credit providers, which we are willing to take up.

Mrs HUTCHISON: I refer to page 33 of the Program Estimates, 'Services for the Aged and Physically Disabled', and also to page 38 'Targets and Objectives'. Can the Minister explain the parameters of the aged care review which is to take place on the West Coast in the Eyre Peninsula region; have these parameters been set at this stage; and, if so, what are they?

Mr Leahy: Under the part of the HACC program that is related to funding provided by the Commonwealth Government on an unmatched basis to the States to pilot new and innovative ways of delivering services, funds went into a non-government organisation at Port Lincoln which provides services right across the West Coast area from Ceduna down to Port Lincoln and up to Wudinna. As part of the operation of that service, which is run by the West Coast community services, there was a perception that Aboriginal people did not have adequate access to the home care services which were available to people in the Anglo-Saxon population. As well as that, obviously a number of services already in place for Aboriginal people, provided through the Aboriginal Health Organisation and other initiatives, were seen to have some capacity to be better coordinated.

As a result of that, the HACC program was funded by the Commonwealth under the unmatched program to do some fundamental research into the needs of Aboriginal people, both in semi-urban areas and also in some of the reserves, to look at their needs for the sort of basic home maintenance support services which the HACC program is designed to provide. In fact, that program has been given to a consultant, and that is in the documentation which I believe has been provided. That research is near completion, and hopefully that will provide a model of service provision which will guide the provision of services through the HACC program in the future.

Dr ARMITAGE: The Estimates of Payments (page 36) reveals that $31.9 million was spent on HACC in 1988-89, against a budgeted figure of $27 million. Page 15 of the Estimates of Receipts shows that 3.3 per cent of this additional spending came from the Commonwealth Government. However, in 1990-91 there will be a reduction of $700 000 million in the Commonwealth Government contribution, and the total spending on HACC is estimated to be (according to page 36 of the Estimates of Payments) $32.16 million, up less than 1 per cent on the total spent last year. This adds up to a fall of 6 per cent in real terms. Given the increasing demands on HACC from a rapidly ageing population, can the Minister explain:

1. Why such a small increase is proposed for the HACC program this year?

2. Where the greatest pressures are being experienced in the HACC program?

Mr Leahy: HACC funding is a very complex issue. I will not pretend to be able to explain it simply here. Basically, the HACC program has funds from two sources. First, the joint program, which is a lot of what we are talking about here, since the program commenced in 1984-85, has increased each year, with the exception of 1988-89, to the maximum amount of funds which have been made available by the Commonwealth Government (the State Government has provided matching funds). The complication has been that the Commonwealth has also provided unmatched funds to pilot innovative ways of delivering services and to try to measure the cost of providing alternatives to nursing homes and hostels. Those funds have increased on a year by year basis, starting in about 1986-87 when the unmatched moneys program was introduced, from about $300 000 in the first year of the program to about $2.509 million in the current year. It was $564 000 million in 1988-89, going to $1.981 million in 1990-91, and that has subsequently been expanded to $2.5 million in this current year.

The way the accounts have been presented has taken those funds away, and then added them in subsequently because, basically, the Commonwealth's decision making processes lag behind the presentation of the State budget papers. So, although the funds have been, in a sense, removed, which has presented this apparent drop in funding this year, we can add this year an additional $2.5 million in unmatched funds to those estimates. Secondly, we are currently negotiating with the Commonwealth to include $1.25 million of additional State funds which have been made available through the South Australian Health Commission's Disability Initiatives program. I suspect that today the Health Commission would have indicated that about $1.3 million has been made available for disability services in the State; $300 000 to the Disabled Persons Equipment Scheme and $1 million which is going to some five different disability groups—people with psychiatric disabilities, people with intellectual disabilities such as brain injuries, people with behavioural disorders, and autism.

We are currently negotiating to try to use that $1 million of additional State funds to attract Commonwealth funds to the State as part of the HACC program. Actually, we have a reasonable expectation that we will be successful in that. In fact, that will further distort the figures in the estimates by about at least $1.6 million in terms of the joint funds.

The other factor those estimates do not report is the round sum allowance, which is the figure the Government provides separately from the estimates for salary increases and national wage increases during the year. I believe the amount we received in the HACC program and passed on to the various funded organisations was about $1.475 million, which has not been included in those estimates as a gross figure.

The figures in the estimates relate to the basic program. In some years the unmatched funds have been added on, and then taken off for the next year, producing the apparent drop. The figures do not include the round sum allowances for salary increases, but they do include the $710 000 made available by the State Government for new initiatives in terms of the dementia respite program, which has been part of the Government's policy commitment from last year.

Dr ARMITAGE: Would the Minister like to pass an opinion about the fact that these figures presented for analysis obviously do not give the full picture?

The Hon. D.J. Hopgood: No, they do not give the full picture. I think we are damned if we do, and damned if we do not. I think that, quite legitimately, the honourable member and his colleagues could criticise a Government that put figures in on the basis of a wing and a prayer. Mr Leahy has indicated that it is a stronger expectation than that. However, I do not see how we can at this stage include in our estimates that which we cannot 100 per cent guarantee we will get. We have a very strong expectation that the one million-odd under the Health Commission program disability will be matched by the Commonwealth, but we do not actually have the money, nor do we actually have approval for it at this stage. I know it makes it a little bit more difficult to analyse the figures, but if we were to put

in wing-and-a-prayer figures, we could equally be under some criticism, and quite legitimately so.

Dr ARMITAGE: Perhaps a footnote to the extent that this money was included one year, not the next, and so on, could be added to make it easier for us to analyse the figures.

The Hon. D.J. Hopgood: It is the old problem again of having to compare what was finally spent last year with what is budgeted for this year.

Dr ARMITAGE: Where are the greatest pressures being experienced in the HACC program?

Mr Leahy: From our observation of people of all ages with disabilities, we are aware that there is an increasing degree of pressure on the health and community services system in terms of dementia, which is associated with increasing age. In the demographic sense, our population is ageing and dementia is seen to be one of the greatest pressure points. That is why priority was given to that in the committed funds appropriated this year. The other area is incontinence and, as the member would know from his experience, it is a key indicator of admission to institutions, particularly nursing homes. It is often the straw that breaks the carer's back.

The HACC program provides funds for an incontinence advisory service to give assistance and specialised treatment to prevent incontinence. Something like 80 per cent of incontinence can be treated successfully. We have also negotiated with the Commonwealth to make additional funds available to provide a system in the country, where people tend to miss out on the intensity of the service to which people in the city have access. We have successfully negotiated with the Commonwealth to include that as part of the unmatched funding proposals for this year. Hopefully, if the Commonwealth Minister agrees, there will be an announcement of that in the near future.

The other area is in basic personal care. The need of people with disabilities to have support to perform the basic tasks of bathing, dressing, showering and eating is a growing area. More people want to stay at home. Hospitals tend to discharge their patients earlier, so they need that support at home. Younger people with disabilities are far more inclined to want to stay at home, and that is putting pressure on domiciliary care services. That has been recognised as one of the key growth areas. If we can successfully conclude the negotiation with the Commonwealth, approximately $3 million of new funds will go into that area of personal care for younger people with disabilities, with the spin-off effect of relieving pressure on the aged care services. We are looking forward to that sort of relief.

Dr ARMITAGE: Will the Minister provide information on the percentage increase in admission of patients over 65 years of age to the Royal Adelaide Hospital, the Queen Elizabeth Hospital, Flinders Medical Centre and Modbury Hospital for each of the years 1987-88, 1988-89 and 1989-90? What are the projected increases for 1990-91? Will the Minister pass comment about the ability of public hospitals to cope with the well recognised increase in the admission of aged patients?

The Hon. D.J. Hopgood: Unless the Commissioner for the Ageing has that information available, I will have to go back to my office in the Health Commission to get it, so I will take that question on notice. One of the sources of increasing pressure on the public hospital system is the ageing of the population. The higher the aged cohort, the greater the impact of ailments, particularly chronic ailments, and people look with some concern to the future of the hospital system because we know that our society is ageing.

Dr ARMITAGE: The 1988-89 annual report of the Office of the Commissioner for the Ageing indicated that there were 320 inquiries or complaints about accommodation to the Commissioner's office. Will the Minister categorise the nature of the inquiries or complaints for 1988-89 and 1989-90 and the type of accommodation to which it relates, for example, private dwellings, own home or rental home, retirement villages, profit or non-profit, etc?

Mr Powell: I will have to take on notice the question of categorisation of complaints. I can give some data on the type of complaints applicable to retirement villages, and that has been a source of concern among older people. I can also give some data on inquiries to our nursing homes and hostels inquiry service, which, as the Committee might be aware, handles complaints and inquiries about those two categories of accommodation.

Over the past two years, the Commissioner's office has received approximately 129 complaints about retirement villages, either directly to the office or through the Age Line, the telephone information service for older people. Those 129 complaints can be broken down. There were 46 complaints about management, the largest single category against which complaints were levelled, and it covered a variety of issues, including increases in maintenance charges in retirement villages, unsatisfactory maintenance arrangements, lack of communication with residents, issues of resident representation on boards of management and other management structures in retirement villages, access to financial information, and so on.

The second largest category of complaint concerned the provision of care in retirement villages or, more precisely, the absence of care. Complaints in this category covered items such as misleading advertising about future access to nursing home or hostel care, failure by administering authorities to build supportive accommodation within retirement villages which residents were expecting or had been led to expect by earlier promotional material, problems with 24-hour on-call services, the extent and quality of care provided to people when they are convalescent or have had an accident resulting in broken limbs, and food. The other two categories of complaint involved matters more directly relevant to financial administration.

Mr QUIRKE: What led the department to change its name on 1 July this year? What were the benefits and costs of that change, and was it worth while?

The Hon. D.J. Hopgood: I will deal with the costs first before looking at the benefits. The design costs of the new logo amounted to $5 380. No additional costs were incurred in relation to stationery, because existing stationery stocks were almost exhausted and normal reordering was about to occur. No stationery was discarded. The small amount that remained was overstamped or used for other purposes. A sum of $1 133 was spent on temporary signage and rubber stamps. Permanent signage will be progressively installed as part of programmed building maintenance and upgrading. As to the benefits of the name—it was felt that the name more correctly incarnates the role and aims of the department as they have developed over the past few years.

There is no doubt that the name 'Community Welfare', honoured though it may be in many quarters, perhaps in the public mind, smacks of the old welfare handout. To suggest that that is the department's only role is a gross caricature.

If we see it in terms of a national program, we would want to say that the family payments from the Commonwealth Government, which have been an enormous boon to low-income earners in the past few years, have demonstrated that simply giving money to people will not resolve

all the social problems. The Commonwealth has indicated to the States that it sees the breakdown of relative responsibilities between the two as very much that the Commonwealth is into what is sometimes called exchange payments—for the aged, or families or whatever—and that the States should be into service delivery to address these other problems which arise irrespective of the resources that are available to particular families.

We are only too happy to respond to that as we have been for some time because of the plethora of initiatives, some of which have been explained this afternoon and this evening, in which the department is involved in endeavouring to keep families together. I guess that our basic philosophy is that the family continues to be the basis of our society and that happy and stable families lead, other things being equal, to a happy and stable society and that we should do what we can to try to ensure that that is the case rather than coming in with palliative or bandaid measures later once the breakdown has occurred. On the one hand the name is an index of the role which the department undertakes, and on the other it is an index of the way in which that role will be intensified in future years.

Mr QUIRKE: I thank the Minister for taking that question so seriously, because it is very important. I want now to consider the question of adoption. Perhaps the Minister will want to take some or part of this question on notice. What is the level of adoption in South Australia? What is the overseas component of adoption in South Australia? May I also have information about the costs relating to those adoptions both to the receiving parents and to the taxpayers?

The Hon. D.J. Hopgood: In 1989-90, 32 Australian-born infants were placed for adoption in this State. Twelve children with special needs, including physical, intellectual or emotional disabilities, were placed. One child with special needs died during the year. Forty-eight children arrived for adoption from overseas. One hundred and seventy-seven applications to adopt were received. As applications were not taken for most of the year, that number is considerably less than in previous years. Forty-six children were adopted by a step-parent, 11 children were adopted by relatives or foster parents and 147 adoption orders were granted.

The honourable member and the Committee can see from the figures that overseas adoption looms quite large in the total scene of adoptions. While it is a source of some satisfaction and joy that childless couples can satisfy their need for a family by going overseas and adopting, it is also a source of concern that the arrangements in some countries are informal in the extreme. The Chief Executive Officer, who has some statutory responsibilities here, is very concerned to try to ensure that, where an overseas adoption is approved, it should apply to an overseas jurisdiction which accepts the rules of the game as we understand them in this country and in comparable countries.

Obviously some people, perhaps in their understandable desperation to have a child, will seek to circumvent those arrangements, or maybe they are in the difficult situation in which they feel they can obtain a child only in a place which simply does not come up to our requirements. Then of course, we have that classic problem on our hands. Perhaps the baby is in the country cradled in someone's arms and we are very concerned about the circumstances in which that has obtained. I do not want to suggest that that is the typical pattern, because it is not. However, that pattern is not unknown and it creates many problems for all concerned, not least for my department. Sue Vardon may want to slightly enlarge on that, but in any event she will give us the budgetary details.

Membership:

Mr Heron substituted for Mrs Hutchison.

Ms Vardon: I will give the answers about revenue raised, the fee structure and the cost to the taxpayer. The revenue raised for 1989-90 from the fees attached to adopting an Australian-born child was $23 075. The revenue received from fees associated with adopting children from overseas was $51 512.50. The fee structure for Australian-born children is $1 300 per application for the first application and $1 000 for the second application. The fee structure for an inter-country application is $1 800 for the first application and $1 150 for the second application. We do waive many of those fees.

The total cost to the taxpayer, taking account of salaries and operating expenses, is $415 000 for salaries and $69 000 for operating costs. The Committee will note the high cost of providing that service, but those salaries involve the cost of providing the family information service. It is in fact a highly-subsidised service.

Mr QUIRKE: In respect of that, what are the main countries in which parents hope to satisfy their desire to adopt children? Has the pattern changed greatly in the past four or five years? Has the number of parents hoping for or anticipating a successful adoption grown over the past four to five years?

The Hon. D.J. Hopgood: We have some of that information, but I will leave the Chief Executive Officer to answer. However, I do not think that we have ever had one from Madagascar.

Ms Vardon: No, we have not. Sri Lanka is a country from which many of the children come. Korea has closed its doors to us for a while. The Philippines provides children and I believe during the year one child came from Yugoslavia, but I will provide the honourable member with the precise information. We have a limited number of people on the inter-country adoption list because the supply of babies, even from around the world, is not very great. Although there seem to be a great many inter-country babies available for adoption, there is hot competition, for want of a better word, from Belgium, France, Germany, England, America and Canada where there are long lists of people wanting babies.

In Australia a baby becomes available every now and then and it goes to the next person on the list. In respect of overseas countries, we rely very heavily on Australians Aiding Children to do most of the work on our behalf. That organisation has very high standards in respect of people who adopt children. The supply of children, both Australian born and from overseas, is small. The number of Australian-born children is reducing and the others are staying level. It is not an optimistic picture; not a lot of babies are available for adoption.

The Hon. D.J. Hopgood: Some figures from two years ago are as follows: India, one; Fiji, two; New Zealand, one; Korea, 21; the Philippines, six; Ethiopia, two; Sri Lanka, eight; Thailand, eight; and Nepal, Chile, Brazil, Japan and Yugoslavia, one each.

Mr QUIRKE: A number of parents feel that the department is their last hope to have a child. Are counselling services provided in the department's budget for parents who opt to adopt this course?

Ms Vardon: Yes, Adoption Services is staffed with many social workers who advise parents of the situation and the possible delay. The wait for an overseas child, once a couple is accepted as an applicant, is between three and four years. Recently, some rules were brought down on a national basis relating to age: some people are now too old to apply

although they feel they are quite young. Our social workers talk to them about the loss and grief associated with not being able to adopt a child, but we do not have a very extensive service for people who are not successful because the resources are available mainly for those people who actually adopt a child.

Mrs KOTZ: I refer to page 63 of the Program Estimates and page 37 of the Estimates of Payments in relation to emergency financial assistance payments. Actual payments during 1989-90 are stated as $1.707 million. Will the Minister provide a breakdown of payments to individual clients by FACS for items of a capital nature above $500 that are written off, such as carpets, furnishings, etc., and which exclude emergency cash or cheque payments of less than $500; and will he explain the circumstances of those payments?

The Hon. D.J. Hopgood: I will try to provide those figures. It would be very rare, if ever, that a capital item in excess of $500 got this sort of funding. The only circumstances that come to mind would be in cases of domestic violence where it might seem appropriate to give assistance along these lines if for instance a drunken husband smashed up the house, but this would be pretty rare. I should imagine that it would not be difficult to obtain that information for the honourable member.

Mrs KOTZ: My second question relates to page 60 of the Program Estimates. The Family Support Program has, by and large, been very successful especially in the areas of community involvement and development. Why has the Government not allowed for an expansion of this program or for increased financial support for community centres and neighbourhood houses?

Ms Howe: The 1990 budget base has not significantly increased in terms of the existing programs, but there has been a significant increase in family support programs in Elizabeth aimed particularly at families at risk of abusing their children or requiring a significant amount of support, such as teenage mothers and parents with a disability.

There is a joint program between the Children's Services Office, FACS and CAFHS that is aimed at meeting the needs of those families quite early and using the resources of CAFHS, child-care centres and kindergartens to develop support for those families while the children are young. In a full year this costs $244 000.

A further program of $409 000 is aimed specifically at families involved with the department who are in danger of separation. That is an intensive ongoing program with families and children using child health counsellors, preschool teachers and social workers. So, a significant new set of programs and innovations for family support have been introduced.

The Hon. D.J. Hopgood: I will not canvass again the task that this Government faced in relation to the budget or the fact that I seem to have been treated reasonably generously compared with some of my colleagues. Notwithstanding that, a very limited growth factor was available to us and we had to decide where the additional funds should go. We decided they should go into two areas: first, the provision of additional social workers, which was the subject of some questioning by the honourable member's colleague before the dinner break for the reasons he canvassed at that time; and, secondly, in the HACC-SAAP areas because, if we do not maintain some sort of effort in those areas, we will lose more than what we are not funding—we will lose Commonwealth funds as well.

A good deal of the HACC-SAAP funding relates to problems identified by the honourable member although not necessarily the forms of service delivery that she identified in her question. Respite care under HACC, increased funding to homeless youth under SAAP and the extension of the ETSA concession scheme to caravan park residents—modest though that extension might be—could be regarded as attempts to address the problem although not in the way envisaged by the honourable member when she talked about the services that will not receive significant additional funding.

Mrs KOTZ: When Ms Howe spoke about the specific program she mentioned Elizabeth. Did the details she provided relate to the specific program in the Elizabeth area?

Ms Howe: That is right.

Mrs KOTZ: None of the details supplied related to programs in any of the other community houses?

Ms Howe: No, it is a brand new program.

Mrs KOTZ: I ask Ms Howe to repeat the amounts that she mentioned in relation to that program.

Ms Howe: The amount of $244 000, which is for the joint integrated program between the Children's Services Office and CAFHS, is new money for new positions, and it includes the ability to buy family support services through the homemakers but, more importantly, it is to help people who generally do not use existing services. With those services we are more responsive to their needs. It is aimed at ensuring responsiveness to these families by contributing additional resources to the existing services. The amount of $409 000 is for a larger program aimed specifically at families which are disintegrating and where children are likely to go into long-term care with the department. It is a major intervention to provide support therapy, skill training and parental support for those families.

Mrs KOTZ: I refer to page 35 of the Estimates of Payments and page 62 of the Program Estimates. Given the number of street kids in Adelaide, and in the light of the Burdekin report which clearly says that most street kids are the result of family breakdown, why is the State Government leaving it to the Commonwealth to provide limited money to this State for this important area of prevention in terms of pre and post-marriage counselling programs and marriage enrichment programs?

I note that other States put money into these valuable programs and I acknowledge that earlier a question from the member for Stuart was asked along similar lines and part of the Minister's statement was, 'We fund in a different way.' I also acknowledge that a statement was made in the *News* of 20 July 1990 that the State Government has cut all funding to the Marriage Guidance Council of South Australia. Has the Marriage Guidance Council received any money from the State Government during 1989-90 and does the State Government intend to provide funds to the Marriage Guidance Council for any particular programs during 1990-91 and, if not, why not?

The Hon. D.J. Hopgood: In relation to the second part of the honourable member's question, that was posed to me by one of the people on my immediate left earlier today when I indicated that we fund COPE, community health centres and other family supports, and that we feel that that is the way to go here. We have recognised the work done by the Marriage Guidance Council. It is only a component of the overall picture and we see no reason at this stage for redirecting the funds that we currently make available.

As to the more general picture which the honourable member paints, a number of programs are administered under the SAAP and HACC programs, and I am advised that, in fact, there is State money in all those programs for things such as the Parent, Adolescent Conciliation and Counselling Service (PACCS) which is operated by the Adelaide Central Mission. The only example I can find here of

Commonwealth funding that does not appear to have a State component is $90 000 of youth justice money from the Federal Attorney-General's Department. I readily admit that the State has put no money into that, because there was no requirement to do so. However, in relation to the other programs, such as Parent, Adolescent Conciliation Counselling Service, these all have some State component of money so the State is involved.

Mr HOLLOWAY: At page 28 of the Estimates of Receipts I note, under 'Fees, Fines and Charges—Adoption and Family Information fees' that the actual amount in the last financial year was considerably less than the estimate. Can the Minister explain the reason for that?

Ms Vardon: We waived quite a few fees, much to Treasury's distress, and that reduced the income somewhat. Also, we did not have enough babies to place, so we anticipated a higher level of placement than actually occurred.

Mr HOLLOWAY: How much will award restructuring within the department cost and how will it affect residential care workers? I understand that there are employees within the department who are not in the professional stream but who might have reasonably expected in due course to gain social worker positions that are now in the professional stream. How will their interests be protected?

The Hon. D.J. Hopgood: As to the cost, it will not be known exactly until the job criteria are determined jointly by DPIR and the Public Service Association and until all the positions are assessed against it. It could be $2 million which is 5 per cent of the total salary budget. The residential care workers will be placed into the operational stream and the department has proposed a grandparent clause to DPIR intended to provide employees in SWO positions who are classified in other than the professional stream to be considered qualified for appointment or reassignment to positions in the professional stream if they hold an Associate Diploma in Social Work at the date of implementation. As I understand it, that matter is currently being negotiated.

Mr HOLLOWAY: I note that from page 65 of the Program Estimates one of the specific targets for this financial year under the program 'Welfare Practice' is the establishment of a Critical Incidents Stress Debriefing Service with the Metropolitan Fire Service, the Country Fire Services and the St John Ambulance Service. I think it is certainly a very worthwhile initiative. Has the Minister any information as to how that might be conducted and can he comment on why the police would not be involved in such a scheme?

The Hon. D.J. Hopgood: We have received salary and contingency money from the MFS, the CFS and the St John Ambulance Service to provide this Statewide Critical Incidents Stress Debriefing Service for the three services. The money is available from 1 July. It is a service which is increasingly being seen as important because we are coming to understand some of the stress which is sometimes associated with people being called to critical incidents. No matter how much a person has been trained for this, when one is suddenly faced with perhaps a serious accident on the O-Bahn, that can have a considerable impact, at least for a short period, on the emotional stability of that individual and, in turn, quite possibly on his physical health. Appropriate debriefing and counselling is seen as a way of minimising that emotional stress and, therefore, possibly the physical illness that can arise. We have people who have the skills to do this sort of thing and, therefore, the other agencies have recognised this factor and are quite happy to play their part.

The police have not asked to be involved and have not come up with any funds to sustain their involvement in the whole process. I am advised that, indeed, the police have their own psychologists who are able to do a similar debriefing program, so maybe they feel that they have their skills within their organisation and do not have to go outside to buy those skills.

Mr OSWALD: Is the Minister in a position to indicate the future of the lease on the Seaforth Community Centre (now the Brighton-Glenelg Community Centre) and does the Government have any plans to sell the property?

The Hon. D.J. Hopgood: Yes, I can give at least part of the answer. The department has had the long-term aim of relocating facilities from the site and of disposing of the property to fund other capital works and, indeed, this goes right back to Minister Cornwall's time. It was recognised that some arrangement would have to be made with the community centre and possibly Patch Theatre before things could progress much further. So it was never envisaged that the occupancy would suddenly be terminated. On the other hand, no ongoing guarantees of occupancy have ever been given either. They have been sought on various occasions over the years when accommodation upgrades or changes were being contemplated or requested by the centre.

The problem is that the centre's building is inefficient to run and maintain. All buildings on the site have very large upkeep expenditure looming, and unless some of this upkeep is carried out in one way or another serious safety issues could arise. The department no longer has a continuing need for facilities on the site for its own operations. There are regular inquiries from prospective purchasers and the department has lost access to Sacon funds for office accommodation.

So, we are considering the future of the site as part of our wider review of services and resources. There is no immediate plan to close or move the centre. Detailed consideration has not commenced, but the department recognises that the future of the community centre needs to be an integral component of plans for the Seaforth land, and every consideration will be given to maintaining its presence in the region. We are certainly aware of the valuable work undertaken through the Brighton-Glenelg Community Centre and the need to continue to support this group. I have visted the centre on a couple of occasions and can certainly testify to the activities that occur therein. The honourable member will get his long-awaited reply from me along those lines.

Mr OSWALD: I have a supplementary question. What does the Minister mean, in his concluding remarks, by 'its presence [the community centre] in the region'? Does that mean that we are looking at a sale of the whole of the property and a relocation of the community centre somewhere in the Glenelg-Brighton area, or at a part sale of the property and retention of part of the property for a community centre or some other option?

The Hon. D.J. Hopgood: I do not know that we should arrogate to ourselves the right to determine where a community centre should go. On the other hand, we have a responsibility to determine where our own offices should go, and given the recent decision in relation to the Department for Family and Community Services office in that area we no longer, as a department, have a responsibility there, although we would be concerned for the community centre as a quite separate operation. If someone would like to buy the whole property from us and make it available to the community centre on the same terms and conditions as we made it available to the community centre, I am sure everybody would be delighted. I am not quite sure who that someone might be and, in the absence of the someone, we

are left with somewhat of a dilemma that will have to be resolved.

All I am saying is that, although we feel we have a fiscal responsibility to eventually quit the centre and to get some funds which we can put into other capital developments, that will not be allowed to override our concern for the future of the community centre and what should happen there. We will approach the whole thing with sensitivity and humanity, and indeed it may be that those considerations eventually will outweigh the fiscal considerations.

Mr OSWALD: I sense a political answer there, because it would be very difficult for the Government, on the one hand, to say that it will sell the property and, on the other hand, to say that it wants to retain the centre, which is the major building on the property.

The Hon. D.J. Hopgood: That is right.

Mr OSWALD: Can I have a reply in writing to pass on to the centre?

The Hon. D.J. Hopgood: I am sure that we will have further discussions on it.

Mr OSWALD: I refer to page 69 of the Program Estimates. During 1989-90 a study of adolescent suicidal behaviour and accompanying guidelines for workers was completed. What did this study conclude and recommend? What is to be implemented during 1990-91 as a result of the study? What additional funds are earmarked in the 1990-91 budget to address the recommendations?

The Hon. D.J. Hopgood: There is no specific allocation for this; it would simply be incorporated in our overall operations budget. However, as to the specifics of the outcome of the report, we will have to get that information for the honourable member.

Mr OSWALD: I have a supplementary question. I would be very pleased to receive a private briefing from an officer of the department on this matter in general.

The Hon. D.J. Hopgood: That will be arranged.

Mr OSWALD: The Minister may recall that I wrote to him some months ago asking whether FACS had commissioned a land agent or agents to find five hectares of land in the Lonsdale area, and the Minister replied and said that FACS had not done that. However, land agents are still telling me that they are authorised to find five hectares of land which they understand is for the use of FACS. We might be playing with words here, but I again ask the Minister in his capacity as Minister of Family and Community Services or our Deputy Premier: has the Government authorised land agents to purchase five hectares of land in an industrial zone and/or in the Lonsdale area which will be for the use of FACS?

The Hon. D.J. Hopgood: The answer is 'No'. The context in which this has arisen has been within the vexed search for land for a new secure centre. The honourable member would be aware that an area in the north-eastern suburbs was identified and was subsequently abandoned. A further area was identified in what we might say is the Regency Park/Wingfield area, and that was also abandoned. The search continues. But, at no stage, I am advised, has anybody had any attention directed to the southern suburbs, more specifically to Lonsdale, for this purpose. It may be that at some stage in the canvassing of options—and my understanding is that dozens of options were looked at—industrial land (or whatever zoned land) in the Lonsdale area, that being the major unused land in the city of Noarlunga and Marion, was on a piece of paper as an option. However, I am not aware of anybody being sufficiently firm on it to indicate to a land agent that there should be such a search, nor is there any other Department for Family and Community Services project of which I am aware that would require five hectares of land in that area. So, I think it is a furphy, but one that keeps coming back.

Mr OSWALD: The Minister referred to a secure institution. To which institution was he referring? There are plans for a SARAC move and long-term plans for a SATAC move.

The Hon. D.J. Hopgood: To SARAC, but in either case there are no plans for the location of a replacement centre in the Lonsdale area.

Mr OSWALD: This time last year the CEO told the Estimates Committee that a move was imminent. Do I gather from what the Minister is saying that it is virtually off the drawing board, that a site has not been selected for SARAC, that the Minister has no idea where it will go and that the search is continuing?

The Hon. D.J. Hopgood: We have had difficulty in locating a site, but it is not off the program; it is very much on the program. We are negotiating. I would prefer, at this stage, not to indicate where we might be negotiating because of the impact that that may have on the price that the Lands Department might be able to secure it for. It is certainly not off the program. We are very keen to build a new secure centre once we have a site for it—a patch of dirt. The honourable member has probably seen the plans that are in hand for the sort of building that would then be placed thereon.

Mr OSWALD: The Minister does not have to pinpoint the site, but can he say whether it can be seen it from the Yatala Labour Prison?

The Hon. D.J. Hopgood: If you stood on the roof with a pair of field-glasses it may well be seen. After all, the roof of Yatala is a fair vantage point, although I have not had the pleasure of walking around on it.

Mr HERON: I refer to page 67. I see that there have been eight editions of the *Child Protection Newsletter*, with a circulation of more than 2 000. Is that going to be a continuous publication, and how long will the plan go for?

The Hon. D.J. Hopgood: Yes, it will be a continuous publication.

Mr HERON: Further down on page 67, it is said that the publication will also go to different multicultural groups. Is that under way as yet, or how are we going to get to that circulation?

The Hon. D.J. Hopgood: No, not at this stage. We need a few more resources for that to happen, important though it is.

Additional Departmental Adviser:

Ms K. Dwyer, Manager, Home and Community Care.

Mr HERON: I have a further question which also relates to page 67. There is a proposal to introduce legislated place of safety orders for children at risk of abuse. What is the basic idea and why is that coming in?

The Hon. D.J. Hopgood: Kim Dwyer, the head of our Child Protection Unit, would like to come to the table and give us a brief rundown on what we are doing here.

Ms Dwyer: The proposal to amend the Act in relation to place of safety orders is in terms of the difficulty that we have now with orders through the court being fairly draconian in that they relate to guardianship and its removal. There is a belief that there is a need for community welfare workers to be able to have a child assessed without having to approach the court, so that they can be removed in an emergency to a place of safety. We would still require the court's approval, but it would not need to continue into a guardianship application.

Dr ARMITAGE: What funding provisions have been made for housing for aged and psychologically disturbed people who are homeless and those not meeting IDSC standards?

Mr Leahy: Those matters are more properly dealt with by the South Australian Health Commission, which has responsibility for those areas. I suspect that I will be able to give some information on that, because of my close liaison with that body. The $1 million, to which we referred earlier in terms of the money which is going to disability services, will be used to provide in-home support for some of those groups. People with psychiatric disabilities are among the targeted areas, as well as people with intellectual disabilities. The moneys may not be used for the cottage or group home-type of support, although negotiations are still going on to see what proportion of funds will go to the intensive level-type needs and to people who have lower needs and who can be looked after in their own accommodation. That process is still going on.

Dr ARMITAGE: Is there any intention to expand HACC transport services to the ethnic frail aged in view of the sharply growing demand?

Mr Leahy: The HACC program already provides funds to the Ethnic Communities Council of South Australia in the form of a one-off purchase of a Toyota Hiace bus, with hoist, and recurrent costs for a coordinator of that service. In the past few months we have been looking at the possibility of expanding that service. The bus is based in the Wayville area and the service is operated from ethnic community councils based in town. We are looking at the possibility of replicating that facility in the northern and eastern areas where there is a perceived high need for assistance. At this stage no decision has been made, although transport has been given priority in the HACC priority setting for this year. From the funds which have been made available, we are looking at the possibility of one-off funding for that purpose.

Dr ARMITAGE: In the Program Estimates, page 37, under the heading 'Services for the Aged and Physically Disabled', an increase from $88 million actual in 1989-90 to $91 million estimated in 1991 is noted. That is an increase of only 3.4 per cent, or half the inflation rate expected this year. Is this realistic, given that the same program shows that there was an overrun of $3 million on what was budgeted in 1989-90, that being $85 million and the actual result being $88 million?

The Hon. D.J. Hopgood: I think that we are into the same old problem. There is a round sum allowance which will cover salary and wage allocation increases. Once that is taken into account, that 3.4 per cent comes much closer to the CPI or maybe slightly in excess of it. What it might be depends on wage movements at this stage. I might ask Mr Leahy to comment on comparing like with like. If we can eliminate that from the two financial years we can see what it means in terms of real service provision. We will have to get more information on that, but that would be fairly easily obtained.

Mr QUIRKE: What is the impact of the new child support scheme on services provided by the department?

The Hon. D.J. Hopgood: The child support scheme was introduced in two stages. Stage 1 came into operation on 1 June 1988 and involved the establishment of the Child Support Agency within the Australian Taxation Office. The agency collects maintenance payments for children whose parents separated on or after 1 June 1988 or who were born on or after 1 June 1988 if their parents did not live together and whose custodial parents received an income-tested pension or benefit from the Department of Social Security. The maintenance is disbursed to custodial parents by the Commonwealth Department of Social Security. A proposal to transfer the department's current cases has not proceeded due to administrative difficulties in the Child Support Agency. Approximately 3 800 cases have been registered with the agency and the department still has 5 800 current trust maintenance accounts. A gradual decline in these accounts is expected as accounts are closed or transferred for registration with the Child Support Agency as a result of new varying orders or agreements.

Stage 2 of the scheme was introduced on 1 October 1989. Maintenance is assessed by means of an administrative formula which applies to parents who separated on or after 1 October 1989 and children born on or after 1 October 1989. I guess that the impact of this area on the department's workload to date is reflected hereunder. On 30 June 1988 the number of active cases was 995. Two years later (30 June 1990), the number of active cases was 1 304. The honourable member can draw his own conclusions.

Mr QUIRKE: Is every custodial parent required to register the maintenance liability against the non-custodial parent with the Child Support Agency?

The Hon. D.J. Hopgood: A person who receives a sole parent benefit or income-tested pension from the Department of Social Security and who has obtained an order for maintenance or an agreement for payment of maintenance on or after 1 June 1988 is required to register. If not, a person can elect to opt out of the scheme and make private arrangements.

Mr QUIRKE: Will the Minister fully review the legislation governing the Family and Community Services Department, bearing in mind its new title and changed functions?

The Hon. D.J. Hopgood: As I have indicated, the amendments to the Act which were introduced in the first session of this Parliament, and which were among the slaughtered innocents when the Parliament rose for the recess, have not, as members would be aware, been reintroduced as yet because there are some further thoughts as to what they may contain. Certainly, some of that is in relation to the directions which the department has recently taken upon itself.

Mrs KOTZ: Referring to Estimates of Payments (page 35), can the Government indicate how many extra dollars in real terms will be spent on those non-government community organisations working with young unemployed people? It has been put to me that it is not fair that mature unemployed and young unemployed, the majority of whom are trying earnestly for work, must be coerced by recently announced Commonwealth social security measures when no new jobs are being created, while there is no full employment strategy, and only the bare maintenance of funding to current employment and training programs.

The Hon. D.J. Hopgood: I think this relates to a program which is under the employment and training area. It is not a program with which we are directly involved, nor do we fund it. So, I would suggest that she or one of her colleagues raise that question on the appropriate day with the appropriate Minister.

Mrs KOTZ: In the Program Estimates (page 33), under the heading 'Services for the Aged and Physically Disabled', it shows that spending on domiciliary care services was 10 per cent over budget in 1989-90. What was the reason for this overrun, and why is there only a 1.1 per cent increase in expenditure projected for these services in 1990-91 over and above what was actually spent in 1989-90?

The Hon. D.J. Hopgood: Although we provide grants to the commission, it tops them up, and it is basically seen as a Health Commission responsibility rather than a FACS

responsibility. I am not trying to be difficult. We want any information that we have at the table to be available to the Committee. If we are somewhat lacking in our information it is because the question really should be referred to other officers by the same Minister.

Mrs KOTZ: How many people are eligible for the Government seniors card? How many people have been issued seniors cards, and how is the Government promoting the seniors card?

Mr Powell: I have information on the cost of the seniors card which was introduced from 1 November 1989. The actual number of cards issued to date is a matter that will have to be taken on notice. The cost of the card to the end of the financial year was $1.68 million. As at 11 September 1990, 50 957 cards were issued. The estimated cost for the seniors card in 1991 is $2.2 million.

The Hon. D.J. Hopgood: At the time of the issuing of the card there was considerable publicity. I think it is probably true to say that the organisations in the aged area have been very active in promoting it to their own membership.

Mr Powell: It is true that the non-government organisations and consumer organisations of older people themselves have been very diligent in promoting the seniors card. In addition, the State Transport Authority has developed some promotional material, as has the Age Line in my office.

Mrs KOTZ: The Program Estimates (page 33), under the heading 'Services for the Aged and Physically Disabled', show that the spending on domiciliary care services was 10 per cent over budget in 1989-90. The basic question there is: what was the reason for the overrun? Why was there only a 1.1 per cent increase in expenditure projected for these services in 1990-91 over and above what was actually spent in 1989-90?

The Hon. D.J. Hopgood: This is a subprogram of health, and we do not have all the detailed explanation here, but in relation to the increase last year the number of active clients under the care of metropolitan domiciliary care services increased by 10.5 per cent to 18 146. In recognition of this increasing pressure on domiciliary care services, an additional $158 000 was allocated in 1989-90; of this funding, $88 000 was used for additional paramedical aides on night duty to overcome security difficulties.

The HACC allocation for 1990-91 has been increased to $10.6 million, and then I have a list of a number of projects that will share an estimated $4.6 million. The problem we have is that those figures do not seem to tally with that which has been quite accurately quoted to me, I am quite sure, by the honourable member, so I will have to seek a reconciliation of those figures and provide it in time.

We cannot always compare like with like. A salary and wage component will have to be added in, which appears as a component of last year's vote, as a result of salary and wage movements in this coming financial year. What we can say at this stage under this program is that there was a blow-out last year. That has been accepted as something that did not arise out of profligacy or inefficiency but a genuine increase in demand for the service. That additional resource has been added to the base for this year and is reflected in the base. What is not reflected in this figure is the possible wage and salary movements for this year which, we can only assume at this stage, are likely to be akin to last year. That is as much as we can give because, basically, the detailed briefing is with the Health Commission officers rather than with the officers who are at the table.

Mr HOLLOWAY: What is the fate of the review of domiciliary care services conducted by Dr Yeatman in 1989?

Mr Leahy: The Yeatman report was completed last year and since then the HACC Ministers have given it to a broadly-based working group to look at its implementation. That group comprises representatives of service providers including domiciliary care and service consumers mainly of the South Australia Council on the Ageing and the disabled persons international group as well as various representatives from the Commonwealth and State Governments. That group has been going through the 53-odd recommendations of the domiciliary care report and it is developing a position on each of the recommendations to advise the HACC Ministers. We anticipate that the final report from that group will conclude between October and November this year and that that will give advice to the Government in terms of the implementation of the various recommendations of that report.

Mr HOLLOWAY: The next matter that I want to raise relates to page 63 of the Program Estimates. One of the specific targets for the current financial year is:

> To investigate alternative approaches to assisting clients currently seeking emergency financial assistance.

Can the Minister give some background about that investigation?

Mr Boxhall: The department has for a couple of years been considering alternative ways, particularly of helping people with financial material assistance that it provides. It is concerned that only relatively low amounts of financial assistance can be given and many people who come and ask for financial assistance do so on three or four occasions. I believe that more than 50 per cent of all applicants come back and make a number of applications. Over the past couple of years we have trialled some alternative approaches and these will be pursued further in the current financial year.

Through the social justice unit we have been given $100 000 specifically to target help for isolated Aboriginal communities, and about 10 communities have been helped in that way. We are looking at ways in which staff of our offices other than social workers can sometimes more appreciate the difficulties that applicants have with regard to the local resources to which they can be referred. Some offices are keen to work with non-government groups, ministers fraternals, and other such agencies to work with us in acting as assessors and distributors of financial and material assistance.

We have given our field officers the opportunity to spend EFA money on particularly designated preventive projects to see whether, by making a major payment or working with a family in a number of different ways (of which financial assistance is only one component), that will make a more significant difference to that family than by just giving them $40 or so over several months.

Perhaps I can give examples of a couple of those programs instead of going into great detail. Programs have been running in the country where they have worked with schools to ascertain children who do not always attend school, arrive late or frequently have not had a proper meal before coming to school. Our program has put together the necessary support mechanisms to pick up those kids, ensure that they have had a decent breakfast, have something for lunch and are attending school.

That has been successful in Ceduna to the point where the local community and the school are taking over that function. In Berri we are working with the Aboriginal community to help them to address issues within their own community by providing a venue and assistance money to bring in speakers to address them. In that way we are

helping them to help themselves rather than relying on the money we might be able to give them.

We have had several programs involving young mothers and mothers-to-be who have not been or might not be able properly to look after their children and, by identifying a particular need in that area and working with those people, we believe we have been able to not only help them directly but prevent the need for some of our other services to come into play later. That is the range of programs on which we are focusing, and this year we hope to evaluate them to see whether we can encourage more.

Mr HOLLOWAY: I refer to the 'support to adolescents and their parents' program (page 69 of the Program Estimates). Under 'Issues/Trends' mention is made of behaviour which 'has its origins in long-term unemployment (for both parents and adolescents), parent-child conflict, abuse from caregivers and the effects of peer and community pressures on developing individuals.' One of the types of behaviour mentioned is substance abuse, including petrol sniffing amongst Aboriginal youths. A great deal of media attention was given to this problem some years ago, but one does not see much of it now. Does this indicate that the problem is under control?

The Hon. D.J. Hopgood: It probably indicates that, while there has been some abatement of the problem, it has not gone away. The department now conducts its services as part of its normal operations with the exception of the administration of a small grant provided by the Drug and Alcohol Services Council, which has been provided since 1987. That program is managed by the northern country region and is administered largely from the department's Coober Pedy office.

There has been a shift in emphasis from youths alone to the family group. The program is hindered by the vast physical courage necessary. There has been a gradual reduction in clinical contacts, and during the recent period of the review of the program there were no sniffing-related deaths but there were three cases of hospitalisation. The number of evacuations for sniffing reasons has reduced significantly since 1986-87 when 35 cases were reported. In 1988-89 the figure was reduced to eight and in the first six months of 1989-90 it was reduced to three.

Mr OSWALD: The age discrimination legislation passed this Parliament earlier this year. When will it come into operation?

The Hon. D.J. Hopgood: It is planned that it will come into operation at various stages according to negotiations that have yet to be carried out. That is not altogether in my hands; the Attorney-General has a large part to play as has the Minister of Consumer Affairs. I will try to obtain information on when the earlier stages of the proclamation will occur. At the time of the passage of the Bill, it was indicated to the Parliament that certain aspects of the legislation would not be proclaimed for up to three years.

Mr OSWALD: What are the problems in terms of the negotiations that are holding up the proclamation?

The Hon. D.J. Hopgood: Mostly industrial awards. The problems arise in the industrial area rather than in the specifically legal areas as purely defined.

Mr OSWALD: To avoid over-medication, the non-English-speaking aged need more information on health matters in their own language. Are there any plans in the department to address this problem?

The Hon. D.J. Hopgood: That would be a matter for the Health Commission rather than the Department of Family and Community Services.

Mr OSWALD: If I could intrude, there is a Commissioner for the Ageing and this is a matter which I would have thought would be of interest to him, hence I am asking this question in the area of the aged.

The Hon. D.J. Hopgood: I accept that. However, I think that it is agreed that this should mainly happen through the community health services rather than the Commissioner's office. After all, the Commissioner does not seek to second-guess all the services that are available to the aged through the traditional agencies, and I will not go on to deliver a sermon as to how I think either individuals or instrumentalities such as the Commissioner for the Ageing and the Department of Aboriginal Affairs and so on operate *vis-a-vis* the traditional service agencies.

Basically, we can say that they have an advocacy role and they can do a number of things which fall within the interstices of the traditional service delivery. In this particular case I think it would be more appropriate that this be a program that is developed through the community health centres.

Mr OSWALD: Page 71 of the white book states that:

> Field work is becoming increasingly complex and legalistic in nature.

How will the department respond to this issue in the future and will the department introduce postgraduate study leave for its staff to better equip them for the new trends in child protection work?

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

Ms Vardon: We have always accepted that undergraduates do not get sufficient knowledge in the area in which we operate. We have recently been involved with the Australian Association of Social Worker Educators (AASWE) in writing a report, which I have and which I am happy to make available, on how undergraduate courses can be changed to be more appropriate for our work.

On the issue of the work becoming legalistic, it has come to our notice that we need to do a lot more training of social workers in the law so that they understand the responsibilities under the legislation. We are running legislative courses. It is difficult to find a postgraduate course which is actually suitable to our work, although I have been pleased to see the development of a Masters Degree in Public Welfare in the social work school of one of the Victorian campuses. The Victorians are making their courses available to our people by external studies and we are encouraging them to take up as many external studies as possible. What we look for at the moment, apart from our compulsory legislative training, is the development of the position of master practitioner or social worker of excellence which will come as a result of the award, and these people will be highly trained and highly skilled. We will encourage them to do master degrees and so on. They will be on-the-spot supervisors and trainers in the more complex areas.

So we will tackle it in many ways: we will do our own training because it is fairly unique, we will encourage entry into postgraduate courses where they are available and suitable, we will work with the Australian Association of Social Worker Educators to make sure that the undergraduate work carries on, we will work out ways of creating people of excellence and we will take every opportunity we can to encourage people to undertake the training. It is difficult to give people years off to do that training. We do not quite have that capacity.

Dr ARMITAGE: The 1989-90 Program Estimates refer to the establishment of geriatric assessment teams in five country areas and the enhancement of teams in the metropolitan area. Will the Minister advise whether the five country teams have been established and will he also advise the location of the geriatric assessment teams in both the

metropolitan and country areas? What are the priorities for new teams in the country?

The Hon. D.J. Hopgood: We understand that teams have been established in Port Pirie, Whyalla and Murray Bridge. The others are in the course of being set up. We can obtain more information for the honourable member if he so desires.

Dr ARMITAGE: Page 63 of the Program Estimates, under '1989-90 Specific Targets/Objectives', states:

'Debt Line' was established in December 1989 as a social justice initiative and has resulted in over 700 cases being assisted in the first three months.

What is meant by 'assisted'? Does this refer to financial counselling on how to pay off the debt? Were there any occasions where the department settled the debt on behalf of a client? If so, will the Minister provide details of those cases?

The Hon. D.J. Hopgood: 'Debt Line' basically is about financial counselling.

Mr Boxhall: The 'Debt Line' service is basically an information referral over the telephone, and in some cases that can go on for a long time. If a person is in financial difficulty the matter may be referred to a financial counsellor in one of our offices. The facility exists to consolidate some debts and make a recommendation to the district office to make a payment to get a person over that immediate financial difficulty, and that would be done by the people who make the emergency financial assistance assessment. I will have to check and see how detailed our records are to see how much information we can provide.

Dr ARMITAGE: I would like to know how many times this has occurred and the details of those cases. Program Estimates states that several hundred cases were assisted in the first three months after December 1989. I presume that 'Debt Line' continues?

Ms Vardon: Yes.

Dr ARMITAGE: Page 64 of the Program Estimates, under '1989-90 Specific Targets/Objectives', states:

All programs funded under the social justice program have commenced.

Will the Minister provide a list of all the programs that have been funded under the social justice program, a list of the costs of those programs, the number of full-time equivalents involved in the programs and the benefits accruable from those programs?

The Hon. D.J. Hopgood: Unless the honourable member insists, in view of the time we will get that information. I have most of it in front of me, but not the full-time equivalents. Rather than at this stage reading it into the record, we will make it available.

Mr OSWALD: When will the Minister establish multicultural kitchen centres in areas with high ethnic populations?

The Hon. D.J. Hopgood: Would this be as a subset of Meals on Wheels?

Mr OSWALD: Yes.

The Hon. D.J. Hopgood: It is something that could be subject to HACC funding.

Mr OSWALD: For some years now there has been discussion about the establishment of multicultural kitchens in ethnic areas, and my question flows on from those discussions. Has the Government reached the point where it is now planning the introduction of multicultural kitchens in consultation with Meals on Wheels or other organisations such as occurs in Unley, where I believe through the council there is a multicultural kitchen?

The Hon. D.J. Hopgood: Earlier Mr Leahy talked about the food services review being conducted. This is being looked at as part of that review. What will specifically come out of it is yet to be determined.

Mr OSWALD: I refer to page 67. The objectives for 1990-91 state that an analysis will be conducted of all child abuse cases proceeding to the Family Court. Who will conduct the analysis; what is his, her or their qualifications for this sort of work; what size of unit will be involved; and what will be the distribution of the data collected?

Ms Ramsey: That analysis is being conducted by the acting coordinator of the Child Protection, Health and Welfare Unit. She has a social work qualification, she has been in the unit as a senior project officer for some time, and she is carrying out that project in that capacity. It was part of the child protection program review for the current year.

Mr OSWALD: Who will conduct the analysis; what are their qualifications; what size will the unit be; how many people will be involved in it; and what will be the distribution of the data that is collected; in other words, who receives all this information?

Mr Ramsey: The information comes into the department. It is basically to look at the cases that the department is involved in which are before the Family Court; to look at the relationship; whether additional work needs to be done; and whether the protocol between the Family Court and the department that has been set up is working and operating as was expected. It is not a unit that has been established: it is part of a person's position.

Dr ARMITAGE: What security measures exist to protect confidentiality between computers with personal records within the department, personal computers in particular? In relation to that, is consideration being given to accessing district offices in cases where children—street kids—are picked up in the central business district of Adelaide early on a Sunday morning and there is difficulty accessing their records if they come from elsewhere? I guess that I am asking two questions about security from a different angle. One relates to confidentiality and, given that, how can that be broken to get the records?

Mr Boxhall: Most client records are progressively being added to the Justice Information System, which has a range of security measures. I guess the most common one is where each user has an access code which enables him to get the information that he is authorised to have. When all our records are on that system, people with the right authorisation will be able to access the records of other offices. Some of that information will be accessible 24 hours a day, and Crisis Care will be able to have access to it. That is the limit of records that we have. Most of it is recording the essentials about each client. The detailed case records and case notes, and so on, will remain on separate hard copy file.

Mr OSWALD: I refer to the Program Estimates, page 70. During 1990-91, $254 000 has been budgeted for new intiatives for a community work option project. If there has been no question on the community work option project, what does the project entail and what staff, vehicles and administrative back-up will be required?

Ms Howe: The program is a new sentencing option for children. It originally arose because of children's graffiti in schools and buses. Basically, it was expected that they would be involved in cleaning up the mess they made. It will operate in conjunction with community service order programs, which have a similar notion. However, they are usually attached to children as an alternative to detention. The support systems will be available through an existing administration. There will be three additional FTE positions, plus money to contract supervisors and suitable community work will be found. I expect that the existing

community work, such as assisting with playground development in kindergartens, cleaning up generally in the community, and assisting aged people with handyman type tasks, will continue under the new program. However, it is a different target group.

The Hon. D.J. Hopgood: We will have to get the information about the number of vehicles and individuals involved.

Mr HERON: In relation to Estimates of Payments (page 35), I have been approached by families in which there have been births of quins, quads or triplets. What provision is made in the State budget to assist those families in need of home help with quins, quads, triplets, or twins? Does the State Government acknowledge the additional physical, emotional and financial needs confronting a family in which there is a multiple birth and the enormous pressure placed on those parents to obtain help and respite in their homes? Bearing in mind that we are talking only about a relatively small group of people, will the Government reconsider any decision that it might have made not to provide assistance?

The Hon. D.J. Hopgood: We are setting aside up to $40 000 to provide a fund which we expect will also be supported by the South Australian Health Commission and CAFHS. This is in response to a deputation which I received not so long ago, and it may be that the same people also contacted the honourable member. Given the information in front of me, I cannot indicate at this stage what the total resources will be, because it also depends on the response of those other two agencies.

Mrs KOTZ: The Program Estimates (page 65) under 'Specific Targets' states that services available to Cambodian refugees will be enhanced. My questions are:

1. What is the present service provision to Cambodian refugees?

2. What enhancement will take place as stipulated on page 65?

3. What is the cost of the present services, and what additional funds have been made available in this budget?

The Hon. D.J. Hopgood: I do not have information about exactly what is in this budget, but between July 1989 and June 1990 the Refugee Services Unit provided post arrival orientation and resettlement services for 30 newly-arrived unaccompanied refugee children and their respective extended family members and, in the same period, 16 Cambodian families were also resettled. From my visit to our Woodville office some time ago, I recall that a good deal of attention was being paid to that problem. We have given a grant to the Cambodian community for it to employ a youth worker.

Mrs KOTZ: One of the issues and trends listed on page 63 states that 'there continues to be a marked discrepancy between take-up and eligibility for E&WS, ETSA and local government concessions'. My question is a point of clarification in respect of what I understand as the 'take-up'. Does that mean that a greater number are taking up the concessions than those who are eligible, or that fewer are taking up the concessions than are eligible?

The Hon. D.J. Hopgood: Fewer, but it varies according to the nature of the concession. According to our information, fewer are taking advantage of the concession than are eligible for it.

Mrs KOTZ: It must be a concern because in the 1989-90 specific targets (page 63) anomalies and inequities in that eligibility criteria were noted, and it is stated that they were removed in January 1990. That still seems to be the case. What strategies will be invoked by the department to look into that?

The Hon. D.J. Hopgood: In relation to people's awareness of the concessions, I do not think that there is any specific strategy except that the officers of the Health Commission and the Department for Family and Community Services in the suburbs make general information available. The Age Line, through the Commissioner for the Ageing, also makes senior citizens aware of their entitlements. That is basically how it is done. As to any anomalies, we are continually reviewing the system. The honourable member would be aware that we are looking at ways in which the concessions can be extended to lower income people generally, and the first instalment of that is the extension of the concessions to people living in caravan parks. That is all in furtherance of our election commitment, which is to be discharged within the term of this Government.

Dr ARMITAGE: I refer to page 67 of the white book and the program titled 'Specialist child protection services'. In the 1989-90 specific targets and objectives, I notice a line that 'over 400 mandated notifiers have received specialised training'. Of what did the training consist? What was the budgetary cost of that training? Are plans afoot to train other mandated notifiers?

Ms Dwyer: Since that report, over 800 mandated notifiers have been trained. The program is run on a trainer-trainer model, so two trainers from the Child Protection Unit train other mandated people from various agencies. They then train people within their own agency, so the cost is very low. I could work out the cost in terms of the salaries of the trainers and the cost of the materials, but I do not have that information with me.

Dr ARMITAGE: Are there plans to train other mandated notifiers?

Ms Dwyer: Yes, that is an ongoing program. These two trainers will continue to train trainers currently undertaking training specifically for country health services with the assistance of the Country Health Service in the commission, which is subsidising some of the costs. In the past 12 months, we specifically worked with educators—teachers—in the northern and southern country regions, and in the metropolitan area, as well as a lot of other people. This year, we are focusing on health professionals.

Dr ARMITAGE: Of what did the training consist?

Ms Dwyer: It is a two-day training program for the trainers. On the first day they participate in a workshop, which is a one-day program with a large number of components. On the second day, the trainers work out ways in which they can adapt that material for their own organisation. They then go back into the one day program for their own people.

Dr ARMITAGE: I am sorry, I still do not understand. Is there training in picking up abuse or in dealing with children who have been abused?

Ms Dwyer: There is a mixture of issues. The major focus is for those people to be aware of their legislative responsibilities so that they will become very clear about their responsibilities in terms of the law and also how to respond to children who disclose to them directly and how to be aware that children may be seeking that assistance. I can certainly provide a package of the training if the honourable member would like that.

Dr ARMITAGE: I would be interested in that.

Mr OSWALD: May I thank the Minister, the CEO and the departmental officers for their cooperation this afternoon and this evening. I also thank you, Mr Chairman. I have no further questions.

The CHAIRMAN: There being no further questions, I would also like to thank the Minister and his advisers and to declare the examination of the vote completed.

ADJOURNMENT

At 9.56 p.m. the Committee adjourned until Thursday 13 September at 11 a.m.