HOUSE OF ASSEMBLY

Tuesday 6 August 2002

ESTIMATES COMMITTEE A

Acting Chairperson:
Ms M.G. Thompson

Members:
The Hon. D.C. Brown
Mr P. Caica
Mr K. Hanna
Mr E.J. Meier
Mr M.F. O'Brien
Ms I.M. Redmond

The Committee met at 11 a.m.

Department of Human Services, $1 488 489 000
Administered Items for Department of Human Services, $95 478 000

Witness:
The Hon. L. Stevens, Minister for Health.

Departmental Advisers:
Mr J. Birch, Chief Executive Officer, Department of Human Services.
Dr T. Stubbs, Executive Director, Metropolitan Health.
Dr M. Tobin, Director, Mental Health Services and Programs.
Prof. B. Kearney, Executive Director, Clinical Systems.
Mr G. Loveday, Chief of Staff.
Ms L. Huber, Senior Policy Officer, Parliamentary and Legal Unit.
Mr F. Turner, Director, Financial Services.
Ms I. Haythorpe, Manager, Parliamentary and Legal Unit.
Mr D. Exton, Acting Director, Asset Services.
Mr P. Jackson, Acting Executive Director, Corporate.
Ms R. Ramsey, Executive Director, Social Justice and Country.
Mr J. Dadds, Manager, Strategic Planning and Policy.

The CLERK: In the absence of the Chairman, pursuant to standing order 269, it is necessary for the committee to appoint an Acting Chairperson.

Mr CAICA: I move:

That Ms Thompson be appointed as Acting Chairperson.

Motion carried.

The ACTING CHAIRPERSON: Good morning. I think that everyone is familiar with the estimates procedure, but I will read the opening statement and then invite the minister to introduce her advisers and make an opening statement. The estimates committees are a relatively informal procedure and, as such, there is no need to stand to ask or to answer questions. The committee will determine an approximate time for consideration of proposed payments to facilitate changeover of departmental advisers. I ask the minister and the lead speaker for the opposition if they could indicate whether they have agreed on a timetable for today's proceedings.

The Hon. L. STEVENS: Yes.

The Hon. DEAN BROWN: Yes. After discussions with Minister Key, we have allowed some flexibility there. It has been agreed that we will switch from health to housing at 4.35 p.m., in that area. Then the minister has agreed that we have a fair degree of flexibility from 5 p.m. on in terms of what time we allocate for each specific area of DHS.

The ACTING CHAIRPERSON: Changes to committee membership will be notified as they occur. Members should ensure that the chair is provided with a completed 'Request to be discharged' form. If the minister undertakes to supply information at a later date, it must be submitted to the Clerk of the House of Assembly by no later than Friday 23 August. I propose to allow both the minister and the lead speaker for the opposition to make opening statements of about 10 minutes each.

There will be a flexible approach to giving the call for asking questions, based on about three questions per member alternating each side. Supplementary questions will be the exception rather than the rule. A member who is not part of the committee may, at the discretion of the chair, ask a question. Questions must be based on lines of expenditure in the budget papers and must be identifiable or referenced. Members unable to complete their questions during the proceedings may submit them as questions on notice for inclusion in the assembly *Notice Paper*.

There is no formal facility for the tabling of documents before the committee. However, documents can be supplied to the chair for distribution to the committee. The incorporation of material in *Hansard* is permitted on the same basis as applies in the House; that is, that it is purely statistical and limited to one page in length. All questions are to be directed to the minister, not the minister's advisers. The minister may refer questions to advisers for a response. I also advise that, for the purposes of the committee, there will be some freedom allowed for television coverage by allowing a short period of filming from the northern gallery.

I declare the proposed payments open for examination and refer members to appendix D, page 2, in the Budget Statement and part 6, pages 6.1 to 6.56 volume 2 of the Portfolio Statements. I now invite the minister to detail any agreed program. Minister, is there any breakdown in the health area, or is it your understanding that we go straight through with health until 4.30 today?

The Hon. L. STEVENS: That is my understanding, Madam Chair.

The ACTING CHAIRPERSON: Would the minister now like to make an introductory statement?

The Hon. L. STEVENS: I certainly would. For my first introductory statement to estimates, I will focus on the change in direction that the government has begun for health. The Rann Labor government is committed to rebuilding the public health system and, as minister, I have begun by addressing urgent areas of health care in this budget. Today I present the government's budget for the health component of the Department of Human Services.

I am pleased to report that one of the most significant actions of this government has been the splitting of the former human services portfolio. I would like to acknowledge my colleague the Minister for Social Justice, Minister for Housing, Minister for Youth and Minister for the Status of Women in her portfolio responsibilities provided by the Department of Human Services. This arrangement has

allowed me, as Minister for Health, to give my full attention to rebuilding the public health system.

Not only does the health system warrant the full attention of a minister but also it desperately needs it. The previous government failed to provide the necessary leadership or stewardship required to ensure that South Australians could feel secure and confident about the quality and capacity of their health services. The previous government had dropped the ball not only in leadership and service planning but also in financial management.

After taking office, I found that the previous government had left an $11 million budget blow-out for this financial year. This would have taken accumulated public hospital debts from the previous record level of $61 million at 30 June 2001 to a potentially massive $72 million by 30 June 2002.

In framing this year's budget, the Labor government has been required to fund the 2001-02 budget blow-out left by the former Liberal government. An additional $28 million was provided in June this year ahead of the budget, enabling the Department of Human Services and public hospitals to balance their books and start the next financial year without the burden of repaying huge debts accumulated from 2001-02. The former Liberal government had imposed an $18 million clawback savings strategy that would have further crippled service delivery in 2002-03 and 2003-04. Labor has released public hospitals from carrying that burden.

The task of rebuilding services and rebuilding confidence is not simply one of ensuring sound financial management, as important as that is. As minister, I encountered a departmental structure that had been severely eroded and undermined during the previous government. On coming to office, the government immediately appointed Mr Jim Birch to bring a fresh approach, leadership and sound direction to the department.

Mr Birch established an intensive review of management structures within the department. The results of this review were chilling and they serve to underscore the problems which have arisen from poor leadership and poor stewardship. The review team found serious and longstanding problems which have hampered the department's capacity to deliver. The review team states in its report:

> It is clear from our research that the current structure of DHS is not appropriate to deliver the government's plans in health and social justice and that the department's efficiency and effectiveness have been affected adversely both by the current structure and the way it has been operated. We also found significant problems within the department in its ability and preparedness to: collaborate across divisions and functions, work transparently and positively with the field and the community, and engage in real and participative planning with stakeholders.

The review team went on to report that it found significant evidence for there being structural, operational, cultural and behavioural problems within DHS. This evidence was gleaned from research conducted both within the department and externally. Of particular concern to me as Minister for Health was the finding that, over the last few years, 'health' had become an unacceptable word within the department and that DHS appeared to have attempted to downgrade its emphasis.

The review found that DHS suffered from a blame culture which had compromised both its effectiveness and its capacity as an organisation. The department was shown to have the characteristics of a controlling culture which discourages consultation, collaboration, experimentation and innovation. The most disturbing finding of this exercise, however, was the fact that these problems were well known to the previous administration. The review team noted that its findings were broadly consistent with the conclusions of a report undertaken by Dr Kathy Alexander in 1999. The review team noted:

> So closely do our findings mirror the Alexander findings that we are fairly certain that this culture has persisted for at least three years and we must conclude that it will persist into the foreseeable future unless a strong and universal culture change initiative is undertaken.

The new chief executive has moved immediately to institute such a change initiative, which has included a careful rearrangement of his executive team and structures within the department to ensure a more functional alignment with government priorities.

I would like to place on record my thanks and appreciation to all departmental staff who took the time and showed the courage to be forthright in their contribution to this review. In spite of the damage done during the previous administration, it is clear to me that there are still many dedicated and determined people within the portfolio who take it as their personal and professional mission to work toward improving the health and wellbeing of South Australians.

However, there is much repair and rebuilding work to do to overcome the damage wrought by the previous government. Theirs is a legacy of financial mismanagement, neglect, blaming, ignoring and downplaying the significance of health, and suppressing collaboration and productive connections between service providers and the community. I must say that theirs is a legacy which the people of this state cannot afford. This government (and I, as minister) are committed to repairing this damage, rebuilding and restoring confidence, and reforming the health system to make it even more responsive to the needs of our community in the new century.

The government has articulated a clear vision for health which can be summarised as follows: a health system that supports and assists you, your family and community to achieve your full health potential; a health system that is there when you need it, that is fair, and one that you can trust; and a health system that encourages you to have your say, listens to you, and ensures that your views are taken into account. The Rann Labor government places prime importance on the delivery of an efficient health care system with quality patient care as its priority and strong public hospitals at its core. We want to rebuild acute health care services and, at the same time, move the system towards primary health care, prevention, health promotion, and safety and quality in health care.

I want to restate that Labor is determined to use this opportunity to reform and reframe South Australia's health services. Our reform agenda and strategic vision is underpinned by five key pillars: improving the quality and safety of services; greater opportunities for inclusion and community participation; strengthening and re-orienting services towards prevention and primary health care; developing service integration and cooperation; and adopting a whole-of-government approach to advance and improve health status.

For this government to move forward on its reform agenda we acknowledge that many factors in people's lives will impact upon their health and wellbeing. These include access to suitable health services, the types of houses we live in, the community we share with others, the way we relate to one another, support and care for families and our children and youth, and how we respond to those who are vulnerable in our community due to age or disability, all of which play a part in our overall health as a community. There are two key commitments that I have upheld since I became Minister for

Health. First, I have delivered on the promise that there will be no cuts to the health sector under this budget; and, secondly, I gained full support and funding from my cabinet colleagues to review the health system.

I now turn to the generational review of health. Integral to the future provision of high quality health services is an understanding of existing services and community needs. I established the generational review into the state's health system on 10 May 2002. The review will deliver a plan of effective strategies for health care system reform. The generational health review is long overdue in this state. The review provides a farsighted investment in the future health and wellbeing of all South Australians. The last such review was the Bright committee inquiry into South Australia's health system back in 1973. Much has changed since then. The Premier said in his campaign launch speech on 3 February 2002:

> . . . the review will be a root and branch examination of everything our health system does and does not do, and most importantly, how we can do it better.

Eminent former businessman and public administrator, John Menadue AO, is leading this far-reaching review into South Australia's health system. I have full confidence that the review will bring about a better understanding of health and wellbeing, which includes a social health perspective. To guarantee the review's success, I have ensured that there will be thorough consultation and participation with communities and individuals in the review process.

The terms of reference of the review committee are broad and attempt to reach every aspect of the South Australian health system. I have asked the committee to make specific recommendations on nine key areas in relation to: future demands on investments that will be required; ensuring that South Australia has an optimal health system; ensuring coordination and integration across prevention and primary health care, community services, general practice and acute services, and public health services, private hospitals and private day surgeries; new funding models for health services; and improving community participation in health care, including decision-making. This is particularly important for this government because consumers are the cornerstone of services and under Labor we aim to support South Australians in accessing appropriate services for their needs.

The review committee will also report on: whole-of-government planning, service integration and social inclusion; how best to develop non-government and private sector initiatives; work force requirements to meet future needs; and rebuilding connections and capacity with South Australian communities that will create the climate and culture to deliver a reform agenda that can be sustained over the long term.

The committee will report to the government within 12 months with an interim report by December 2002 to allow for early indications from the review to be factored into the 2003-04 budget process. I intend to be strategic and ensure that the review provides the necessary guidance for three, five and 10 year planning horizons which will build into an indicative 20 year planning horizon a blueprint for the health system for the next 20 years.

Another promise made by this government was to set up a truly independent complaints and resolution process for health services. I have introduced legislation establishing a Health and Community Services Ombudsman in the budget session of the parliament.

I turn now to mental health. The World Health Organisation is predicting that in the next decade mental illness will outstrip cancer and heart disease as the leading cause of morbidity and mortality. This is an area of serious unmet need in South Australia with a prevalence of 18 per cent and an estimated unmet need of 62 per cent. Mental health is a major priority area for this government, and we are committed to improving access to high-quality mental health services for all South Australians. An additional $2.25 million per annum recurrent funding over the next four years has been allocated to improve mental health services for South Australians. The additional funding will help develop new models of care across primary, specialist and community based support sectors to meet demand for early intervention to minimise the impact of mental illness and provide community based alternatives to acute in-patient care.

The major areas of reform are $500 000 recurrent funding for services to children and young people, including a focus on Aboriginal young people and improving country services; $1.25 million recurrent funding for adult mental services and systemic change; and $500 000 recurrent funding to pilot rooming-in facilities in selected country hospitals.

The chief executive has specified mental health as the top priority of department. The whole of the department is committed to the current mental health reform process and the establishment of a formal change management process. Due to their unique circumstances, some population groups clearly require special consideration in promotion, prevention and early intervention in their mental health. The department, through the Aboriginal Mental Health Task Force, will undertake planning and service reform to the evaluation of the Aboriginal and Torres Strait Islander Emotional and Social Wellbeing Action Plan (Mental Health). The priority is to ensure that mental health treatment protocols and policies work effectively across cultures, and that the culture of those utilising the services and their traditional healers is acknowledged and respected. The department currently funds Ngankaris—traditional healers—who operate from the NPY Women's Council as part of its commitment to Aboriginal cultural practices.

With regard to Aboriginal health, a number of initiatives are in place to assist in reducing the health or disadvantage gap for Aboriginal people. These include the Agreement on Aboriginal and Torres Strait Islander Health; 'The first step' Regional Plans; Statement of Reconciliation and Business Plan; 'Our Journey', Aboriginal Services Division Business Plan; the COAG Commitment to Reconciliation; and the State Government/ATSIC Partnering Agreement.

The Department of Human Services is in the process of examining the reporting requirements under these agreements to ensure that outcomes are measurable. The department has contributed to the development of a set of performance indicators in line with national health priorities, and incorporating the health targets identified by the NHMRC Standing Committee on Aboriginal and Torres Strait Islander Health. The Australian Health Ministers Advisory Council has now endorsed these performance indicators.

In our hospitals current challenges included nurse, pharmacist and anaesthetist shortages, medical indemnity insurance and the increased demand for hospital beds during winter. Service rationing and budget reductions have previously been used without making a proper assessment of the reform needed to ensure that all South Australians continue to have access to safe and high quality services. As a new initiative, this government has allocated almost $51.8 million over the next four years to phase in an extra 100 beds.

Addressing the shortage of nurses through the development of a strategic plan is under way, with this government allocating $2.7 million, this year, to establish an appropriate recruitment strategy. Work with nursing agencies, unions, universities and hospitals is occurring to devise sustainable solutions to nursing recruitment and retention. A report highlighting the need for significantly increased numbers of nurse graduates has been released. Addressing the previous government's neglect of medical workforce planning is a further area where I have asked the department to undertake special studies and strategy development.

Medical indemnity is a complex issue that requires a collaborative and supportive approach in seeking a resolution. We negotiated a new contract for rural practitioners' medical indemnity from 1 July 2002 and have organised a medical indemnity round table to review national reform proposals and ensure that they suit the South Australia context.

A set of initiatives to help hospital emergency departments cope with high levels of demand over the winter months was released on 11 June. Winter is the time of greatest pressure on our emergency services, and the winter bed strategy is a key part of the Rann Labor government's commitment to rebuilding our health services. Each winter a significantly higher number of patients a day are treated in our hospitals, mostly suffering from pneumonia, asthma, flu and flu complications such as heart and respiratory disease . The stresses on public hospital emergency departments are exacerbated by private hospitals operating on diversion and the shortage of nursing staff. Careful management of resources and a close collaboration between hospitals will put the health system in a much stronger position to be able to cope with the peak winter demand.

I turn now to the hospital infection review. Following concerns about hospital-acquired infections which led to the temporary closures of the IC unit at the Queen Elizabeth Hospital, the neonatal intensive care unit at the Women's and Children's Hospital and the cardiac surgery theatres at the RAH, I instructed that an urgent independent review should be carried out. Interstate experts, under the leadership of Dr Peter Brennan, began their review of South Australia's public hospitals on 3 June, and I expect to have their full report soon. The government has also provided $1.5 million (new money) in the 2002-03 budget to enhance infection control, reduce cross infection and improve hygiene standards in our hospitals.

I turn now to women's health. The government recognises that women have different and varying needs at various stages of their life and require services that support their many roles. The government will therefore continue its commitment to the special health needs of women and recognise that the participation of women in decision-making about health must be strengthened in the health system. An Obstetric Shared Care Program will improve access for all women to contraceptive advice, pregnancy advice and birthing options. In the Shared Obstetric Care model, the majority of antenatal care is provided by the general practitioner rather than the hospital's outpatient clinic, with the birth occurring in the hospital. This model provides continuity of care and caregiver for women experiencing a low-risk normal pregnancy.

I also appointed Ms Jocelyn Auer, a well-regarded and respected person in women's health, to investigate more workable options for women's health statewide based on wide consultation. This was necessary because the previous government had conducted a review (one of its 69 reviews last year) which was substantially flawed and based on inadequate consultation.

The Hon. DEAN BROWN: I rise on a point of order, Madam Chair. I have sat in estimates committees for many years, and I think this is the longest speech—it is almost a Castro-style speech—I have heard. Today is a day for questions and answers, not for half-hour speeches by a minister. As I said, I cannot recall a minister giving a half hour speech before.

The ACTING CHAIRPERSON: There is no point of order. Although the guidelines ask for about 10 minutes, the best procedures we have give the lead speaker unlimited time. However, I would ask the minister to draw her remarks to a conclusion.

The Hon. L. STEVENS: I have just about finished. The result of the meddling was that this vital and undervalued women's health service was left floundering without a clear view of its future. Ms Auer has recently reported to me, and I have greatly appreciated her clear prescriptions for how women's health statewide can be restored to a position of strength within the health system and how the department can improve its own capacity to respond more sensitively and adequately to women's health priorities.

In conclusion, our election commitment was to rebuild services. The government has already taken corrective action in the most urgent areas of health care, and I have set in place new initiatives to reform and reframe South Australia's health services. The initiatives announced in this budget are part of the down payment promised to the people of this state at the last election. This is the down payment on the government's firm pledge to improve health services as a matter of priority. It is just a beginning. The rebuilding is beginning to take shape. This government recognises how important health is to South Australians, and this is reflected in the priorities set out in the budget. Thank you.

The ACTING CHAIRPERSON: Deputy Leader, do you wish to make an opening statement?

The Hon. DEAN BROWN: No, Madam Chair, I do not. I think today is a day for asking questions and getting information.

The ACTING CHAIRPERSON: I invite you to start the questioning.

The Hon. DEAN BROWN: I refer to Output Class 6, page 6.26, concerning the winter bed strategy to which the minister has referred. Under that strategy, the minister announced in June that 25 per cent of all elective surgery would in fact be cancelled as part of the winter bed strategy. How many outpatient consultations have been cancelled and how many elective surgery cases have been cancelled at the major hospitals since the beginning of June? Will the minister acknowledge that there has been an enormous number of cancellations for both outpatient consultations and elective surgery and orthopaedic surgery? Will the minister release the elective surgery bulletins for the months of June and July, a bulletin which I know is produced and which gives detail of the cancellation of surgery and what surgery took place?

A number of people have come to me to complain about the cancellation of both outpatient procedures or appointments and cancellation of surgery, particularly at the Flinders Medical Centre but also at other major hospitals. One of the key areas where complaints have been targeted has been orthopaedic surgery. In fact, I know that a number of these people have been to the minister's office and have come to me as a result of not getting any satisfaction out of the

minister's office or the minister's staff. As a result of that, they have outlined some of the cases.

I give one example of an elderly gentleman, normally a very fit and active person, who needs hip surgery. His outpatient appointment, due on 15 July this year, was cancelled on 4 July and put back to 2 September, a delay of almost two months. This particular gentleman is now suffering considerable pain and in fact went to his GP as a result of the cancellation. His GP has said, in a letter to the hospital, 'I would appreciate him having joint replacement surgery as soon as possible as his quality of life is severely restricted.'

I said at the time that I believe across the board 25 per cent cancellation of surgery as part of the winter bed strategy was the wrong approach to take. I think now we are seeing the huge human cost. I stress the fact that I have pointed to just one example: I could quote others. I know that in one case the family are so distressed that they are concerned that their parent may not be able to continue to put up with the pain and agony and in fact may die as a result of the delay occurring.

I stress the fact that these cancellations have occurred within the new budget period. They are cancellations that have occurred in July and certainly there is no money apparently for elective and orthopaedic surgery during most of August. I would appreciate knowing how many outpatient procedures have been cancelled, how many consultations have been cancelled and how much elective surgery has been cancelled; and will the minister release the elective surgery bulletins for June and July?

The Hon. L. STEVENS: I must say that I have been in estimates committees for many years now and that would have to be the longest question that has ever been asked. But I would be very happy to provide the shadow minister with an answer. I would like to start by saying that issues in relation to pressure in winter are not new. Before I even get into talking about the winter bed strategy this year, I would like to refer to some press cuttings that I have saved from recent years. The first one comes from the *Advertiser* of 22 July 1999, about the same time of the year, during winter. It states:

> Professor Kearney said the situation was similar to last year when winter illnesses caused elective surgery suspensions and emergency patients to be diverted to other hospitals during overloads at the Flinders Medical Centre and the Queen Elizabeth Hospital. The Australian Medical Association says public hospitals are surviving only on the goodwill of staff working countless hours overtime. The state Vice President, Dr Michael Rice, said yesterday that, if staff stopped propping up the system, there will be an absolute breakdown.

I found another one in the *Advertiser* dated 13 October 2000, headed, 'Apology for Surgery Delays'. It starts off:

> Human Services Minister Dean Brown has apologised to elective surgery patients whose operations have been cancelled amid claims a new crisis has enveloped the public hospital system.

It goes on a little about the extent of that and finishes with a quote from Mr Brown:

> 'I apologise to those people in South Australia who have had their elective surgery cancelled because there are quite a few people in the last month. It distresses me,' he said. 'We are looking for solutions but there are no short-term immediate solutions.'

I started quoting from that because I wanted to point out that this is what the current government was left with. This was the legacy of the previous government that we were faced to deal with. I have been shadow minister since 1994, and year after year things became worse and worse, particularly in the winter months. So this was the situation that we were faced with. Knowing that our budget was not to be delivered until 11 July, not only were we facing again a winter demand as I explained in my opening remarks, but also we discovered there actually had never been a system response to winter. That is staggering. In fact, year after year things were getting worse and worse, and there had never been a coordinated system response.

As shadow minister I remember how on occasions the minister would come out and make these statements, how he had had this meeting or that meeting, but essentially the hospitals had never worked in a coordinated way together. In fact, they had never met regularly in a cooperative, coordinated, strategic planning way, so we decided that this would change.

The Hon. DEAN BROWN: That is wrong.

The Hon. L. STEVENS: Well, it is not wrong.

Mr Meier interjecting:

The Hon. L. STEVENS: It is not wrong. So we decided that things would have to change. There needed to be a coordinated and organised approach to winter. I want to talk about the winter bed strategies. There are a number of facets to the winter bed strategy. The following strategies were implemented: the continuation of staff flu vaccinations; the establishment of emergency extended care units; an increase in 'hospital at home' utilisation; a review of medical admission protocols, including a formal assessment of the appropriateness of admission and discharge protocols (especially increasing same-day services, particularly in medical admission areas); targeting a reduction in the length of stay in areas where recent increases have not been explained; improving the management of mental health patients within emergency departments; and monitoring and managing of hospital diversion.

As well, there was a reduction of 25 per cent in elective surgery, but not category 1 elective surgery. The reason for that was a clear recognition that when things are really tight in winter, and when people are presenting to the emergency departments in large numbers with winter-related illnesses, we needed to refocus the efforts of our hospitals to deal with the sickest people coming through the emergency departments while, at the same time, keeping category 1 elective surgery going. That is what has occurred since 11 June.

In relation to the cancellation of elective surgery cases, I would like to give the following information: to 28 July (which is the most recent date provided to me), 599 elective cases have been cancelled, 189 of which have been medical and 410 surgical. There have been 69 cancelled at the Flinders Medical Centre, 238 at the Queen Elizabeth Hospital, three at the Lyell McEwin Health Service, 132 at the Royal Adelaide Hospital and 157 at the Repatriation General Hospital. It gives me no joy at all to report that we have had to cancel elective surgery. The fact is that we have inherited a system that has been run down in an unrelenting manner for eight years.

It will be a long haul to rebuild our hospital services, but we have started that process. I would also like to make the point that the number of cancellations that have occurred to date are interesting when one puts them into perspective with some of the statements that were made at the time the winter bed strategy was announced, that is, that in the next three months there will be 1 000 cancellations at the Royal Adelaide Hospital alone. In fact, in two months there have been 600 cancellations across the metropolitan system. We are monitoring this situation on a weekly basis. We know that things are very tight in our hospitals.

I have visited the hospitals and my chief executive is visiting the hospitals and talking with people on site. We know that all cancellations of elective surgery are rescheduled within the required times, and we are working with hospitals to ensure that when surgery is postponed it is done in the most sensitive way.

In relation to the other questions asked by the shadow minister, I will be very happy to make public the information relating to waiting times when it becomes available. I repeat: this is the legacy of the former government and this government is now in the process of rebuilding.

The Hon. DEAN BROWN: My second question relates to the purchase of the MRI machine at the Queen Elizabeth Hospital. The former government announced in December that MRI machines would be purchased for the Queen Elizabeth Hospital, the Lyell McEwin Hospital and the Women's and Children's Hospital. In fact, those machines had been through the Supply and Tender Board process, they were ticked off by that process and firm contracts were in place and, in December last year, funding had been provided. An MRI was purchased for the Queen Elizabeth Hospital and, in fact, installed at some considerable expense.

I am now informed that the Queen Elizabeth Hospital has been ordered not to use the machine. It has been ordered to remove the machine and to send it back to Holland. Will the minister confirm that information? The hospital has gone to all the expense and bother of obtaining a machine and now discovers that it must be returned to the supplier or manufacturer and that another machine must be purchased. Was authorisation obtained for the purchase of that machine?

The Hon. L. STEVENS: Thank you very much for the question, which I am very pleased to address. I would like, first, to put on the record that this government is concerned to ensure that the Queen Elizabeth Hospital is equipped, as soon as possible, with the right MRI machine. I would also like to say that, as part of this government's election policy, the Labor government made a commitment to provide $1.5 million towards the purchase of MRI machines at both the Queen Elizabeth Hospital and the Lyell McEwin Hospital. This money has been set aside for the year 2003-04.

I want to put on the record, too, that this government is concerned to ensure that, as soon as possible, the Queen Elizabeth Hospital is equipped with an MRI because the Lyell McEwin Health Service already has an MRI. I acknowledge that for too long patients have been transported to the Flinders Medical Centre or to the Royal Adelaide Hospital for a scan. I am well aware of that because, as shadow minister, I had a number of conversations with relevant people, and certainly that matter was brought to my attention. Such an arrangement requiring patients to be moved by ambulance from one hospital to another, as the shadow minister would know, can be clinically undesirable and, obviously, ties up the precious resources of our ambulance service.

In fact, as shadow minister, I was concerned that, year upon year under the previous government, nothing seemed to be happening about MRIs. It was for these very reasons that on 6 December 2001, prior to the last election, Labor promised $1.5 million capital and $250 000 recurrent funding to help fund the purchase of two MRIs for the Queen Elizabeth Hospital and the Lyell McEwin Hospital. As I said, this funding is in the budget for 2003-04. In November 2001, the previous government had given approval to the North Western Adelaide Health Service to purchase two secondhand MRI machines at a strength of .5 tesla at a total cost of around $2.5 million from hospital funds.

This cabinet approval was based on a recommendation by the North West Adelaide Health Service concerning the size of the machines and followed the usual approved tender processes. One of these two machines has been delivered and is now being installed at the Lyell McEwin Hospital. For some reason, the machine on offer to the Queen Elizabeth Hospital was not purchased as approved by cabinet. On 25 July 2002, I became aware that, instead of the approved machine, the Queen Elizabeth Hospital had in storage a new MRI with a strength of 1.5 tesla, that is, three times the strength of the approved machine worth $2.7 million.

This more powerful new machine appears to fall outside the tender process and the cabinet approval for a second machine to cost less than half that amount. I have also received a letter from the Chairman of the Women's and Children's Hospital board arguing in the strongest of terms that, if the government is to approve the purchase of a 1.5 Tesla MRI machine, that machine should not be located at the Queen Elizabeth Hospital but should be installed at the Women's and Children's Hospital. Accordingly, on 29 July 2002 I instructed my department to conduct an audit of the process that led to the failure of the Queen Elizabeth Hospital to purchase the approved machine and the circumstances surrounding the delivery of the new more powerful and more expensive machine. I also asked my department to inform the Auditor-General.

I have also asked my department to provide advice on the financial capacity of the Queen Elizabeth Hospital to fund an MRI acquisition and the process for the acquisition of an approved machine to proceed. It is important that the Queen Elizabeth Hospital has an MRI installed as soon as possible. I would be pleased if the member for Finniss would the tell committee why the Queen Elizabeth Hospital did not proceed with the purchase of the MRI approved by cabinet in November 2001.

The Hon. DEAN BROWN: You're the minister.

The Hon. L. STEVENS: You were the minister then. I certainly undertake to forward this information he may like to provide to me to the Auditor-General for investigation.

The Hon. DEAN BROWN: I point out that the current minister was the minister when the machine arrived; therefore, the current minister is accountable for the machine that arrived. It appears to me to be a classic case of *Yes, Minister*. My third question relates to an announcement that the minister made earlier today just before the estimates committees about the setting up of a task force to tackle passive smoking in entertainment venues. That is really a body she has set up to replace the ministerial task force that was already doing this work. I accept that; it is her choice to do that. In a press release, she said:

> The Rann Labor government is committed to the promotion of good health and healthy lifestyles, and that requires strong tobacco control legislation.

I refer to Budget Paper 4, volume 2 (page 6.10), which relates to health promotion. The health promotion budget for the year is $4.976 million. Each year the previous government committed $3.9 million to the anti-tobacco strategy. Almost all those funds go towards the anti-tobacco strategy, even though there are a number of other programs in terms of health promotion. Therefore, it was with interest that I looked at last year's budget papers and found that the allocation last year for exactly the same line under health promotion was $7.105 million. In other words, there has been a 30 per cent cut in health promotion funding this year compared to the budget put down last year. I ask the minister to confirm that.

Mr MEIER: Is that what the news conference was about this morning?

The Hon. DEAN BROWN: No, there was no mention of that. In fact, they attempted to create just the opposite impression. This government has significantly downplayed and devalued health promotion, even though during the election campaign it promised to do just the opposite. In terms of this morning's announcement that 'the Rann Labor government is committed to the promotion of good health and healthy lifestyles, and that requires strong tobacco control legislation,' the facts say otherwise, because there has been a 30 per cent cut in the health promotion budget as covered in the two budget papers both last year and this year.

The Hon. L. STEVENS: Before I answer that question, in response to the shadow minister's comments I will make a couple of extra points on the Queen Elizabeth Hospital MRI. I want to clearly make the following three points to the estimates committee: first, we will investigate why the approved machine was not purchased, and if irregularities are found, heads will roll. Secondly, it is unacceptable for precious taxpayers' dollars to be spent on very expensive unauthorised machinery. Thirdly, I want to just say again that we will deliver an MRI for the Queen Elizabeth Hospital. However, it will be the right MRI, and we will not allow taxpayers' dollars to be wasted. That is a very clear undertaking from this government.

In relation to the next question, I was very pleased an hour or so ago to be able to announce a task force to tackle passive smoking in entertainment venues. I would like to spend a couple of minutes giving some information to the estimates committee so that those present can be aware of what we have announced. Today I announced this task force. The state government and the hospitality industry are coming together to look at extending smoke free areas in licensed premises and gaming venues. We have established a task force into smoking in hospitality venues in response to the growing concern about the health and comfort of patrons and staff in licensed premises and gaming venues. The task force will provide advice on measures including legislative changes and time lines to extend smoke free areas and review evidence about the health effects of exposure to tobacco smoke in these sorts of venues.

I am sure the shadow minister would agree with me that we all know that tobacco use continues to be the largest cause of preventable deaths of South Australians. People may be interested to know just how serious this issue is in terms of health costs. Tobacco use accounts for 75 000 hospital bed days a year in South Australia, and the total cost of tobacco use and tobacco health effects to the state is excess of $1 billion per year. So it is an enormous issue. Anything we can do to protect the health of people in relation to tobacco smoking—and in this case tobacco smoke—is a good thing for health and health care. I am very pleased to announce that the task force will be chaired by you, Madam Chair, the member for Reynell. It has a broad representation from industry, and it has representatives from the Australian Hotels Association, Restaurants and Catering SA, the Licensed Clubs Association of South Australia, the Liquor Hospitality and Miscellaneous Workers Union, a representative from WorkCover, and health experts. It also has a representative from the casino in Adelaide. The task force's terms of reference are:

- to provide advice on further measures, including legislative changes and time lines, to extend smoke free areas to protect staff and patrons from exposure to tobacco smoke in licensed premises and gaming venues;
- to review evidence about the health effects of tobacco smoke exposure in enclosed areas; and
- to review evidence and advise on the anticipated health, social, environmental and economic impact of the introduction of additional smoke free areas in licensed premises and gaming venues in South Australia.

I am very keen for this task force to do its work. It is very important work, and it is very important that this issue be tackled in a collaborative manner; and that is why we have involved all players at this early stage. I am confident that they are all keen to get down to the task and to provide us with the advice that will inform changes to policy and changes to legislation that this government will bring in as soon as we possibly can.

In 1995, when I was shadow minister and the minister for health at the time was the Hon. Michael Armitage, I remember very clearly that when the current smoke-free dining changes were introduced into the parliament there had been little consultation with the industry. I remember that quite clearly. I remember learning very quickly and seeing very clearly that when you want to make these changes it is important to get people in the tent working with you and, so far, all the people who have been approached to be on this task force have indicated their willingness to get down in a constructive way and to address this very important health issue.

In relation to health promotion and the other part of the shadow minister's question: health promotion combines a range of strategies including advice, legislation and services to the community to promote health and wellbeing. Health campaigns are varied from time to time according to assessment success and the emergence of new priorities. Under the previous minister the number of campaigns was reduced in the budget strategy from nine to eight. In the final outcome, only seven of these campaigns were actually implemented by the previous government. The previous government conducted a review in 2001 and the results showed that too many campaigns can dilute the message. My department is examining the currency of the present campaigns and the need to consolidate some of these in terms of the number and range of issues addressed. I would like to invite the chief executive, or one of his officers to—

The Hon. DEAN BROWN: Madam Chair, on a point of order. I remind the minister of my simple question: will she confirm that there has been a 30 per cent reduction in funds allocated this year compared to last year?

The Hon. L. STEVENS: Madam Chair, I am actually answering the question. I would like to hand over to the chief executive to provide some further information.

Mr BIRCH: Thank you, minister. In answer to the question, firstly we will need to get this confirmed specifically, but we understand that the estimated outcome in the budget papers for 2002-03 was similar to the budget papers estimated outcome for 2001-02. The actual outcome, which we believe the shadow minister is referring to, is greater and most probably resulted from a reallocation of funds from within the department. It is not intended, within the budget allocation process this year, to reduce the amount of tobacco funding—

The Hon. DEAN BROWN: Not by the former government, I might add. The reallocation did not occur by the former government.

Mr BIRCH: It is not intended to reduce the amount of funding going into tobacco control as part of the department's budget allocation process this year.

The Hon. DEAN BROWN: So that is to confirm there has been a 30 per cent reduction?

The ACTING CHAIRPERSON: Is this a supplementary question, deputy leader, for clarification?

The Hon. DEAN BROWN: Clarification on two points: one is that there has been a 30 per cent reduction in the allocation and, secondly, I just seek clarification—and the minister may not be able to give it today—but as to the installation cost of the MRI and the other associated purchase cost of the MRI at the Queen Elizabeth Hospital (the minister mentioned a figure of $2.7 million), I want to know specifically the installation cost and other costs that would be lost if that machine is now removed.

The Hon. L. STEVENS: In relation to that last question, I have actually asked for a full report from my department which I have not yet received, but I have asked for all the details. I cannot give the answer at this point. However, when I get that report those findings will be referred to the Auditor-General, and I am quite happy to let the shadow minister have those details. In relation to the health promotion issues, I refer to the chief executive, Mr Birch.

Mr BIRCH: Again, we will need to get clarification, but there has definitely not been any reduction from budget to budget on health promotion in relation to tobacco control. We believe the budget papers refer to an estimate that was made and, if compared to the previous estimate made in the previous year's budget papers, we believe that that will be similar. So, in answer to the question, we are not intending to reduce the budget allocation to tobacco control.

Mr CAICA: Given statements by the member for Finniss that the commonwealth had agreed to provide $5 million over two years for after-hours GP clinics, can the minister tell the committee if she has been able to contact the federal Minister for Health and Ageing to find out what happened to this funding, and whether any other amount was involved in this deal?

The Hon. L. STEVENS: After the member for Finniss revealed the $5 million after-hours clinic deal to the media on 29 May 2002, members will recall that my department wrote to the commonwealth Department of Health and Ageing and sought advice on this funding—members will recall that I made statements in the house to that effect. The Secretary of the federal Department of Health and Ageing then advised my department on 28 June 2002 that they had no record of this commitment. Then, on 8 July 2002, the member for Finniss disputed the federal department's advice and told the house that he had personally negotiated the deal with the Prime Minister and the Minister for Health and Ageing. Accordingly, on the morning of 9 July 2002, I faxed the federal Minister for Health and Ageing asking for confirmation of this claim. While I have received no reply to my letter, later that same day the member for Finniss read to the house a letter that he had requested from the federal minister's chief of staff which confirmed that a commitment was made by the federal minister.

After that statement by the member for Finniss, my office immediately sought further advice from the federal minister as to whether the commitment extended to the incoming Labor government. Unfortunately, Madam Chair, I am disappointed to report that there has been no response. My chief of staff sent a further request for information on 30 July 2002, but this has also not been answered. I raised this issue personally with Senator Patterson at a recent health ministers' conference on Friday 19 July 2002. Surprisingly, the federal minister was unable to corroborate the statements made by the member for Finniss. So, I provided the federal minister with copies of all the statements made by the member for Finniss together with a request that the federal government clarify this issue. To date, I have had no further advice. Given this extraordinary situation, I can only presume that the member for Finniss made a deal with the Prime Minister and the federal Minister for Health for the federal Liberal government to fund the state Liberal election promise, but that the deal does not stand for the new state Labor government. After all, neither the federal department nor my department has any record of the funding, and the federal minister has been unable to confirm the grants.

However, my office has now found a copy of another interesting document. It is a copy of a document that purports to be a copy of a letter addressed to the Chief of Staff of the Prime Minister, setting out a proposal for commonwealth grants, $5 million for after-hours care and another $7.5 million for a program about better home care. This is the first time that we have heard about the $7.5 million for home care. I stress that this document is a photocopy of a letter that has sections blacked out and is undated and unsigned. I do not know whether or not these details have been removed or whether the letter was ever sent. However, I am happy to table the document because it mirrors announcements made by the former minister and sets out in detail arguments as to why these grants would not create equity problems for the commonwealth with the other states.

It talks about $5 million over two years for after-hours GP clinics and $7.5 million over three years for a pilot program about better home care. Interestingly, both these packages as set out in this document were announced by the former minister on 7 February 2002, in the lead-up to the last election. In fact, I have a copy of the media report, so let me read what it says, because this is what the federal Liberal government now says it knows nothing about. The media report is from an *Advertiser* article entitled 'Federal funds for clinics', by Greg Kelton, and states:

> The federal government has agreed to provide $12.5 million for after-hours GP services and help to assist older South Australians to stay at home longer. Deputy Premier Dean Brown said his federal counterpart (Kay Patterson) had agreed to fund the two new after-hours GP clinics at Noarlunga and in the northern suburbs. He said the commonwealth also had agreed to expand the new home and community care program announced last week, with $7.5 million in extra funding over three years.

All this is becoming more than just a bit of a mystery. We now have $12.5 million of promised commonwealth grants missing. On 8 July the former minister told parliament that he went to the Prime Minister's office during the last week in January. After that meeting with the Prime Minister, the former minister announced on 7 February 2002 a $12.5 million package of federal funding for two programs. The commonwealth department now says that it does not know anything about the deal and there is no money. The state Department of Human Services was never advised. The federal minister now has not confirmed the deal, even though the member for Finniss told the South Australian parliament on 8 July that the federal minister telephoned him personally and gave him a commitment for the $5 million for after-hours GP clinics.

We know that the Prime Minister was involved in some way and met the former minister on the eve of the state

election. There are many questions for the member for Finniss to answer, because it seems that South Australia has lost $12.5 million. Perhaps the member for Finniss could explain whether the agreement for $12.5 million in grants was discussed with the Prime Minister and whether the Prime Minister agreed. Can the member for Finniss confirm that the undated and unsigned letter went to the Prime Minister's Chief of Staff and whether this document is the basis of the agreement? Perhaps the member for Finniss can clarify whether this state Liberal election announcement was contingent on the Liberal government's being re-elected.

If the funding was contingent on the election of a Liberal government, why did the member for Finniss claim three months later (on 29 May 2002) that this funding had been secured and, wait for it—

Mrs REDMOND: On a point of order, I am new to estimates, but my understanding was that the minister was here to answer questions, not to ask them of the opposition members.

The ACTING CHAIRPERSON: That is correct. I am interpreting the minister's comments as being rhetorical questions. There is no power for her to ask for an answer.

The Hon. L. STEVENS: The second point was this: if the funding was contingent on the election of a Liberal government, why did the member for Finniss claim three months later (on 29 May 2002) that this funding had been secured and that the new state government had cut the funding and broken an election promise? Knowing what we know now—that his federal Liberal Party colleagues now deny that the deal ever existed—members would have to agree that the claim by the member for Finniss that Labor cut the funding is breathtaking.

Mr CAICA: What steps does the government intend to take (given the Budget Statement pages 3.9 and 3.11) to improve the safety of blood to South Australians over the next 12 months?

The Hon. L. STEVENS: At the meeting of health ministers on 19 July I, as the minister for South Australia, agreed in principle to support commonwealth legislation that will create the National Blood Authority (NBA). The NBA will contract with the Australian Red Cross Blood Service (ARCBS) and the Commonwealth Serum Laboratories for the supply of fresh blood and blood products to South Australians. This authority will lead to the safer supply of blood to all Australians through a national integrated supply planning, production and distribution capability and better mechanisms to ensure safety and quality of both the supply and the use of blood products. Each state will maintain direct influence on policies concerning blood through the establishment of an interjurisdictional committee.

The key initiatives to improve safety and quality of blood, which are funded under the new appropriation in the 2002-03 budget, include:

- An increase of the supply of recombinant blood factors to South Australians (recombinant factors are considered safe for use and represent a low risk of transmission of infectious agents).
- A national initiative in fresh blood regulation will ensure that the ARCBS is compliant with the Therapeutic Goods Administration, thereby ensuring the quality of fresh blood.
- The ARCBS is expanding the national supply of Anti-D for women who are RhD negative and carry an RhD positive child and develop Anti-D which, in subsequent pregnancies, can cross the placenta and cause haemolytic disease of the newborn.
- In order to address haemolytic disease of the newborn, Winrho will be supplied to mothers in an ante-natal setting.
- The South Australian government will increase funding for Nucleic Acid Testing (NAT) of donated fresh blood to ensure, as far as possible, that no blood used is infected with HIV, hepatitis B and hepatitis C.
- A Bloodsafe project to improve the management of blood inventory within hospitals will reduce blood wastage.
- Funding for the National Blood Cord Bank initiative.
- Continuation of the implementation of the ARCBS blood management system will ensure that the improved inventory practices lead to improvements in the blood supply.
- The South Australian government will progressively introduce leucodepleted blood in areas where there has been shown to be clinical benefit from doing so (leucodepleted blood is blood from which the white cells have been removed and results in a reduction in febrile haemolytic transfusion reactions, and is safer for patients who undergo frequent repeat transfusions or who are candidates for transplantation).

These are significant measures that have been taken by the government to address the issue of blood and blood products and their safe use as therapeutic agents for the benefit of all people. I invite Prof. Brendon Kearney, Executive Director, Clinical Systems, to expand on that information that I have just given to the committee.

Prof. KEARNEY: The state is leading, with other jurisdictions, several initiatives to improve the blood supply. One of the important developments is to improve plasma products, particularly factor 8 and 9, which are used for people with haemophilia A and B. Commonwealth Serum Laboratories produces that plasma, which is collected by the Red Cross Blood Service. There have been concerns in the past about transmission of infectious diseases—and, in particular, HIV in past years. These new production processes, known as Biostate, which are due to come into effect at the end of this financial year, will provide a safer plasma product for administration to patients with haemophilia and will improve the supply. At the same time, the government is increasing the availability of recombinant factors—these are factor 8 and 9, the same as those produced from plasma donations. But, because the factors are grown in cell cultures, they are much more free of the risk of transmission of infectious diseases. Those supplies will also be increased over the financial year.

In addition, South Australia is leading an initiative in leuco depletion of blood; that is, removal of white cells from blood transfusion. Again, it is known that the white cells in blood transfusions cause a number of reactions that are responsible for what are called 'transfusion reactions'. These are particularly in post-transfusion febrile reactions, and can cause significant morbidity and distress to the patient. It is particularly important in people who have recurrent transfusions, such as people with thalassaemia, people with recurrent heart operations or people on the waiting list for transplantation for kidney, liver or other transplantations, to receive this blood in which the white cells are removed, as it significantly improves the outcome for those people and their quality of life. It is also particularly important for people with malignant disease receiving platelet transfusions, because their treatment often requires them to have platelets donated from other

people. But if there are white cells there, this causes a very rapid resistance to that transfusion. So, that development is happening, and will increase during the year.

In addition, nucleic acid testing is reducing the window period in which blood that is donated can be regarded as safe from transmission of infectious agents, and further funds have been put into increasing that testing. There is also a problem in production of immunoglobulin, which is used in a variety of conditions to increase the immunity of patients who have immune deficiencies and, in particular, as the minister indicated, Rh immunoglobulin, which about 2 000 women in South Australia require each year to prevent them from further pregnancies having Rh negative disease, which causes haemolytic syndrome in newborn babies, and which is quite devastating. Again, South Australia is part of a move in increasing the supply and availability of those products. So, a range of initiatives in the blood transfusion sector are being taken this year, which will improve the availability and the safety of a range of products.

Mr CAICA: Since the federal government axed the commonwealth dental health program in 1997, pensioners and other disadvantaged people in South Australia have faced increasingly long waits for dental treatment. What is the state government's strategy, in line with Budget Statement pages 3.9 and 3.10, to improve waiting times for dental treatment?

The Hon. L. STEVENS: Issues relating to dental health have been of ongoing concern to the government ever since the axing of the commonwealth dental health scheme. The federal government axed the commonwealth dental health program in 1997 and, in doing so, effectively halved the funds available in South Australia for basic dental care for concession holders. All MPs during that time, and current MPs, would be aware of these issues, as they impact upon our constituents.

Not surprisingly, waiting lists for dental care, such as fillings and dentures, began to increase rapidly. Our public dental services were overwhelmed by the demand for emergency treatment, as cardholders could no longer receive their dental care in a timely fashion. This was an insidious new form of poverty trap, as simple dental problems deteriorated to the stage where extraction of teeth was the only option. Pensioners and other disadvantaged people were set on an inexorable path to more and more complex and costly dental problems, with their associated impact on general health and wellbeing. It is interesting to note just how much poor dental health impacts on the general health of a person, and certainly how dental problems can cause social issues and social problems for the people who suffer from them.

The state government is committed to breaking this cycle. Over the next four years, an additional $8 million will be provided to reduce waiting times for public dental care. This will allow an additional 35 000 people already on the waiting list to be offered preventively focused dental treatment either at a public dental clinic or through a participating private dental practice. As a result, waiting times will begin to reduce immediately, and will fall to 30 months by the end of the four years at this level of funding.

However, South Australia is not alone in facing the problem of growing waiting lists since the withdrawal of the commonwealth dental health program. We will also continue to attempt to convince the federal government to recognise its responsibilities in this key area of health. This was something that the federal Labor opposition promised in the lead-up to the previous federal election and readily committed to redressing. But, to this point, the Howard federal government has refused to take up its responsibilities. We will continue to work to encourage a national approach to oral health services that includes the reinstatement of the commonwealth dental health program funding.

Our ability to achieve dramatic improvements in oral health through a concerted community effort has been demonstrated through our children, who now have the best oral health in the OECD, and we are certainly committed to overcoming this major health inequality. I would now like to hand over to Dr Tom Stubbs to expand on the comments I have made, and certainly on the strategies that we have in place and the challenges in the future.

Dr STUBBS: I am pleased to endorse what the minister said in terms of the impact of oral health on general health, and I think that is something that is not fully appreciated. We are paying particular attention to certain target groups and population groups for which that is particularly true and, obviously, indigenous health is one of those, and aged health is another. A lot of the problems for older people occur because they lose some of their dental health. They lose their teeth and, therefore, they have much more trouble eating nutritional food, which puts them on a cycle that is really constantly downhill.

The Oral Health Advisory Committee (in collaboration with the universities, the Dental Hospital, the South Australian Dental Service and the department) has formed two working groups, one that is looking at indigenous oral health and the other at aged health problems. So, that is one of the things we are doing. Another important issue in the dental area—and in the medical area generally—is the work force issue. We have been exploring new ways of improving recruitment and retention of dental staff generally. One of the most exciting is the Limestone Coast initiative where, again, the university has combined with the department and the South Australian Dental Service to introduce new initiatives to recruit dental staff. For example, the university is prepared to give lectureship and professorial appointments for particular staff who may be working but can also do some teaching in association with the university. So, there is a range of those sorts of initiatives happening in the dental area.

I think it is also important to note that South Australia is leading the way nationally and that Dr Arthur van Deth, who was previously with the department, is leading a national committee which will attempt to influence the commonwealth not just on funding issues but on a range of issues on which we need a national approach. The funding issue is well known. When the commonwealth withdrew its funding in 1996-97, about $10 million was taken out of the state in terms of its capacity to meet dental demand. We will continue to pursue the commonwealth on that because we do not believe that the state on its own can fully reach the number of people who need dental services.

The waiting list was as high as 100 000, equivalent in time to something like a five year wait. That has come down to about 80 000 now, but we cannot be complacent because there is a very fine line between providing instant emergency services in dental, which we attempt to do, and getting more emphasis on prevention. Obviously, there has to be a balance between those two. The problem with just handling emergencies is that you will always be just handling emergencies. So, part of the demand management strategy in the dental area is to improve our focus on prevention. To that end, we have developed with the South Australian Dental Service a range of models which enable us to look at how best we can use the funding which has been promised over the next four years

and strike that balance. This is an important initiative, and we will give it emphasis over the next few years.

The Hon. L. STEVENS: There is money in the budget for a new capital works project at Salisbury. I will ask Dr Stubbs to give the details of that.

The Hon. Dean Brown interjecting:

The Hon. L. STEVENS: That's terrific. We are very pleased because we are actually going to build it; it is not just an announcement. Perhaps Dr Stubbs could explain.

Dr STUBBS: We are looking at a range of dental services around the state to see whether we can rationalise them. There is a large capital investment in infrastructure and a large number of clinics and school clinics. We are finding that the concept that is working particularly well is that of a polyclinic, which is situated in a way that enables us to close, say, five existing clinics but provide a similar service and take into account transport and navigation requirements of the people using those services.

The Salisbury polyclinic is a classic example of that, but we are also doing similar things in other parts of the state. So, capital investment is obviously very important in the dental area to maintain not only major infrastructure in service clinics but also equipment. By rationalising some of the infrastructure in terms of a number of locations, we will be able to better manage the need to have up-to-date equipment and a long-term replacement strategy, something which in the dental area as well as in the medical area has been deficient in the past.

The Hon. DEAN BROWN: We spent $600 000 on it last year.

Mr Caica interjecting:

The Hon. DEAN BROWN: We spent it. Your own budget papers show that it was spent. I would like to ask a question about HomeStart loans for aged care facilities in country hospitals. I draw to the attention of the minister a very good memo written by Mr Jim Birch, Chief Executive of the Department for Human Services, on 9 April this year. In this six page memo he sets out a very cogent argument for why the HomeStart loan scheme is a very good scheme and should be continued. This memo was sent to the Under Treasurer. It states:

> One of the reasons for unavailability of aged care places is the delay in allocated places becoming operational due to lack of financing for the construction of new facilities.

He states further:

> In many areas of South Australia the supply of aged care facilities has fallen behind the demand for those facilities. This has led to pressures building up elsewhere, for example, in the state's hospitals where it is estimated that upwards of 10 per cent of all beds are occupied by patients who would be more appropriately cared for in an aged care facility.

So, about 300 people in acute hospital beds would be more appropriately cared for in aged care facilities. He goes on to say:

> The Department of Human Services, HomeStart Finance and Treasury collaborated to develop a suitable. . . product for the aged care sector to expedite the take-up of aged care places in South Australia using standard HomeStart loan and Advantage loan products.

In other words, he formally acknowledges that Treasury approved the scheme. In his summary and recommendations, he states:

> The current strategy for offering the aged care loan facility to the not-for-profit sector should be maintained.

I also draw to the attention of the minister a minute prepared for the Treasurer by the minister's colleague, Minister Key, in which she acknowledges two things:

> The suggestion that the program was never intended for government health units [that is, hospitals] carries with it the implication that DHS, HomeStart and the previous minister for human services have exceeded their authority by entering into discussions with a wide range of government health units and approving loans to three such units. This is not an accurate reflection of the facts as I understand them.

In other words, Minister Key is saying that the defence used by the current Treasurer is not accurate. The third matter that I highlight is that, in the same minute, Minister Key goes on to acknowledge that loan approvals have been finalised for the Gumeracha hospital, the Kangaroo Island Health Service and the Naracoorte Health Service. Does the minister agree with what her Chief Executive said in his minute; does she agree with what her ministerial colleague said in the minute that she sent to the Treasurer; and, as the minister has made a statement that she will find alternative funding, what action will she take for the other 15 hospitals—that is, other than the Naracoorte that are seeking funds? The Chief Executive Officer, Mr Birch, acknowledges that virtually every country hospital is interested in these loans.

I also point out that last week—because the Millicent hospital was applying to build 30 aged care facilities—a longstanding Millicent resident had to be transferred from the Millicent hospital to a high dependency unit at Mount Gambier because there were no available beds in the aged care facility at Millicent. In the previous week, the three elderly Millicent residents who were all waiting to go into the aged care facility at the hospital (Sheoak Lodge) tragically passed away before they were able to get appropriate care in their own community. This highlights the demand in country areas for these sorts of aged care facilities. In fact, the documentation released by the government to me under freedom of information shows that there would have been 269 aged care facilities built if the applications had been approved. Does the minister agree with her own Chief Executive Officer and her ministerial colleague and, if so, what other funding arrangements have been made to ensure that the facilities can proceed as quickly as possible?

The Hon. L. STEVENS: The provision of aged care beds in country South Australia is a very important issue. I am very well aware of that, as is my department. We are certainly working towards improving the situation we have been left with. First of all, in relation to the shadow minister's questions, that really is old news. The Treasurer has answered these questions in this very chamber—

The Hon. DEAN BROWN: These are all new documents that have just been released by your department.

The Hon. L. STEVENS: I know that the shadow minister is very pleased to put before us the results of his FOI application—but the point is that the questions in relation to why the Homestart financing strategy was postponed or put aside have been answered on numerous occasions by the Treasurer inside this house and in the media. So, I would suggest that the deputy leader goes back and reads *Hansard* carefully and he will see what the Treasurer has said about this matter.

In relation to his question about where we go from here, I would like to inform the deputy leader that my department is working—notwithstanding any of the material that he has in front of him—on an alternative mechanism to enable these country hospitals to get appropriate financing so that they can

capitalise on the commonwealth bed licences they hold, and that work is well advanced. I cannot give him details of that today, but I will say that it is well advanced. He will just have to be patient. We are doing it as quickly as we can and we understand the urgency of these issues.

My own information from the department is that, in relation to the old Homestart loan applications, there were 10 beds for Naracoorte which are now proceeding under an alternative arrangement; 10 for Kangaroo Island; six for Gumeracha; and then we have issues involving Millicent, Balaklava, Barmera, Bordertown, Eastern Eyre Health Service, Eudunda, Kapunda, Renmark, Paringa, Strathalbyn and district and the Wakefield aged care project at Burra. So, just to reiterate, the position of the Treasurer and the decision made in relation to that funding mechanism have been repeated numerous times, and I am not going to repeat them again, but we are well advanced with an alternative mechanism, and we will announce that as soon as we possibly can.

In relation to the broader issues around the shortfall in aged care accommodation and the policy issues—federal and state—that that involves, I would like to invite the Chief Executive, Jim Birch, to expand.

Mr BIRCH: At the recent Australian Health Ministers Advisory Council meeting held in Darwin, all states raised the issue of aged care commonwealth places with the federal minister and it was agreed that information would be provided by all states to the commonwealth regarding the current shortfall, as well as discussing how, at a future meeting, AHMAC would recommend back to the health ministers a proposal for possible consideration of capital funding in the future. I should point out that the current undersupply of operational, commonwealth-funded residential aged care places in South Australia is significant. There are growing numbers of older people. There are many more being assessed as eligible and needing residential care. Many remain in hospital beds for extended periods of acute episodes because of lack of operational residential aged care places.

The current shortfall between state allocation and the number of operational beds for high care places is 398. The current shortfall in low care places between state allocation and the operational bed allocation is 1 164, making a total of 1 562 beds short at this time. There are 84.7 places per 1 000 population (aged 70 years and over) that are operational and 94.2 places per 1 000 population approved; that is, it exceeds the commonwealth's planning benchmark of 90 places per thousand population. That basically means that we have more places approved than the current commonwealth benchmark. There is a shortfall between approved places and operational places which is a very significant issue for older people in terms of being able to access secure care, particularly in country regions.

It is anticipated that the following places will become operational by the end of September 2002: aged care and housing, Yankalilla—30 low care places; Port Adelaide Central Mission Hawkesbury Gardens—45 low care places; and private provider, Ingle Farm—20 high care places. The best available estimates suggest that the bulk of beds allocated in 1999 and 2000 will be operational by 30 June 2003. On 2 May 2002, the commonwealth Minister for Health and Ageing announced an allocation of 608 additional places for South Australia. This constitutes 250 high care places, 289 low care, and 69 commonwealth aged care packages. These allocations, along with the allocations on 20 January 2002, will not become operational for up to two years or possibly longer.

Without some change of commonwealth policy on capital provision, there is a risk that the gap between allocated and operational places will persist in the longer term. This is a problem that all states identified, not just South Australia, at the meeting in Darwin. High care residential facility operators have difficulty accessing capital to build new facilities owing to the high cost of construction. In other words, it costs approximately $120 000 per bed to meet the commonwealth certification standards. There is an increasing number of operators, especially in small facilities, whose financial viability is thought to be marginal.

In addition, it is increasingly difficult to recruit and retain nursing and other staff to work in the aged care industry due, in part, to wage and salary disparities with the acute hospital sector and difficulties in recruitment and retention in country areas.

In summary, the South Australia government will continue, through the Department of Human Services, to work with the commonwealth to increase the supply of operational residential care places and bring them onstream more quickly. As the minister has indicated, we are very advanced in working on a proposal to obtain further capital for beds in the country. The commonwealth recently threatened to revoke provisional approvals for beds where operators concerned cannot demonstrate substantial progress. We are working with the commonwealth to see whether we can get an extension to the current licensing requirements of two years, and this is also an issue that is consistent with the other states' requirements, as announced in Darwin at the Australian health ministers' meeting.

The Hon. DEAN BROWN: My question now is quite specifically about finance. The minister may need to seek assistance because it is about figures. What is the cost of salary increases for the current year 2002-03 for nurses, doctors and other public sector staff within DHS? I am quite happy to have a rounded estimate.

The Hon. L. STEVENS: I will actually require some assistance here: the honourable member is quite right. While it is coming, I have some information on a previous question which I can provide to the committee. It relates to the question the deputy leader asked earlier about health promotion. The 2001-02 estimated result was $4.012 million. The 2002-03 figure is $4.976 million. In comparing those two figures, apples for apples, there is an increase of $0.964 million in relation to health promotion. I will hand over to the chief executive to answer the question in relation to the salaries.

Mr BIRCH: The indexation amount for 2002-03 for nursing is $19.59 million, $4.99 million for medical, $8.20 million for superannuation, $26.29 million for the PSA and ancillary staffing, and $13.27 million for goods and services, giving a total indexation in the budget of $72.33 million.

The Hon. DEAN BROWN: I refer to page 6.27 and the benchmark price per equisep allocated to metropolitan and country hospitals. I see that, comparing the end of year result with the target for 2002-03, there has been a 7.1 per cent increase in the metropolitan hospitals; in other words, a procedure carried out in a metropolitan hospital on average will increase by 7.1 per cent, whilst in country hospitals they will increase by 2.4 per cent. What will be the impact of that on country hospitals? In particular, I take you back to an earlier figure in terms of outputs which shows that the

number of aged care places in country hospitals will be significantly reduced this year compared to last year. I refer to page 6.24, which shows 155 bed day positions last year and 146 positions this year, despite the increase in demand and despite the stopping of the HomeStart loans and the ageing of the population. What will be the impact of that 2.4 per cent increase on country hospitals this year, which is less than the increase for CPI and salary increases for those country hospitals?

The Hon. L. STEVENS: I know that we have only five minutes to respond. We may need to carry over this answer. I ask Mr Frank Turner, Director, Financial Services, Department of Human Services, to start the answer in terms of the financial mechanics and we will see where we are at the end of that section before we finish the answer.

Mr TURNER: The benchmark price which is published in the portfolio statements is a price we derive before we have actually finalised the actual price through the casemix modelling. What we are indicating in that exercise is that we were going to maintain that as a very minimum price in line with CPI. In fact, the final price has not yet been determined, but it is likely to be significantly above the price that we have published.

The Hon. DEAN BROWN: Is that for both metropolitan and country or just for country?

Mr TURNER: That is the case for both metropolitan and country.

The Hon. DEAN BROWN: You think the increase per equisep will be greater than 7.1 for metropolitan and 2.4 for country?

Mr TURNER: No, I think it will be greater than 2.4 for country.

The Hon. DEAN BROWN: A 7.1 per cent increase has been allocated for the metropolitan area and a 2.4 per cent increase for country hospitals.

Mr TURNER: I cannot comment on the—

The Hon. DEAN BROWN: That is per equisep, your weighted average of separation?

Mr TURNER: In terms of the country, I can indicate the price will be greater than 2.4. I do not believe it will be greater than 7.1 in metropolitan hospitals.

Mr BIRCH: In relation to country hospitals, we are well advanced in the budget allocation process. Without having the specifics for each hospital, we can say at the very least there will be no reduction in real terms funding to the country hospitals against budget to budget, but we are not yet in a position where we can actually announce the specific allocations. We are still running various figures.

Mr HANNA: What was the budget overrun for 2001-02, what was the total accumulated debt at 30 June 2002, and how has this been managed in the 2002-03 budget?

The Hon. L. STEVENS: It is actually quite a complex question. I would be pleased to start answering and then we could continue after the lunch break. What are the rules?

The ACTING CHAIRPERSON: We are scheduled to go until 1 o'clock. There is a little discretion. You are welcome to start the answer and then we will continue after lunch.

The Hon. L. STEVENS: In framing this year's health budget, the Labor Government has been required to fund the 2001-02 health budget blow-out left behind by the Liberal government. Additional funding of $28 million was provided in June this year ahead of the budget enabling the Department of Human Services and public hospitals to balance their books and start the next financial year without the burden of repaying huge debts accumulated from 2001-02. That is a significant change in the way health budgets have operated in recent years. We have taken the debt and wiped the slate clean. As well as that, the Liberal government had imposed an $18 million claw-back savings strategy that would have crippled service delivery in 2002-03 and 2003-04 financial years, and we have also released the public hospitals from carrying this burden. I will ask Frank Turner to provide the details.

Mr TURNER: It is not expected that the Department of Human Services will experience a significant budget overrun or a budget overrun for 2001-02, although I have to say the final position will not be known until we have completed the end of year statements, which we are in the process of completing now. We will not know the budget outcome for the whole of portfolio until we have completed the consolidation of the 84 entities that comprise the portfolio, and we will not complete that until we have received and consolidated the financial statements of all of the health units.

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

Mr TURNER: The Department of Human Services is not expected to experience a budget overrun for 2001-02. The final position of the department will not be known for a couple of weeks until we finalise the financial statements for the last financial year. We will not know the overall budget position of the portfolio until we have completed the consolidation, and we are not expected to complete that until late September at the earliest. Whilst it is expected that the Department of Human Services will achieve a balanced outcome, this is basically as a result of additional funding that was provided to the department in May in recognition of projected budget deficits and predicted overruns.

The department had been predicting those overruns for some months previously, as early as December 2001. In May, the government allocated an additional $19.8 million for health unit expenditures which related primarily to projected 2001-02 budget deficits. That $19.8 million was broken up as between $12.3 million being the actual deficits that were projected at hospitals; $3 million representing savings that had been required in addition in the last financial year; and I cannot quite recall to what the balance of $6.5 million related.

In addition, there was another $6.5 million for Department of Health expenditures relating to the projected overspending of the Department of Human Services. That made up a total allocation of $26.3 million for the Department of Health units. In addition to that funding, approval was given for the housing trust to run down its cash balances by a further $1.6 million, which related to additional expenditure primarily in property-related transactions, and a further $230 000 run-down for the Aboriginal Housing Authority, again related to property transactions.

The action of the government in providing additional funding has broken the cycle of the debts of hospitals impacting in future years' budgets. The effect of the additional funding is that the budget that was allocated for this financial year is in fact the total funding available for the department to spend during this financial year; and none of it is to repay deficits from the previous financial year.

In relation to the question about the total accumulated debt as at 30 June, because we have not completed the end of year financial statements for the health units, it is not yet possible for us to say precisely what that level of debt will be,

although the indication at this stage—and as late as yesterday—was that we are not expecting the debt to increase beyond the level of last financial year. The additional funding that was provided in May was, in fact, intended to eliminate that debt from last financial year, and that result looks to have been achieved. It is clear that there will not be a growing indebtedness in this financial year as a result of the additional funding that was provided and, in effect, the additional money has broken that cycle of cumulating debts.

What is significantly different about this budget is that additional funding has been provided and, if one refers to table 3.10 in Budget Paper 3 (page 3.9), one will see a line for hospital system funding of $10.5 million. Effectively that is additional funding which has been provided and which reflects almost the annual increment of debts that have occurred in public hospitals over the last four years. In effect, this budget has addressed that structural budget problem which has existed in the public hospital budgets for some time. A further measure that has occurred this time is that the over-expenditure from previous financial years, in particular the claw-back savings which had been factored into the forward estimates for 2002-03 and 2003-04 and which totalled approximately $18 million, has been removed.

Again, the system starts from a position of being able to manage with the funding that has been provided and that funding not having to be made available to address the deficits of previous years. In relation to how the debt will be managed in the 2002-03 budget, I think I have indicated that this budget has eliminated the root cause of the growth in debt, and that has been the structural under-funding that has existed in the system for some time. The representations in the development of the budget in previous years has consistently highlighted under-compensation for inflation, as well as pointing out that there has been a substantial unfunded activity.

So, in framing this budget there is no cut to the funding base of the hospital system, notwithstanding the fact that some funds have been redirected to high priority areas. It is worth noting that the requirement for budget savings is not a new requirement in budget terms, and, in fact, if we go back over the last four years particularly we can see that, prior to the 2001 budget, a 1 per cent efficiency dividend was required in budgets prior to that budget. There was, in fact, unfunded enterprise bargaining outcomes that existed from 1997 through to 2000 and 2001, and that accounted for about $2.6 million a year.

In addition, there was an unfunded element of the previous nurses' enterprise agreement of .9 per cent, which represented about $4.5 million annually to the budget. If we go back to the 1998-99 budget, there was an overall strategy to achieve a savings of $108 million over the four years. Those savings currently are running at an analysed rate of about $40 million a year and, as part of the implementation of GST, approximately $12.5 million is currently recurrent savings that sit within the budget. The past position has been that the department and the public hospitals system have received additional funding, and that is certainly acknowledged.

However, in the past all the additional funding has been tied to specific spending initiatives. There has been no discretion about using that funding to address other pressure points in the system. I make the point that the hospital system funding within the budget—the $10.5 million—has no strings attached to it. In fact, it is funding that has been injected into the system to provide a solid budget base, and a base upon which the system can go forward with some certainty.

Mr HANNA: That is one of the most comprehensive answers I have ever heard in an estimates committee, and I thank Mr Turner for providing that information. I had not realised how revolutionary the budget was in terms of eliminating that debt cycle within the health budget.

The Hon. L. STEVENS: It will make a significant difference for hospitals, and it is something that has not happened in recent years. They do not have to start the new financial year with this huge debt hanging over them.

Mr HANNA: I realise the minister is doing a lot for rural health and rural hospitals. Will the minister outline what commitments her government has made to capital works projects in the major metropolitan hospitals for the forthcoming financial years?

The Hon. L. STEVENS: The government has endorsed the existing redevelopments currently under way at the three major teaching hospitals—the Royal Adelaide, the Queen Elizabeth and the Lyell McEwin—and, through the bilateral process, has endorsed additional funds for those projects. The Royal Adelaide Hospital redevelopment is currently under construction, within stages 2 and 3A of its redevelopment, with an approved budget of $74 million. The project has experienced a number of major latent conditions and additional cost pressures which have been placed before the government. I am pleased to advise that, as a consequence, the government has endorsed additional funding of $4 million, thereby taking the project to a new approved budget of $78 million.

In addition, the government is keen to progress stages 3B and 4 of the redevelopment works, and therefore we have endorsed the estimated capital cost of $130 million and directed the departmental officers to begin the early planning of these works as soon as possible, with the aim of appointing consultants in the next financial year. From our experience in the Public Works Committee over recent years you, Madam Chair, and I would both know the importance of trying to get stages to flow on from each other quickly, rather than having large gaps where the building just stops.

With regard to the Queen Elizabeth Hospital, stage 1 of the project is currently under construction, with an approved budget of $37.4 million, and completion is projected to occur in April 2003. In addition, the government has directed that stages 2 and 3 will be commenced as soon as possible at an estimated cost of $60 million. In order to expedite stage 2, the government has approved new funding of $500 000 in the current financial year to allow early planning consultations and consultant appointments to occur.

Stage A of the Lyell McEwin Health Service redevelopment is currently in construction with an approved budget of $87.4 million—and this is important for the member for Napier's constituents, as well as for my constituents. This project has recently experienced trade package tender prices above the estimated sums, and additional funds of $3.8 million have been sought to cover these cost pressures. The government is pleased to advise that, through the bilateral funding processes, we have endorsed this additional funding with the actual cash funds being made available when required in the next two financial years. This approval will take the approved budget for stage A of the Lyell McEwin Health Service redevelopment to $91.4 million.

In addition, the government is supportive of expediting stage B of the redevelopment, currently estimated at $32 million. In order to progress these works, I have directed departmental officers to immediately commence early planning to ensure that consultants are appointed early next

financial year. An indicative sum of $1 million for 2003-04 has been endorsed through the bilateral process to allow this to occur. In summary, the government has endorsed the previous government's redevelopments totalling $198.8 million, approved additional funding of $7.8 million for those three projects and endorsed new further stages on these three sites, totalling a further $222 million. In the current uncertainties of the public health environment, the government believes that our support must be demonstrated publicly, and these budget approvals firmly demonstrate such support. We also believe that these commitments form a sound basis for future public hospital developments within metropolitan Adelaide. The generational health review has been informed of the government's commitment to fund and complete the redevelopment of these major metropolitan health facilities, and will, I trust, take this into account in its own review and planning work.

Mr HANNA: My third question is about early childhood intervention. For some years now, families have had to wait a long time if their preschool children needed services such as speech pathology or occupational therapy. In view of the evidence demonstrating the effectiveness of early intervention and the positive impact it has on better health and well being for children and families, what plans does the state government have in line with Budget Statement pages 3.9 and 3.10 and Portfolio Statement page 6.52 to deal with this?

The Hon. L. STEVENS: It is well recognised that advancing and enhancing child development and early intervention is the key to preventing developmental and health problems later in life. Unfortunately, sometimes those very important priorities get lost in the hurly-burly of acute care demands. However, two key initiatives in this area have already been put into place, underscoring the importance that this state government places on early childhood intervention. Firstly, the budget has allocated an extra $4 million over four years to strengthen locally based childhood development programs. These will focus on responding to developmental delay, for example, through speech pathology, recognising that early responses will have a positive impact on children's health and development in later years. This will provide extra support for parents to deal with such problems as their children may have and give them a chance to nip those problems in the bud. These measures will be broadly placed within the context of children's development. It is recognised as important that services be family centred and work collaboratively with, for example, kindergartens and schools, and other child health programs.

Secondly, early childhood intervention is the specific focus of attention for the parliamentary secretary, Jennifer Rankine, MP, the member for Wright. Ms Rankine will be working with me to ensure that child development issues retain a permanent policy focus for the government. This will encourage the integration of early intervention services with other services for children and families. The aim of this integration is that there be a coordinated approach to supporting children that builds on the strengths of families and communities. Most importantly, the government will seek to initiate a broad range of measures designed to enhance child development more generally. This is a vital area of priority for the government. As we strive to rebuild health services in Australia, we will be strengthening and reorienting services towards prevention in primary health care, and this is one of the clearest examples of that drive and that commitment.

Mr MEIER: My first question relates to private hospitals, namely Hamley Bridge and Ardrossan. In fact, the minister is probably aware that, of the five country private hospitals in the state, four are in my electorate. In increasing numbers it appears that particularly Ardrossan and Hamley Bridge are having to receive uninsured patients in the accident and emergency department as a result perhaps of a motor accident or an accident that occurs in the nearby area. That means that, if they are admitted to this hospital, the hospital does not get any money unless they insist on taking them to court or whatever—a practice hospitals generally prefer not to adopt. In the last year, I noted that the Wakefield Regional Health Service has made available $5 000 to help support the public emergency and casualty admissions to Ardrossan. That was received in July this year, just a few weeks ago for the previous 12 months. There is a statement in that letter that it is not possible to guarantee any recurrent amount for the present year.

Hamley Bridge, I believe, has written a letter to the minister in only the past couple of weeks or so, asking whether it can receive $5 000, at least, to assist it in that same respect. Can the minister give an assurance that the government will seek to provide some assistance to private hospitals that are carrying out accident and emergency for public patients and that it will not come out of the local regional health board's budget, when it is recognised that four out of the five private country hospitals are in one regional health board? It would be very well if it were evenly distributed around the state, but that is not the case and Wakefield, therefore, would suffer significantly in its budget compared to any other area.

The Hon. L. STEVENS: I will ask the Executive Director, Country Service, Ms Roxanne Ramsey, to respond.

Ms RAMSEY: The hospital that the department has supported most intensely has been the Keith private hospital, because it sits on a busy highway and a decision was made previously, when that hospital was not able to sustain its activity with the funding that it was receiving through private sources, that we would put some funding into it. Following that decision, we looked at the other three hospitals which, as you have said, sit in the Wakefield region. They have not had the level of activity, nor have they been on a busy highway or somewhere where the services could not be redirected to a public hospital in the same way as are those of the Keith hospital.

So, we have not funded them in the same way as we have historically funded the Keith hospital. However, we have agreed to pay for particular bed days and services, as has happened with the Ardrossan hospital. It is something that we have always been open to discussing but, having said that, all the money goes into regional health services, so it becomes their decision about how they allocate the money within their region. If the decision is made that we need to consider funding any of those private hospitals in buying services into them, we would need to have the discussion with the region, and that would be the Wakefield region.

The commonwealth government has had a consultancy that has gone out and looked at small private hospitals in the country across Australia, and it looked at ways that some of those smaller hospitals could remain sustainable. Some funding was provided, particularly for aged care services, and it was certainly their view, supported by the state government's view, that that had made those smaller hospitals more sustainable. But it is something which historically we have

considered and which we would be open to again if the approach was made.

Mr MEIER: Whilst Keith is probably on a busier road, the coast road past Ardrossan is exceptionally busy for much of the year and, hopefully, the minister will give full consideration to any approaches that are made for what I would regard as minimum funding, at least, to help the hospital. If any of those hospitals closed, it would put enormous pressure on the nearest public hospital. I know that discussions are occurring between CYP and Ardrossan, and I welcome that. Ms Ramsey referred to the aged care accommodation that has been provided by the commonwealth government. Were they dementia units? Would I be correct in saying that? Hamley Bridge also is affected by the HomeStart loans no longer being available.

They are seeking a loan of $400 000 and are getting quite worried. I was heartened by the minister's earlier answer that alternative arrangements are being made. When she mentioned the hospitals, understandably, Hamley Bridge was not mentioned because it is a private hospital but, since it was brought up in that last answer, I must ask whether that also is going to be considered for Hamley Bridge.

The ACTING CHAIRPERSON: That is a separate question, relating to HomeStart loans. The minister may answer.

Mr MEIER: I am happy to go to a separate question.

The Hon. L. STEVENS: I heard the question and the member heard my earlier answer. Hamley Bridge, as the member would have noted when I read out the names, was not on the list that we had, but we take on board what the member has just said and will take that into consideration when we come up with the new scheme.

The ACTING CHAIRPERSON: I take that as clarification of an earlier question, if the member would like to proceed with the second question.

Mr MEIER: I hope that provision can be made because in my opinion it is critical for Hamley Bridge to get that. It was a $1.3 million project, and I think they have to borrow $400 000, so it is no small thing. My second question relates to Balaklava hospital. I wrote a letter to the minister back on 12 June in relation to the proposed helipad for Balaklava. This goes back some three years when they first wanted a helipad, and they have been seeking to raise money for a long time now. I believe that they sought approval from Planning SA at the end of last year, and that has been provided now. Then they sought the land, which is crown land, to be put into the hands of either the local hospital or the helipad committee, whichever is most appropriate.

They felt that because of the change of government it had been delayed, but the latest information I have is that the Department of Environment and Conservation will not give the Wakefield Regional Council authority to use the land for its intended purpose. I recognise that the minister is not responsible for environment and conservation. However, she is responsible for health, and the locals are very concerned that it looks as though they may be prevented from having a helipad if they do not act within literally the next few weeks. There could be another three year delay before any other assistance was given. Has the minister any updated information on this matter, or can she use her resources to help overcome what to me seems like the bureaucracy stalling an important project?

The Hon. L. STEVENS: If the honourable member provides me with the information, I will be happy to take that up with the Minister for Environment and Conservation and see whether we can get some resolution of the issue.

Mr MEIER: My third question relates to a constituent of mine who contacted me on 24 July saying, 'I know you can't do much about it, John, but I want to bring it to your attention.' Whilst he is happy for his name to be mentioned in parliament, I do not see any real need for it, but I am happy to give the minister my constituent's name. About a year ago he found that his eyesight was deteriorating, so he went to the specialist who visits Wallaroo hospital and was told that he needed a cataract operation. He said, 'I'll put you on the waiting list and we'll get you in as soon as possible.' He went, I think, on 23 July this year, as he contacted me on the 24th, and the specialist said, 'You're on the list. In fact, you're No. 20 on the list. However, we are able to do only 12 per year, so it will be another two years before we can operate on you.'

Naturally, my constituent is very distressed. He said that he is almost blind in one eye, which has clouded right over. He has great difficulty reading and finds it very difficult to drive, particularly at night, and I can understand that. Can the minister assist at all in getting the waiting lists down for a country hospital where, I assume, only a limited number of operations can be performed by any particular specialist or specialists in that area?

The Hon. L. STEVENS: I am sympathetic to the plight of the member's constituent. I will ask Ms Ramsey to respond in terms of the way in which these things are decided in the country area.

Ms RAMSEY: The funding is provided to regions, which then allocate their money to the local hospitals. The Wallaroo Hospital has been under quite a bit of pressure in terms of the demand that has sat around that health service, and there has been additional activity in the previous year that has been provided to that hospital. Having said that, the waiting times have been a little longer than we would be seeking in that health service. We have been having discussions with the region about how they might be able to allocate their funding to address that matter. But, of course, if they provide more funding to the Wallaroo Hospital, they have to make a decision to stop some other activity. It is for the Wallaroo Health Services management and board to decide whether they use their money to buy cataract services or some other sorts of services. But the waiting time is something that we monitor to see how we can work with them to try to reduce that. Two years is quite a significant waiting time for a cataract operation in the country, and it is certainly something that we will take up with the region.

Mr MEIER: Ms Ramsey said words to the effect that Wallaroo Hospital had gone over budget (and I think it has acknowledged that). The minister said in her earlier answer that she was seeking to not carry over the debt for health services that she felt the previous government had left behind. Does that include hospitals such as Wallaroo that have had an overrun?

The Hon. L. STEVENS: I will ask the Chief Executive to answer that question.

Mr BIRCH: The process for allocating budgets this year in the metropolitan health and the country health is that, whilst debt has been extinguished, we are implementing a policy whereby we still include what we call a clawback—it may not be a full clawback—of funds from hospitals that have generated debt. The reason for that is that, if we were not to provide some penalty for hospitals which had previously generated debt, it would give no incentive for those

hospitals which had not. In the metropolitan area this year, for example, we are creating an incentive pool, which is an amount of money for those hospitals that meet budget, and at the end of the financial year they can gain access to that pool for one-off purposes. However, we will also be working out an arrangement that has a percentage debt repayment in future years. I know that, in the country, previously there were hospitals, such as Whyalla Hospital and Mount Gambier Hospital (and, certainly, Wallaroo may have been one, but the rest of the hospitals, I think, were quite small in terms of their debts), where it has been necessary to claw back—usually for the bigger overruns over, say, a 10 year period—a small amount per annum.

Again, I stress that this is quite important, because it is extremely difficult to get hospitals to meet budgets, and if we do not create an environment where they have an incentive to do so, I think we would find that budget overruns would exist across the entire sector. So, whilst I cannot specifically answer the question about Wallaroo (and perhaps Roxanne Ramsey can), if there is a clawback it is usually a small clawback, and it is an inter-departmental decision, not a Treasury decision, to seek that clawback.

Ms RAMSEY: Yes, Wallaroo Hospital did have a budget overrun. It was our view that some of that was to do with some of the activity pressures but, equally, some of it was within its control. As Mr Birch has said, we have made the decision within the regional budget that Wallaroo Hospital should address the deficit that it had last year. The Wakefield region has balanced its budget, so it is something that needs to be managed within the Wakefield region. But if the Wallaroo Hospital goes over, some other hospital within that region has to make up the difference. It is our view that, unless we manage that fairly stringently, it encourages locations to go over budget when some others might work quite hard to balance their budgets. And Wallaroo is one of those about which we are having discussions.

Mr MEIER: And do not forget that Wallaroo, and Yorke Peninsula, is a rapidly growing area, with thousands more people coming in.

The Hon. L. STEVENS: The member's comments are noted.

Mr O'BRIEN: Will the minister outline the strategy for the upgrade of country hospital facilities referred to in Capital Investment Statement pages 7 and 25-28?

The Hon. L. STEVENS: The Department of Human Services is currently undertaking the upgrade and redevelopment of infrastructure at a number of ageing country hospitals to provide facilities that meet the current roles of major country hospitals and allow for the provision of a high standard of modern clinical care. As part of this program, a total of $10.6 million has been provided in the DHS capital program.

In summary, the following projects have been undertaken. First, there is the Whyalla engineering upgrade, with an allocation of $2.8 million. This work involved the upgrade of the engineering services, including the replacement of the hot ablution water plant and reticulation pipework (which I saw); operating theatre heat recovery; chiller and control systems; airconditioning systems and return systems; and the hot heating water system. Major milestones achieved included the installation of a solar hot water plant and airconditioning chillers. The practical completion of the work occurred on 5 June this year. Ongoing monitoring of engineering systems is in place to optimise the level of savings achieved.

The second hospital is the Murray Bridge Hospital. This is the Murray Bridge redevelopment, with an allocation of $3.5 million. Stage 1 of the redevelopment of acute and diagnostic facilities at the hospital includes the extension of day surgery; construction of new acute inpatient accommodation; and the extension of the community health facility. The health service planning study was approved by the hospital and regional boards and the Executive Director, Country, in November 2001. The architect was appointed in April this year to undertake detailed design and documentation, and a master planning study of the engineering infrastructure upgrade and replacement has been completed. The target is to complete the construction of stage 1 by August 2003.

With respect to the Clare Hospital redevelopment, which has been allocated $3 million, the work includes the provision of a new 12 bed acute ward with single and shared ensuites and associated service facilities; relocation of the existing casualty department and minor upgrade to the existing operating theatre; and an upgrade of aged infrastructure to address inadequacies in electrical services, the nurse call system, fire services and the warm water system. Greenway Architects has been appointed, and the detailed design and documentation has been completed. The building tender approval was given on 10 April this year and the builder, Cox Constructions, has now commenced work. The construction is estimated to be completed in March next year.

The Renmark Hospital redevelopment has been allocated $1.3 million. The original concept for the Renmark redevelopment stage 1 was for the refurbishment of the birthing unit and the theatre suite. This work was anticipated to occur in two stages. The total project value of the redevelopment is approximately $2.6 million, based on the concept plan. Of this amount, the government contribution is $1.3 million, as detailed in the budget. The remainder has been committed by the Renmark Hospital Board to enable the works to be completed in one stage and to allow the inclusion of some upgrade to the acute area to be included in the scope. The work will provide an operating theatre and birthing unit to enable the hospital to provide an excellent standard of service in modern, efficient facilities.

A service concept plan was completed and approved by the hospital and the regional board in November last year. Architects, Hames Sharley, were appointed in April this year and a detailed design and documentation is being undertaken. An engineering services master planning study is also being undertaken to identify the impact of services upgrade requirements against the total project scope. The construction is estimated to be completed by August next year.

Mr O'BRIEN: My question relates to the Regional Health Service Program. How was this program initiated and progressed in Coober Pedy and are any additional programs expected to be implemented in that area?

The Hon. L. STEVENS: I will ask the Executive Director Country, Ms Ramsey, to respond.

Ms RAMSEY: The Regional Health Service Program has worked exceedingly well in the country, particularly in some of the small locations such as Coober Pedy. It is a commonwealth and state funded program, and it broadly aims to improve the health and wellbeing of people in rural Australia, particularly in small locations where it is hard to get good services going because there are only a small number of people living there. Coober Pedy is an important area. In terms of services, as everyone would know, it is a long way away, but a lot of tourists visit the Coober Pedy area, so it is important that we have a functional health service there. It

also has a very large indigenous population and a lot of people with ethnic backgrounds. So, it is a town where we need to ensure that we provide high quality health services.

Primary health care, which is one of the big focuses of regional health services, is about keeping people healthy and, if they are unwell, trying to stop them from getting sicker. Diabetes is a good example where people can get assistance to better understand and manage their diabetes so that they do not end up with problems such as leg ulcers.

For Coober Pedy, the introduction of the Regional Health Service Program arose two years ago when there was a major crisis for the community in accessing doctors. There were only two doctors in Coober Pedy, one of whom did not have admitting rights to the local hospital and the other was particularly pressured in terms of the number of people who were seeing him. A group of local indigenous and non-indigenous services and commonwealth and state departments got together and planned how the community could have access to better health services and get more doctors to service the town. As in all rural areas, but particularly in remote communities, recruiting doctors is not easy. So, we got assistance from the South Australian Centre for Rural and Remote Health which is predominantly a commonwealth funded agency. They were invited to work with us to try to assist this process.

Whilst recruiting doctors was a big issue for the Coober Pedy community and one on which the local community was quite focused, primary health care services were also identified as a matter of concern. For this purpose, the commonwealth was prepared to work with us and consider Coober Pedy as a target for a regional service. Out of this a memorandum of understanding was developed between the District Council of Coober Pedy, the South Australian Centre for Rural and Remote Health, the Umoona Community Council (the indigenous council), the Umoona Tjutagku Health Service, the Coober Pedy Hospital and Health Service, the Umoona Aged Care Aboriginal Corporation, the Northern and Far Western Regional Health Service, the Department of Human Services, and the commonwealth Department of Health and Aged Care. This MOU, which was signed in July 2001, was a significant event given the number of parties that were involved.

A great deal of progress has occurred since July 2001. The community needs assessment has been completed; two additional doctors have been recruited to Coober Pedy, and the doctors' practice operates from the Umoona Tjutagku Health Service. The new practice has had to work hard to get up to speed. It has not been an easy process and I suppose there has been quite a lot of pain involved. Having said that, working relationships between the indigenous and non-indigenous health services have been greatly improved, the number of personnel and health providers involved is consistent, which was not the situation before, and it is anticipated that the practice will be self-funding by the year 2004. The major focus of the practice is to better meet the needs of the indigenous community and also to ensure that the non-indigenous community has access to services. This is happening through greater collaboration between the two health services, and it has helped hugely in getting Aboriginal people to health appointments. There are improved client follow-up mechanisms and a program has been initiated for doctors to obtain cultural training and development.

The Coober Pedy community has completed its funding proposal to the commonwealth for an increase in primary health care services. Other proposals for this program have already been accepted and funded in terms of regional health services, but the Coober Pedy proposal has not yet been approved. This is in no small part due to the fact that the community spent a lot of time ensuring that the Aboriginal needs were identified and addressed within the proposal. It has taken a lot of time to work through those processes. The proposal has now been signed off locally and it will be submitted to the commonwealth in the next few weeks.

Whilst there will be an increase in primary health care services once the proposal is funded, additional positive offshoots have occurred locally during the consultation process. One of these is that an Aboriginal advisory group has been established and local working relationships have been hugely improved, something which I am very pleased about. Coober Pedy elected to build on existing programs rather than introduce new ones. We thought it was particularly important to build on existing programs rather than reinvent the wheel. The communities of Coober Pedy have identified children, youth, families and mental health as their top priorities. They have also looked at traditional healing through the services of Ngankari. The community rated employment, particularly for indigenous people, as a priority. Whilst funding is not available for this purpose through this program, if we are able to employ indigenous people in the health services, by default that will improve employment for indigenous people.

The following programs have been proposed: family health/wellbeing; mental health/wellbeing; child health; youth health; Ngankari; an Aboriginal liaison person to work between programs and services; and primary health care/health promotion. All of these programs are for the whole of Coober Pedy and its surrounding areas. The future directions for services will involve stronger partnerships between agencies. This will include not just departmental agencies but also indigenous agencies, the school, police, the council, Centrelink and correctional services. We are also now able to provide improve services for the AP lands, which we are very pleased about. That is just an example of how regional health services can really improve services for some quite small towns.

Mr O'BRIEN: Will the minister outline from the Budget Statement (pages 3.9 and 3.11) and the Capital Investment Statement (pages 7 and 26) what capital works have been supported in regard to aged care facilities in country regions?

The Hon. L. STEVENS: As I said earlier today, there is an urgent need for the redevelopment of state funded long stay and aged care beds to meet commonwealth standards. The current redevelopment program will enable the provision of a combination of single and double rooms with ensuite or shared ensuite facilities. The sites selected currently provide long stay accommodation in four to six bed wards. The redevelopment will consist of the provisional separate lounge and dining areas to provide accommodation at current commonwealth aged care standards. There will also be an upgrade of aged infrastructure to address inadequacies in electrical services, nurse call systems, fire sprinklers and compartmentation. The sites currently undergoing work include:

- Cummins—$0.894 million for provision of eight long-stay aged care beds due for completion in September 2002.
- Tumby Bay—$1.2 million for the provision of 12 long-stay aged care beds due for completion in October 2002.
- Laura—$1.387 million for provision of 13 long-stay aged care beds due for completion in October 2002.

- Crystal Brook—$1.4 million for the provision of 16 long-stay aged care beds due for completion in November 2002.
- Quorn—$1.097 million for provision of nine long-stay aged care beds due for completion December 2002.
- Bordertown—$2.673 million for the provision of nine aged care beds due for completion in August 2002.
- Naracoorte—$0.539 million for the provision of four aged care beds due for completion in October 2002.

In addition, the hospital has been successful in gaining a further six commonwealth beds and is contributing the $862 000 necessary to undertake the required capital development.

Mrs REDMOND: Minister, I have a concern about the provision of obstetric services in the state, which appear to me to be becoming less rather than more available. I note in your opening address that you referred to the Obstetric Shared Care model in which you indicated that GP antenatal care occurred but with delivery in hospitals. Are public hospitals in country areas now paying local GPs to do antenatal work through hospitals, rather than through the GP clinics under MBS?

The Hon. L. STEVENS: Yes, the provision of obstetrics services across the state is of concern, as is the way that we organise them. That is one of the major issues that the generational health review is considering in relation to the advice and the plan it will provide on the way that we spread services across South Australia. Certainly, obstetrics is one of those critical services that it is addressing. I will now hand over to the Executive Director, Country, to answer this question.

Ms RAMSEY: Obstetrics services is something that country locations hold very dear and fight very hard to retain. A range of things must be in place before you can safely provide obstetric services. It is not just the GP; we need to have anaesthetists or GP/anaesthetists; we need to have midwives; and they need to be able cover seven days a week, 24 hours a day to safely provide those services. So, we need to get all those things in place.

GPs provide services privately and for public patients. I am unaware of the details of the question that you have asked: it is certainly something on which I am happy to get further information. Because GPs operate basically as private practitioners within their town, although they do provide services to public patients within hospitals, we often do not have the details about how they are operating town by town, but I can certainly get the information for you.

Mrs REDMOND: Just following on from that, Madam Acting Chairperson, in relation to your comment, Ms Ramsey, about the need for various services—and I note that you said it involves not just the GP, but specialists and potentially anaesthetists, midwives and so on—clearly women have been having babies for a very long time without all those services. I understand that an assessment occurs during the antenatal period which would enable some reasonable assessment as to what is likely to be a straightforward and safe birth and one that is likely to be complicated. I know that you cannot always tell, but is any consideration being given to going back to a system where we have more flexibility for the vast majority of births which are straightforward and without complications, rather than becoming increasingly focused on the need to have a specialist anaesthetist, who may well not be involved in the birth at all but who must necessarily be there simply because that is a requirement of the system we have now developed?

The Hon. L. STEVENS: I will ask the Chief Executive, who has had some background in those services in his past appointments, to answer this question.

Mr BIRCH: There are already a number of birthing options available within metropolitan and country areas in the state which involve minimal intervention. They vary from birthing suites, where there are midwife deliveries with—as has been requested by women—minimal intervention, right through to full higher dependency requirements. One of the problems with obstetrics now is declining birth rates. There is expected to be in the next 10 years a reduction of about 4 000 in the birth rate in South Australia.

Mrs REDMOND: And an increasing age of first time mothers.

Mr BIRCH: That's right. This means that there is likely to be fewer births in any particular given postcode, and it also means that the number of births that a midwife, an obstetrician or, indeed, a GP will have within a particular region is likely to decline. Irrespective of what the department or the government would want to do, it is well established that you do need to undertake a certain number of births to be able to maintain competence, and there are now some concerns because of this and because of medical malpractice and midwife insurance issues about whether there is a viable number of births within particular country areas to enable a practice to be maintained.

I am not a doctor but, given my experience at the Women's and Children's Hospital, you are correct in that assessments can be made antenatally regarding the likely outcome of a normal delivery. However, there are numerous examples where those assessments are incorrect, and it is known to be much more dangerous to transfer someone whilst they are in labour, rather than determining in advance whether a person is high risk, medium risk or low risk.

So, in answer to your question, it is complex and, indeed, the market in many ways, unfortunately, is sorting some of this out. We are finding it increasingly difficult for doctors, for midwives and for nurses who wish to undertake this work on a small number of babies in country towns. We are well aware of the question of accessibility for mothers and parents in outback and rural locations, to the extent that there are many small country hospitals in which we ordinarily prefer births not be undertaken. However, because of the balance between access and safety we are continuing with births in those areas.

I expect that over the next 10 years substantial changes will have to be made. Those will include the metropolitan area. As the minister mentioned, the generational health system review will consider those over the next 12 months.

Mrs REDMOND: Obviously there are already three metropolitan or near-metropolitan private hospitals (Western Community, McLaren Vale and Stirling, and Blackwood prior to that) at which obstetrics services have previously been available for many years and which are now closed. Does this budget make provision for any likely increase in births in public hospitals that may spring from the closure of those birthing units? If so, where does it do so, because I could not find it?

The Hon. L. STEVENS: The Chief Executive will answer.

Mr BIRCH: The budget does not make any specific provision for an increase in the public system. It is my understanding in talking to the chief executive of ACHA, which covers the Western Community, that it intends that all births that would previously have been undertaken at Western

Community—and I understand that they will continue undertaking births there until November—will be transferred into its other hospitals—Ashford, in particular; and it has capacity. I think Flinders Private also has capacity. At this stage I am not aware of any other hospital in the metropolitan area which is privately operated and which intends closing its obstetrics service. As you would know, an obstetric service is really a critical component of a private hospital. It is a lost leader in many respects, but it is the basis upon which they get repeat business. I am not aware of any others closing. We would anticipate some shifts within the metropolitan public hospital system.

I think Modbury is likely to have an increased number of births because of the opening of the new obstetric wing there. We anticipate the Lyell McEwin being stable. We would anticipate a small decline in the Queen Elizabeth Hospital, largely because of the demographics within that area. Both the Women's and Children's and Flinders hospitals should remain stable. In this coming financial year we are not anticipating any significant increase in births in the public system.

Mrs REDMOND: As a supplementary question, in relation to Stirling, which has only just closed its obstetrics unit last month under sufferance after 75 years, the nearest hospital is Mount Barker. With respect to those who live in the area beyond Stirling, obviously a number would come down the hill possibly to another private hospital, but the nearest hospital for people living in Echunga, Macclesfield and a whole range of other places would be Mount Barker, so I anticipate that the closure completely of the unit at Stirling would impact significantly upon the public hospital at Mount Barker.

Mr BIRCH: I am prepared to say that we will take a look at that and see what the shift might be at that time. I assume that most of the patients who went to Stirling would be privately insured. That may be incorrect. If they are—

Mrs REDMOND: Privately or self-insured.

Mr BIRCH: If they are, it is equally likely that they may be attracted to Burnside Memorial. The distance is not radically different in terms of time for travel. Burnside has just been revamped. We will take a look at that over the coming year to see whether there has been a shift to Mount Barker and certainly that will be taken into account in next year's budget. If Mount Barker is finding it difficult, we will look to see how we can help this year.

Mr CAICA: As you are aware, the state is facing a critical nursing shortage and this is expected to worsen over the next decade. What progress is being made to ensure that we have sufficient numbers of nurses in our health system for today and the future?

The Hon. L. STEVENS: This is a critical issue. The question is certainly relevant given the current difficulties we are facing in being able to provide a sustainable level of staffing within both our hospital and community settings in order to meet the increasing needs of our community. As members would be aware, health is one of the key priorities of this government, and as Minister for Health I am acutely aware of the significant issue facing us as a government to ensure that we are able to provide sustainable nursing and midwifery services within the state.

I am personally committed to working with the department and all the key stakeholders, which include the Australian Nursing Federation, the three universities and the public, private and non-government sectors, in order to produce a sustainable, effective and valued nursing work force in this state. South Australia already has a shortage of nurses in the metropolitan area and in particular in rural and remote areas. This figure stands at approximately 400 FTEs in the public sector.

My department has recently endorsed the South Australian Graduate Nurse Requirements report prepared by Debra Pratt and Edward Rawinski of Professional Services—Nursing Division. This report provides information on the number of graduates required to maintain an adequate nursing work force. The report highlights that the problem dates back to before 1997.

In 1997, an intake of 1 162 students was required to maintain the registered nurse work force, but only 609 students were enrolled, and just 564 completed their studies. That was back in 1997. In 1997 alone, therefore, there was a shortfall of 598 graduate nurse enrolments, and in each subsequent year the number of enrolments fell even further. Over the next three years, the expected numbers of graduates will be 480, 640 and 520, and it is simply not enough.

The Graduate Nurse Requirements report highlights that the number of graduate nursing degree students required annually could be as high as 1 350. The average age of nurses in South Australia is 41 years, and for midwives it is 44 years. This is higher than the national average. Retirement or changing to part-time work is possible for up to 1 000 nurses a year. Therefore, it is expected that South Australia's requirement is at least 1 000 graduates per year.

This means that the nursing intake will need to be close to 1 300 students, because there is an attrition rate of approximately 30 per cent. Even this number of 1 000 graduating students could still lead to an undersupply of nurses over a decade. If the number of graduates fails to be increased to these recommended levels, South Australia will face a shortfall of some 1 500 nurses by the year 2004-05. This equates to the number of nurses required to staff one of the larger metropolitan hospitals.

The cumulative effect of producing graduates at current levels will be to halve the available nursing work force by 2112. The ageing of the nursing work force will further exacerbate the shortage. These current and predicted shortages of a trained, professional work force have huge implications for the quality of patient care and the capacity to deliver services at current levels.

This appalling state of affairs, I have to say, is due to the lack of action by the previous government to take stock of the labour force needs of this state, and indeed the failure of the previous minister for health to engage with work force planners in the critical area of nursing. Once again, we have to pick up the pieces resulting from the abysmal strategic leadership by the previous minister and the previous government.

Since my appointment, I have initiated a range of strategies with the department in order to provide a platform for us to move to a more solid future for the recruitment and retention of nurses in this state. As soon as possible, I established a high level task force to develop a nursing and midwifery recruitment and retention strategic plan for the state. I appointed one of my officers to oversee the advancement of this initiative. This task force consists of public and private nurses, union representatives and the education sector. They have worked long and hard to produce a comprehensive and contemporary work plan to address this significant issue. The recommendations in their report will reflect a broad range of strategies to deal with the current issues while ensuring effective risk management for the future.

On Friday 26 July I had the pleasure of welcoming 120 participants to a final consultation workshop at the Entertainment Centre where every aspect of the draft document was scrutinised and prioritised before presentation of the final report to me. That final report is due for completion by the end of August 2002, and I must say I was pleased on that day to see on the media that the former minister congratulated the government on its efforts in this regard.

To support the priorities of this report, the government has increased funding to $2.7 million in 2002 for a wide range of nursing recruitment and retention strategies to be conducted over the next 12 months. Examples of the strategies include refresher and re-entry programs for registered and enrolled nurses, funding for post-graduate nursing scholarships for rural and remote, metropolitan and Aboriginal and Torres Strait Islander nurses, recruitment of overseas nurses, the continuation of the enrolled nursing cadetship program in regional areas, and ongoing funding support for the 40 additional undergraduate places at Flinders University and the University of South Australia.

A total of 222 students will complete the free hospital-based clinical refresher and re-entry programs for registered and enrolled nurses by December this year. Programs are available to both metropolitan and rural and remote nurses. The theory components of the programs are conducted through the Royal Adelaide Hospital and Flinders Medical Centre for registered nurses and through TAFE for enrolled nurses, with students being able to conduct their clinical placements in health units of their choice.

In recognition that only a limited number of nurses are available within South Australia who will be recruited back into the profession through refresher and re-entry programs, an additional 40 undergraduate nursing places (25 at the University of South Australia and 15 at Flinders) will continue to be funded for the next three years through a collaborative partnership between the department and respective universities. These additional student places commenced in the March 2002 academic year. I have personally met with the vice-chancellors of the three universities to discuss the requirements for additional nurse graduates and addressed the chronic shortfall that exists.

We have reached agreement about the need to increase significantly and immediately the number of available places. The department has also been working on strategies to strengthen the relationship between the higher education and VET sector to facilitate the development of a more strategic focus on the training and educational requirements of the human services work force. An additional $160 000 has been provided to metropolitan, rural and remote and Aboriginal and Torres Strait Islander nurses. This is in addition to the existing scholarships available to nursing students and nurses for undergraduate and postgraduate studies through the department.

There needs to be strong leadership by nurses working in the clinical setting to ensure that the care provided is commensurate with the levels of quality that meet government expectations and support the directions set by the Department of Human Services. There is an urgent need to look at how we develop nursing leaders. Senior nursing positions often do not attract a strong field of applicants, and fewer nurses stand out as potential nurse leaders for promotion or involvement in the broader health care arena. To develop and support our future nurse leaders, funding provision has been made for the Nursing Clinical Leadership Program for senior nurses to be conducted through the Royal Adelaide Hospital in partnership with other health units.

In addition to increasing the number of undergraduate nursing students in the pre-registration programs in universities, my department has negotiated to increase the number of students undertaking training to become enrolled nurses in regional areas of the state. Each rural and remote health unit in South Australia has been provided support funding to employ an enrolled nursing cadet student for a period of 12 months, and I recognise that that program was initiated by the previous minister. There are 66 health units in country South Australia. The cadets undertake Certificate 4 'Health (Nursing)' through the Department of Education, Training and Employment.

The course involves 1 065 hours of course-related study over a 12-month period, and that equates to approximately 20.5 hours per week. During this 12-month period the cadets will be employed by local health units for approximately 15 hours per week. The Nursing Media Campaign and the establishment of a Nursing School Speaking Program and a Nursing Job Shadowing Program have addressed the issue of image and desirability of nursing as a profession. Both programs have been well received by students, schools, the nursing profession and health units. The program will be evaluated after 12 months.

Regional health units are establishing strong relationships through the VET in the schools 'Pathway to Nursing Program'; and is partnering with local secondary schools and TAFE institutions to develop traineeship career pathways to support young people to remain within their local communities, providing employment and career opportunities in nursing. When I visited Whyalla recently, I was particularly pleased to hear about the efforts made to work with secondary schools and young adolescent students in relation to a nursing career. Financial support has also been provided to the Royal College of Nursing Australia to hold its 'Nursing Career, Employment and Education Expo' in Adelaide.

Funding support for the graduate nurse programs at our public hospitals occurs through the department's casemix nurse teaching grant. A total of 280 graduate nurses and midwives have started the program in the metropolitan area, while 66 carried out their programs in rural and remote health units. Employment of an additional 200 nurses in our public health units continues to be a goal. The challenges facing this task are compounded by the mobility of the nursing work force, the shortage of nurses and the higher rates paid by nursing agencies to attract nurses to their employment. My department also continues to address the nursing shortage, as well as from a state perspective.

The department has been participating in the review of work force reviews on critical care and midwifery currently being conducted by the Australian Health Workforce Advisory Committee (AHWAC), and has submitted submissions to both the Senate Inquiry into Nursing and the Nursing Review of Nursing Education. Clearly, a range of strategies is being undertaken that demonstrates the commitment of this government, the department, academia and industry leaders to ensure that the future foundation of our nursing and midwifery work force will be sustainable.

However, this is not a task that will have overnight results: it will require the ongoing commitment of all those people involved. I do want to say to the committee that the dedication and the application of departmental officers and other stakeholders to the urgency of this task has been exceptional. I will receive the final report and strategy very shortly. We

will then be rolling up our sleeves and getting into it. We will be monitoring it year by year and pushing it forward because it is probably one of the most urgent issues that confronts us.

Mr CAICA: How does the Rural Health Enhancement Package mentioned in Budget Paper 3 (page 3.10) enhance the requirement and retention of the medical work force in South Australia, and is this the only strategy being implemented by the state to address the medical work force situation in rural and remote South Australia?

The Hon. L. STEVENS: I will answer a little of this question and then hand over to Ms Roxanne Ramsey (Executive Director, Country), because my voice is running a little thin. The Rural Health Enhancement Package provides doctors who live and work in the country and who can undertake anaesthetics, obstetrics or surgery with a significantly boosted loading to the fees that they can receive for public patients: 20 per cent for anaesthetic and surgical procedures and 50 per cent for obstetric procedures. In addition, doctors participating in the accident and emergency roster are eligible for an on-call fee of $100 per 24-hour period. I will now hand over to Ms Ramsey.

Ms RAMSEY: The Rural Health Enhancement Package does not apply to metropolitan doctors. It is regarded as quite an incentive for GPs to establish themselves and to remain in rural practice, but it is only part of a range of strategies that are necessary to attract a medical work force to rural and remote South Australia. Historically, it has been quite a test to provide the work force within the country. A number of joint commonwealth and state-funded programs are provided by the Rural Doctors Work Force Agency, which offers a range of support mechanisms to doctors to remain in or to go to the country.

Relocation grants of $10 000 per medical practitioner are available. Training grants of up to $10 000 are also available; these are currently for Australian-trained doctors only but they relate particularly to anaesthetics, obstetrics or surgery, although it can be used for mental health or emergency medicine. Grants of $5 000 are available for upskilling, which is particularly important for temporary resident doctors and medical practitioners, and these are primarily available in the areas of procedural skills. A $10 000 isolation support grant is available for communities, and it is limited to 10 communities. The recipient GPs must commit to at least one year in the community.

The overseas-trained doctors scheme recruits overseas-trained doctors with the required skills and knowledge to provide medical services to rural and remote areas. In addition, South Australia is participating in the commonwealth overseas-trained doctor five-year initiative, which allows for the 10-year moratorium to be reduced to five years for the doctors to become permanent residents, provided that they complete the requirements of the Fellowship of the Royal Australian College of General Practitioners within two years and, in addition, they must be prepared to go to nominated remote locations.

The Rural Doctors Work Force Agency's locum scheme is important because this provides support to doctors to take time off or to undertake training, and for solo doctors in a remote community this is very important. The continuing medical education support scheme is also available. All rural doctors are eligible for some reimbursement of expenses incurred in undertaking continuing medical education—again, very important for rural doctors, particularly the solo ones. Eligibility for the state funding varies with the size of the practice. A solo doctor in one town receives the highest level of support at $1 080 per annum, whilst doctors in a two-doctor town receive the next level of support.

There is the solo practitioners' recreation leave allowance, which is state funded for solo doctors in a one practice town, and this is accessed through the Rural Doctors' Work Force Agency. This provides GPs with an allowance of $1 900 a week for up to four years in any one financial year, on the condition that they engage a locum to run the practice during that period. In addition to the centrally funded schemes—and they are the state and commonwealth ones I have outlined—in some towns the local health services and/or the local council provide a variety of local incentives such as subsidised or free residence, surgery, car and free use of the hospital's accident and emergency department. In addition, there are attention grants administered by the Health Insurance Commission. These vary with location and time spent in the location. The amounts vary from $3 600 to $18 000 a year, and the qualifying periods vary from one year to six years.

A range of other recruitment strategies have been implemented by the Department of Human Services to enhance training and recruitment. These include the Pika Wiya Unique Centre of Learning, which provides a culturally appropriate learning centre for indigenous students. That is based in Port Augusta. There is the rural undergraduate scholarship scheme, which is the provision of financial support to undergraduate students with a requirement that they undertake employment in a rural or remote setting. Then there are clinical placement schemes which provide financial support to students to enable them to do a clinical placement in a rural location. There is also a DHS careers pathway CD-ROM, which is available and provided to all schools to promote human services as a career to high school students. There is also a number of commonwealth funded tertiary strategies—the general practice education and training, and the rural clinical schools—which are funded through the commonwealth.

Mr CAICA: My next question relates to a matter raised very briefly by Ms Ramsey earlier. Will the minister provide information on employment and training programs currently being initiated by the Department of Human Services to increase scholarship employment opportunities for Aboriginal students within the health portfolio?

The Hon. L. STEVENS: An Aboriginal Employment Work Force Planning Committee has been established within the Department of Human Services with representation from across the portfolio, as it is acknowledged that a well trained Aboriginal work force is the foundation upon which improvements in Aboriginal health and wellbeing are built. The importance of the recruitment and retention of Aboriginal employees is also reflected in the Department of Human Services' reconciliation statement as it commits to increase and retain Aboriginal employees within the portfolio; increase Aboriginal people in decision making positions; eliminate systemic workplace racism; and increase understanding of Aboriginal identity and experience in the portfolio and broader community. The Department of Human Services has made some significant advances in increasing Aboriginal recruitment and retention through several initiatives, including the South Australian Aboriginal and Torres Strait Islander People's Scholarship program and the joint Rotary/Ministers' Indigenous Medical Scholarship program.

Since the inception of the South Australian Rural Education Scholarship programs in 1998, 12 recipients of these scholarships have graduated with registered nurse qualifica-

tions, bringing to 19 the total number of Aboriginal RNs employed throughout the portfolio. The sum of $60 000 from the $1 million allocation to recruit and retain RNs has been allocated to increase the numbers of Aboriginal RNs. One recipient has graduated with a Bachelor of Medicine, bringing to three the total number of Aboriginal doctors practising in South Australia. Members can see that we have a long way to go. Five other recipients have graduated and are now employed within the DHS. Their qualifications range from Bachelor of Behavioural Science to BA in Aboriginal Affairs Administration, social work and dentistry. Further, 40 Aboriginal undergraduates are currently on scholarships through the Department of Human Services' Rural Development Aboriginal and Torres Strait Islander and Rotary Scholarships initiatives.

The department also actively participates in the state government youth recruitment initiative such as the graduate and traineeship programs. Nine Aboriginal graduates have been recruited to central office through this initiative. To date, 23 Aboriginal trainees have been recruited throughout the portfolio, including one identified Aboriginal person with a disability. The Nurses (South Australian Public Sector) Enterprise Agreement 2001 provides for the introduction of a new undergraduate nursing student classification. This new classification is provided to facilitate the part-time and/or temporary employment of final university nursing students. Third year undergraduate nursing students will be employed subject to their working under the supervision of a registered nurse. Three Aboriginal undergraduates are currently working on this program at the Port Lincoln and Royal Adelaide Hospitals.

The nursing job shadowing work experience program provides an opportunity for school students to undertake all aspects of work experience in a health care setting where a professional level of care is required. Students undertaking this program, therefore, shadow their supervising partner and may be able to undertake minor tasks if appropriate. Involvement in the program is aimed at providing participants with a unique opportunity to observe nurses at work in a clinical setting and assist with some of the activities in their role. Two Aboriginal youth have completed this program. Approval has been granted to establish the unique centre of learning at Pika Wiya in Port Augusta which aims to provide a culturally appropriate learning facility for Aboriginal people training as registered nurses, enrolled nurses, Aboriginal health workers and allied health professions. The centre's emphasis is on providing culturally appropriate, academic, personal, peer, social and administrative support to enhance the Aboriginal graduate outcomes of students studying at the university or TAFE institutions.

I must say that I am particularly impressed with what is happening at Pika Wiya. We hope that we can implement similar programs elsewhere. The report 'Future pathways: Aboriginal health workers in South Australia,' released in December 1999, notes three key recommendations—training curriculum, status and support. An elected Aboriginal advisory committee has been working on an implementation strategy. At the Aboriginal health workers' state conference held in November last year 150 Aboriginal health workers attended. Health workers endorsed the business plan, vision and definition of role of Aboriginal health workers. DHS submitted a request to the Equal Opportunity Commission and received an exemption to employ only Aboriginal and Torres Strait Islander people as Aboriginal health workers.

The recently released Aboriginal and Torres Strait Islander Health Work Force draft national strategic framework recommends that each state and territory establish their own Aboriginal health worker professional association. Seed funding for the establishment of these associations will largely be met by the commonwealth. However, there is an expectation that states and territories will pick up the ongoing running costs after the first three years. An application for this seed funding has been submitted and is expected to be supported.

The Hon. DEAN BROWN: I come back to the issue of obstetrics. Which specific country public hospitals are no longer providing either private births (because many of those private hospitals would have done private births under health insurance) or public births compared to 1 January of this year (2002); and how many GPs in country towns have decided not to continue doing obstetrics in country public hospitals? There was some talk that a number of the GPs at Mount Barker were looking at dropping out of obstetrics work. I acknowledge that it may be necessary to contact each of the hospitals to ask them for that information, but I would appreciate an overall picture of which areas are now struggling significantly in terms of getting GPs to do work.

I am told by some of the GPs that they are no longer going to do the private births even if someone turns up with private health insurance, therefore I would appreciate an assessment in what the drop in private health insurance income would be for the public hospital system in the country as a result of doctors no longer doing private births, in other words, health insurance births within those public hospitals.

The Hon. L. STEVENS: Some of this information, as the deputy leader just indicated, we may need to take on notice. I can give him some information about the locations in the country that are unable to provide obstetric services, but I would also like to say that there are 45 rural locations that do provide obstetric services. I am advised that the following locations do not provide maternal services: Andamooka Outpost Hospital; Angaston Hospital, which is part of the Barossa Area Health Services; Burra, Clare and Snowtown Health Service, the Snowtown Hospital; the Eudunda Hospital; Hawker Memorial Hospital; Karoonda and District Soldiers Memorial Hospital; Lameroo District Health Services; Laura and Districts Hospital; Leigh Creek Health Services Inc.; Oodnadatta Hospital; Penola War Memorial Hospital; Pinnaroo Soldiers Memorial Hospital; Port Broughton District Hospital and Health Services; Strathalbyn District Health Services; and Tailem Bend District Hospital.

The Hon. DEAN BROWN: Maitland, for instance, has now also dropped out.

Ms RAMSEY: Particularly as the medical indemnity matter kicks in, more doctors are dropping out of providing services. I do not have an up-to-date list because we are still collecting the information about what insurance doctors are taking and what services they are able to provide. There are a couple of locations where we are able to provide limited obstetrics services. Ceduna is one of those where we can actually do planned caesareans now, if we can get enough midwives. We now have a doctor who can do them but have not enough midwives to do the seven day a week cover. It may be best if we take the question on notice and respond more fully.

The Hon. DEAN BROWN: My second question is about ambulance bypasses. Figures have been available on a monthly basis, so can the minister give me the figures for the months of April, May, June and July for both the private and

the public hospitals? That is, the percentage of time that they are on bypass from both private and public hospitals in the metropolitan area.

The Hon. L. STEVENS: I can give you some of the answer but will need to take the rest of the question on notice. During the 2001-02 financial year the amount and percentage of time on diversion remained low for public hospitals and high at private hospitals. That probably is not a surprise to the Deputy Leader from his own experience. The public hospitals were on diversion for 0.4 per cent of the time and the private hospitals have been on diversion for 43.4 per cent of the time. Obviously, as part of the pressure that we spoke about earlier in relation to public hospitals, a number of strategies have been implemented during 2001-02 to manage ambulance diversion and the blocking up of emergency departments. These include:

- the ongoing management of an ambulance diversion policy;
- the provision of emergency extended care units at the metropolitan and public hospitals;
- the allocation of additional funding to manage the pressures on the emergency departments;
- the implementation of the winter bed strategy, which we are still in; and
- the implementation of mental health emergency demand management strategies.

I have just been informed that, unfortunately, we have no figures for the last three months because of industrial action by the South Australian Ambulance Service. We will need to take that question on notice and do the best we can to provide the information as soon as possible.

The Hon. DEAN BROWN: Someone from the ambulance service indicated to me that in May there had been a record number of diversions.

The Hon. L. STEVENS: I cannot comment on that, but I will certainly undertake to obtain the information for the member.

The Hon. DEAN BROWN: I think it was either May or June. I would appreciate those figures.

The Hon. L. STEVENS: We will endeavour to obtain them.

The Hon. DEAN BROWN: I would also like to know whether they were from public hospitals, private hospitals, or whatever.

The Hon. L. STEVENS: We will do what we can to obtain the figures.

The Hon. DEAN BROWN: My third question is asked on behalf of the member for Flinders, who requested me to ask two associated questions. I will ask them together. Can the minister give an assurance that acute care services in the 10 hospitals located across 45 000 square kilometres of Eyre Peninsula will remain? When will the minister be able to appoint a second public dentist to Port Lincoln to help deal with public patients at Port Lincoln?

The Hon. L. STEVENS: I will refer that question to the Executive Director, Country.

Ms RAMSEY: The hospitals in the Eyre region outside Port Lincoln and Ceduna are minimum funded hospitals. There is no intention to change any of that. I would not foresee that there are likely to be any particular changes. The smaller locations, as the member would be aware, predominantly provide aged care and sort of a triage accident and emergency service. In locations such as Ceduna and Port Lincoln there is, in fact, increased activity. I would not anticipate any changes, although I have not had any discussions with the minister about that. I will ask Dr Stubbs to answer with respect to dental services.

Dr STUBBS: I will take that question on notice, if that is all right.

The Hon. DEAN BROWN: Certainly. Can the minister give an assurance for the member for Flinders about the acute services for the 10 hospitals on Eyre Peninsula?

The Hon. L. STEVENS: I think Ms Ramsey answered that question. There is no intention to make any changes in that regard. I think I may have informally mentioned that to the member previously.

The Hon. DEAN BROWN: She still asked me to ask the question.

The Hon. L. STEVENS: I am happy to say that on the record. I am not sure what that little smile is for, but I am happy to say that.

Mr HANNA: The Budget Statement, at pages 3.9 and 3.10, refers to $1.5 million each year for the next four years for cleaner hospitals. Will the minister tell the committee about the hospital cleaning audit and the recommendations from the infection review?

The ACTING CHAIRPERSON: I see that Professor Kearney has joined the minister. He might like to tell us about pigeon droppings at Flinders Medical Centre.

The Hon. L. STEVENS: I will certainly ask Professor Kearney to answer some parts of the question. Prior to the election of the government and my appointment as Minister for Health, I had become increasingly concerned about the apparent increase in infections and, certainly, about the state of cleanliness in our hospitals. The cleanliness of our hospitals was the most frequent of the concerns and issues raised with me when we went through our Labor Listens program and were talking to people across the state. Earlier in the year, we experienced the closure of the Cardiothoracic Unit at the Royal Adelaide Hospital. This followed the closure—I think in January—of the Neonatal Intensive Care Unit at the Women's and Children's Hospital, and the closure last October of the Intensive Care Unit at the Queen Elizabeth Hospital as a result of infections.

There has been a worldwide increase in antibiotic resistant organisms, and we must be in a position to ensure that all our hospitals are as safe as possible and that the risk of cross infections between patients is minimised. In April this year, I announced an infection control review, which is currently in progress. Dr Peter Brennan and Dr Clifford Hughes are undertaking the review, and a full report will be provided in late August. This review has involved detailed consultation with infection control staff, chief executives and medical staff of our hospitals, in addition to references across Australia and New Zealand, on best practice relating to infection control. Whilst the final report is not yet completed, preliminary discussions with the consultants lead us to anticipate recommendations that will certainly deal with the situation that confronts us at the moment.

In addition to the infection control review, I also have asked the Department of Human Services to undertake an audit of the cleaning standards across the hospitals. Following a number of patient complaints about hospital cleanliness, I am seeking reassurance that the cleaning standards are being regularly monitored and that there is no link between the standards of cleaning and the level of infections in our hospitals. The cleaning audit involves auditing the contract arrangements for cleaning, auditing the standards used in the performance management of the contracts and consulting with the cleaning industry, unions and hospitals.

Following the completion of both the infection control review and the cleaning audit, I will make an announcement about their outcomes and about the action plans that will arise from both those reports. The recommendations from those reports will inform us about the way in which our $1.5 million annual investment over the next four years will result in cleaner and infection risk managed hospitals. I will ask Professor Kearney whether he would like to provide any further information to the committee in relation to the issues of infection control and hospital acquired infections.

Prof. KEARNEY: The issue of resistant organisms in our community is one which is common and widespread, and growing. Each of the three closures were as a result of resistant organisms spreading from patient to patient or from staff to patient due to different antibiotics. The common organisms that we are facing in our community are methicillin resistant staphylococcus aureus, resistant pseudomonas organisms and vancomycin resistant enterococci. Most of those organisms develop resistance because of previous use of antibiotics, often in our community and often in a non-human setting. It is not commonly known that nearly 90 per cent of all antibiotic use occurs in other than non-health issues. The minister and the department have been working with other jurisdictions to reduce the use in the non-health sectors, and this has involved work with the veterinary and agricultural sectors with respect to acute treatment of animals rather than as growth promotants.

At the recent Food Ministers Standards Council the minister moved that residual levels of antibiotics in meat for consumption be reduced to safe levels, and that was supported by the other jurisdictions. Within the health sector it is important that within both the community and the hospital we limit the use of antibiotics and develop systems that prevent what we call nosocomial infections, which are organisms that normally cause major infections except where the person is unwell or has a compromised immune system.

The review is aimed at a number of issues surrounding infection control in hospitals, and it is expected that the report will be presented to the minister shortly. It will describe the events at the three hospitals which the minister outlined. It will describe the need for facilities to work best in safe infection control environments and it will make a number of recommendations with respect to changes in infection control practice. In particular, the review has identified that our reporting systems can be enhanced and developed. It also suggests that we look at the governance within individual clinical units. That relates to leadership by clinicians in units and the amount of care and attention that they give to infection control as part of their everyday work.

It looks at the relationships between infections and control units in hospitals and clinical units, and it also looks at how the department might strengthen and coordinate those activities across the whole system. As I mentioned, these organisms are resident in the community. They are also resident in private hospitals as well as public hospitals. The review will look at how we work collaboratively with private hospitals to ensure that, although theirs is probably a lower risk environment because of the acuity of patients involved, they, too, join in these infection control processes.

The review will cover a number of other issues, but it is wide-ranging. It is looking at the steps that we need to take to improve infection control in our hospital system. I think it will be extremely helpful for us to ensure that, having implemented the findings of the review, South Australian public hospitals will be much safer from an infection control point of view. It is important that we have strategies to disseminate the findings and to involve all our hospitals in looking at education, information and consultation about the findings and how we implement them.

Mr HANNA: I have a supplementary question on this very point, but I do not expect an answer right now. It is a matter for the minister—and, if she pleases, Professor Kearney—to take away and think about. I raised this issue with the minister when she was shadow minister for health and it relates to a lack of systematic checking of the cleaning processes for surgical instruments and bits and pieces which are reused from surgery to surgery. Obviously, unless this process is very thorough and the process itself is subject to systematic checking, there is the possibility of bodily fluids being transferred from one to another. I just want to leave that with the minister. It may well be covered in the infection review. I noted that Professor Kearney referred to infection control units within hospitals looking at the governance of chemical units. Perhaps that takes on board my question already. I do not expect a comment now, but I wanted to chip that in because I am aware of it having been a problem.

The Hon. L. STEVENS: I recall the honourable member mentioning this to me when I was shadow minister. I wonder whether Professor Kearney would like to make a brief comment.

Prof. KEARNEY: The review will cover the issue of sterilising processes within hospitals and infection control procedures within operating theatres. I omitted to mention that, but those two specific areas will be covered by the review.

Mr HANNA: My second question relates to the Exelcare system. I refer to Budget Statement Output 3 (pages 3.9 and 3.11). Will the minister indicate the strategies that the Department of Human Services has in place to upgrade and replace the nursing clinical information system (commonly referred to as the Exelcare system) given the imperatives placed on this government from the previous government's negotiations in the Nurses SA Public Sector Enterprise Agreement 2001?

The Hon. L. STEVENS: In order to address this question, members clearly are required to understand the background and purpose of the information system called Exelcare. It was first introduced in 1992 in 14 of our public hospitals (10 metropolitan and four rural). The system was introduced as a response by the nursing profession to enable it to better facilitate the appropriate nurse care planning, supporting quality activities and the allocation of nurse staffing resources in order to meet the individual care requirements of patients. Clearly, each patient has a different set of needs and requires individualised care planning.

Given the complexities within our hospitals, having a clinical information system to support nurses in undertaking what is clearly a complex task was seen as an opportunity to maximise and enhance patient care. However, with the passage of time and changes in technology, the current system is now unstable in that it is on a DOS platform and is becoming more difficult to maintain from both an IT perspective and certainly a user's perspective.

At the time of negotiation of the recent nurses' enterprise agreement, the previous government made a commitment within that agreement that the current Exelcare system would be replaced in August 2002. However, that commitment was made without considering its full impact, the cost or the time frame that would be required in order to achieve a successful implementation. It was astounding to find that this was the

case as soon as we took office in March. I understand that this process was established in good faith by the Department of Human Services in conjunction with health units and the Australian Nursing Federation in order to facilitate the development of the service specifications and a formal request for tender for the new system. The tender was released to the market in November 2001 with submissions being evaluated in mid-January 2002. However, given the calling of the state election and the caretaker conventions, the project was held in abeyance until our government took office.

One of my first priorities as minister was to clearly understand the issues around supporting nursing within our state. As a result I had an early briefing on the status of the Exelcare tender process. Clearly, I was alarmed—and that is putting it mildly—that no funding had been provided by the previous government in the forward estimates for this system, which I understand will require significant upgrading of the current infrastructure and software requirements. This negligence by the previous government has resulted in a significant delay in the tender process given that there was no formal allocation of resources. As a consequence, the government and the department are working closely with the Australian Nursing Federation in order to minimise any potential industrial action that may occur given that we will clearly be in breach of the enterprise agreement.

Following discussions with the Prudential Management Group and Treasury, Stage 2 of the tender process has now been activated with the short-listed applicants being notified on Tuesday 16 July 2002 to have full technical and costed proposals to the department within a four-week time frame. Therefore, I am pleased to be able to advise that within our first budget we have allocated $3.5 million over three years to support the implementation of the project, and it is anticipated that the successful tender will be awarded in late September/early October 2002. Clearly, the implementation of the system will be dependent upon the solution chosen from the evaluation process, but our commitment is to ensure that we have the best system that will support both the nursing profession and technical requirements for the next five to 10 years.

As a result of the delay in the implementation of the replacement system, the department has been proactive in order to ensure that the current ExcelCare system could be maintained. The department has been working with health units to ensure that the systems database is reflective of current needs, so that wherever possible staffing requirements reflect the complexity of the needs of the patients. We are acutely aware of the current industrial obligations as outlined by the nurses enterprise agreement and, as a result, both my office and the department have been liaising with the ANF and the health units in relation to the status of the replacement process. We are doing the best we can as fast as we can to fix a very serious situation that we inherited.

Mr HANNA: Will the minister advise the committee on the measures taken by the Generational Health Review to ensure that the community will have an opportunity to give its views on the review of South Australia's health system?

The Hon. L. STEVENS: I am very pleased to answer this question, because increasing community participation and encouraging community input into the planning and delivery of health services is one of our top priorities as a government in terms of the future rebuilding of our health services. There will be a range of opportunities for the community to input into the review of South Australia's health system. It is my intention that the generational review into South Australia's health system will be driven by community views and expectations of their public health system. The community has had access to information pertaining to the review since it was announced in May this year through the Generational Health Review web site.

For the record, I will give the web-site address: www.dhs.sa.gov.au/generational-health-review. There is also a freecall telephone number—1800 090 800—and an email address: generationalhealthreview@dhs.sa.gov.au.

Input from every interested community member is essential in rebuilding the state's public health system. The review is specifically structured around ensuring that there is community debate and discussion about what the South Australian public health system could and should deliver. Every South Australian is being given a unique opportunity to help shape the future of the state's health system.

The Generational Health Review called for written submissions from the community and other key stakeholders on 10 July 2002. The South Australian community will have the opportunity to submit a submission until 26 August 2002. Submissions are invited on all the state's health system issues, with a specific focus on the following five key areas:

- Better services (health care models);
- Better community involvement (community participation);
- Better management (governance and funding);
- Better work force (work force and education, training and research); and
- Infrastructure (information technology, major equipment and capital assets).

The call for submissions and input into the review is being widely advertised throughout the state and in a variety of languages. There have been advertisements in the *Advertiser* and *Sunday Mail*, as well as a targeted mail-out to 800 organisations and individuals. All metropolitan Messenger Press and selected regional press will also announce the opportunity for the community to input into the review.

Calls for submissions and announcements about inputting into the review have been advertised on ethnic radio. Radio stations 5EBI and 5PMA have broadcast announcements in Greek, Italian, Vietnamese, Cantonese, Mandarin and Khmer. Furthermore, the Generational Health Review intends to hold open public meetings throughout October and November across South Australia. The public meetings will be held in regional and metropolitan locations, the details of which will be advertised widely throughout the community.

I am confident that there will be strong interest in the review and the shaping of South Australia's health system of the future. I must say that in my travels as health minister that interest has certainly been there. Three hundred and thirty-nine submission information packages have already been downloaded from the Generational Health Review web-site, and that occurred in the period between 10 July and 16 July.

The review presents a unique opportunity for the people of South Australia to give us their views on health services and, more importantly, what health services should deliver in the future. Five task groups for key areas of the review have been established to provide strategic advice to the review committee. Membership of the task groups encompasses a very broad range of stakeholders, including community members, health professionals, university academics, as well as experts from industry and the private sector. We thought it was really important that we established structures that could provide the widest possible advice and opportunity for participation across the community.

The Task Group on Health Care Models will be chaired by Dr Helena Williams of the South Australian Division of GPs and co-chaired by Dr Michael Rice who was, of course, as people will probably know, the former president of the AMA here in South Australia. They will advise on the development of health care models, opportunities to strengthen existing whole-of-government mechanisms and collaboration across health and related services, as well as analyse and review evidence-based initiatives.

The Community Participation Task Group is co-chaired by Ms Sue Crafter and Mr Ian Yates, the latter of whom is the Executive Director of the Council on the Ageing. They will develop strategies that improve community participation in health care, including decision-making.

The task group reviewing the current governance and funding arrangements in the South Australian health care system will be chaired by Associate Professor Judith Dwyer and co-chaired by Professor John Blandford, both of whom have coincidentally been chief executive officers of Flinders Medical Centre at different times. This group will develop options to improve the current arrangements and reflect contemporary views of health and health system governance and funding.

The Workforce Research and Training Task Group will be co-chaired by Dr David Wilkinson, formerly of the University of Adelaide rural health faculty, and co-chaired by Ms Jane Pickering. This group will provide advice on appropriate structures for health care staffing and linkages between work force issues, service delivery, finance and infrastructure planning. The group will also advise on what new knowledge and skills will be required of the work force over the next 10 years, as well as advice on education and training issues and strategies for recruitment and retention of the health work force.

The task force charged with looking at information technology, telecommunications and capital will advise on an appropriate structure for integrated information management, technology and telecommunications systems, and will also consider the impact of future technologies. The chair and co-chair for this task group have not yet been appointed.

At its last meeting on Friday, 26 July, the review committee endorsed the terms of reference for the Community Participation and for the Workforce, Research and Training Task Groups. I encourage all members to take an interest in the generational review, to put in their own submissions and to encourage, wherever possible, groups and individuals in their constituencies to have their say.

The ACTING CHAIRPERSON: I note that it is almost time for us to complete this section. I know that the members for Heysen and Goyder have further questions, and the deputy leader has something to read in. Would you all like to read them into *Hansard*?

Mr MEIER: Could I just ask a supplementary question to the previous one? Are the five rural not-for-profit community hospitals all included in the review?

The Hon. L. STEVENS: Yes, they are.

Mrs REDMOND: I was pleased to hear the member for Mitchell ask his question about Exelcare, because I think it relates to what I want to ask the minister. On page 6.26 of Budget Paper 4, volume 2, there is a table for Output Class 6. The twelfth dot point in the 'Targets for 2002-03' column states:

> Implement electronic patient care planning and information system management in accordance with enterprise bargain agreement commitments.

I assume that is what you spoke about in response to the question about Exelcare. Does that patient care system extend to the provision of appropriate discharge letters upon discharge from hospital? The reason for my concern is that in the last few days I have received a letter from a local GP with respect to two elderly constituents who have a limited command of English. The wife was hospitalised in the Royal Adelaide for a period of 13 days, including a week in high dependency intensive care with quite significant problems. She was released for return to outpatients in six weeks' time without a discharge letter. She turned up at her doctor's surgery as instructed when she was discharged, but without any information for the doctor. He then rang the nurse—a GP liaison person at the hospital—who undertook to get him information that day. He sent the patient away, but got her to return the next morning, and again he still had no information. Eventually, he obtained some information over the phone from an intern.

This lady had been clearly in intensive care for a week with quite significant health problems, quite likely life-threatening problems, yet was discharged for six weeks, not to return to the hospital, without obtaining an appropriate letter. I understand that that is actually a breach of the hospital's requirements. Will the intended implementation of this new health care planning system of nursing for patients extend to ensuring that the discharge papers adequately give coverage and protection to people being discharged?

The Hon. L. STEVENS: Before handing over to Dr Tom Stubbs to give the details in relation to the system, I must say that I am really concerned to hear that. It is not the first time: over recent years I have heard of cases similar to the one you have just recounted. I will be very pleased to receive the details.

Mrs REDMOND: I have written you a letter, minister. It has just been signed this morning, so it will be in the mail today.

The Hon. L. STEVENS: I will be looking out for your letter and I will be very pleased to investigate it, because it is not good enough, and that needs to change.

The ACTING CHAIRPERSON: The member for Heysen is happy for that question to be taken on notice. That will enable us to put the other questions on the record.

The Hon. L. STEVENS: Fair enough.

The Hon. DEAN BROWN: I will read the omnibus questions, so we do not expect answers now!

1. For each year 2002-03, 2003-04, 2004-05 and 2005-06, and for each department and agency reporting to the minister, what is the share of the total $967 million savings strategy announced by the government, and what is the detail of each savings strategy?

2. For each department and agency reporting to the minister, what is the share of the $322 million underspending in the year 2001-02 claimed by the government, what is the detail of each proposal and project underspend, and what is the detail of each carry-on expenditure to 2002-03 which has been approved?

3. Will the minister advise the committee as to how many reviews have been undertaken or are scheduled to take place within the portfolio since the government was elected? What matters do these reviews pertain to, which consultant or consultancy organisation has been hired to undertake this work, and what is the total cost of these contracts?

4. Will the minister advise the committee how many of the 600 jobs to be cut from the Public Service will be lost from within the portfolio?

5. Will the minister advise the committee which initiatives contained within the government's compact with the member for Hammond have been allocated to this portfolio, how much will they cost each, and whether these costs will be met by new or existing funding?

6. Will the minister advise the committee of the number of positions attracting a total employment cost of $100 000 per annum within all departments and agencies reporting to the minister as at 30 June 2002, and of the estimates for 30 June 2003?

The ACTING CHAIRPERSON: Thank you minister, and thank you advisers. The time for examination of matters relating to health is concluded. We will now proceed to housing in accordance with the agreed timetable.

Witness:

The Hon. S.W. Key, Minister for Housing.

Additional Departmental Advisers:

Ms. M. Crearie, Director, Regional Services (Metropolitan), South Australian Housing Trust.

Mr G. Storkey, General Manager, HomeStart Finance.

Ms C. Shard, Acting General Manager, Aboriginal Housing Authority.

Ms C. Davidson, Acting Director, Finance, South Australian Housing Trust.

Ms J. Connolly, Project Officer.

Ms R. Ambler, Director, Policy, Department of Human Services.

Mr B. Moran, General Manager, South Australian Community Housing Association.

The ACTING CHAIRMAN (Mr Caica): Minister, do you wish to make an opening statement?

The Hon. S.W. KEY: Yes, I would like to make an opening statement. Before I do that I would like to thank all the staff in the housing portfolio not only for the furious work in which they have been involved for estimates but also for their work generally, and to acknowledge some of the positive programs that I have had the pleasure to inherit from the previous Minister for Housing, Hon. Dean Brown. The Rann Labor government believes that all South Australians, where ever they live, should have access to safe, secure, appropriate and affordable housing. Good housing contributes to the development of a socially just, inclusive and sustainable community and helps address poverty.

It is fundamental to people's health, their wellbeing and their capacity to participate in the community's economic and social life. Housing investment also has a positive multiplier effect on the economy. The private market houses most Australians whether through private rental or home purchase. This is complemented by public, Aboriginal and community housing programs and housing support services managed within the Department of Human Services. We take a whole of government approach to housing policy across portfolios and in conjunction with local government, the commonwealth, the broader community and industry.

We have diverse tasks ranging from addressing the personal and community costs of poor housing and homelessness to improving planning and development processes, supporting industry viability and enhancing community wellbeing. Some of the government's current initiatives are:

- the homelessness initiative, that we will reduce homelessness by 50 per cent;
- continued urban regeneration activities across the state;
- creation of a State Housing Council within the Department of Human Services to raise the housing profile and leadership role;
- focus reviews in areas such as residential tenancies, supported residential facilities and the Retirement Villages Act; and
- establishment of a Housing Industry Advisory Committee to complement the existing community based Advisory Committee;

Most importantly, the government is fulfilling an election commitment to develop a state housing plan by:

- creating a 10 year strategic outlook for South Australian housing;
- outlining housing priorities and facilitating industry and community input; and
- helping to coordinate activities across government by opening up channels of communication to improve strategic planning, coordinated decision making and integrated policy making.

The state has four housing authorities: the Aboriginal Housing Authority; the South Australian Housing Trust; HomeStart Finance; and SA Community Housing Authority. To improve the effectiveness of our social housing programs, I am establishing a new State Housing Council in the department to bring together the four authorities to ensure better planning and achievement of housing objectives. I am committed to ensuring that the commonwealth continues to support social housing. For this reason we will protect the state's interest in the renegotiation of the new Commonwealth State Housing Agreement (CSHA) to take effect after June 2003.

Securing appropriate funding is crucial to maintaining viability for public and community housing in South Australia. Further decreases in commonwealth funding would undermine our capacity to meet the current and projected housing need. With declining commonwealth funding, the previous government oversaw an almost 12 per cent reduction in the state's public and community housing stock, from 62 501 dwellings in 1995-96 to 55 119 in 2001-02. Reduced accessibility has placed stress on families, households and communities. This government is committed to ensuring that issues of supply and distribution of affordable housing in the state are addressed.

For over 60 years the housing trust has played a valuable role in the state's development, including its economic development. More recently, it has been the main provider of affordable housing for households with low incomes and/or special needs. For a decade it has operated within an environment of a declining CSHA funding coupled with a reduction in rent income due to increasing allocation of housing to those in greatest need who usually pay a reduced rent. Rebates to assist low income earners means that no tenant pays more than 25 per cent of the gross accessible income in rent.

The rent increases announced in the budget will remain within this affordability benchmark. In 2002, 84 per cent of tenants pay a rebated rent. These drivers, along with the ageing asset base, are impacting on the trust's financial viability and long-term sustainability—a reality identified in successive triennial reviews and ignored by the previous government. In the coming year the Housing Trust will manage almost 50 000 housing assets valued at $3.1 billion and provide housing for about 48 000 households, with some 4 400 new households being allocated accommodation. Some 11 500 of the properties are allocated in regional South

Australia. Last year, 1 274 households were allocated homes in regional areas.

I will now deal with the capital program. The trust's $87.2 million capital program for 2002-03 covers new-build and spot purchases, maintenance and renovation. These will provide:

- $3.1 million for the acquisition of 20 existing homes to support urban regeneration projects and other special needs;
- $28.8 million to build 280 new homes in areas with high demand;
- $26.9 million for renovation and upgrades of 1 400 existing houses (with $1.9 million to be spent on security upgrades to walk up flats); and
- a further $20.1 million will be invested into urban regeneration projects, funded through project sales of housing and land.

The trust's urban regeneration projects at Westwood and Hawkesbury Park will provide significant economic and community benefits to their local areas. Projects have also been established in Port Lincoln and Port Pirie, and a range of special initiatives operate in other country areas, including Mount Gambier and with the Whyalla City Council.

Through the better neighbourhood and development opportunities programs, the Housing Trust is building on urban regeneration principles to accelerate the replacement of poor quality and ageing stock. The Housing Trust will spent a further $63 million to maintain housing stock, including $3 million to modify properties to help new and existing tenants with special needs remain in their homes. In regional South Australia, capital and recurrent maintenance and improvement programs will involve 106 contracts, employing some 360 workers.

I will now deal with environmental initiatives of the Housing Trust. The trust has initiated an environmental management policy that aims to ensure that all new houses built by it achieve a minimum four star energy rating. Other initiatives include:

- a demonstration home renovation in Whyalla using solar features and ecologically sustainable design materials and technology;
- commencement of a program to install up to 100 solar hot water systems in trust houses in Port Augusta; and
- undertaking ecologically responsible management of disposable material arising from the demolition process of trust maisonettes.

A major source of trust income is the sale of the properties to tenants and surplus properties to the market. In 2002-03 it is anticipated that 650 houses will be sold, generating $34.3 million. Our sales policy will be developed to reflect this government's commitment to end the selling off of public houses unless balanced by new development. The Housing Trust is noted for targeting housing assistance to those in the greatest need, including the homeless, people with disabilities, migrants and students. The government has allocated $4.7 million in 2002-03 to the trust to provide emergency accommodation for homeless and other special needs groups. The supported tenancy scheme provided 710 properties to community and government agencies for housing and related support services for people in need of emergency and transitional housing. The trust also owns nine boarding houses used for short to long-term accommodation. I note that the deputy leader has a boarding house project in Victor Harbor, and that is being supported by some units through the community housing authority. So, it is good to see that we also have some examples in the country areas.

A further 146 properties are provided to organisations that assist people with disabilities. The trust will spend $3 million recurrent funds on modifications to enable aged or disabled people to stay in their homes. The trust also assists newly arrived skilled migrants by offering three months tenancy in 51 centrally located houses. Finally, 257 student low demand Housing Trust properties awaiting redevelopment are provided for short-term low cost secure housing to eligible tertiary students.

The Housing Trust provides financial assistance, information, referral, advocacy and counselling to assist households experiencing instability, poverty or inadequate housing in the private rental market. In 2001-02, approximately 26 000 such households were provided with financial assistance, including 3 755 households in regional South Australia, to a value exceeding $15 million. This included direct payments for bonds, rent in advance, rent in arrears, rent relief and bond guarantees. Similar levels of activity are expected in the coming financial year.

The trust's most recent triennial review concluded that it is an efficient and effective housing provider. But it is noted that the threat to viability is due to declining CSHA commitments and increasing numbers of households paying rebated rent. The review suggested opportunities for improved outcomes, including in relation to:

- improving the CSHA financial arrangements;
- increasing rents for some households (as done in the last budget);
- further development of the Better Neighbourhoods strategy to improve levels of replacement housing;
- improved targeting of home renovation; and
- trial and evaluation of prevention and early intervention programs for high and complex needs tenancies.

The Housing Trust will continue to manage housing allocations to help ensure that balanced, sustainable communities are maintained in areas where the Housing Trust has a significant presence.

The Aboriginal Housing Authority is a statutory authority that provides housing and related services to South Australia's Aboriginal community. It is involved in a national and state level through ATSIC, regional councils, statewide workshops and with indigenous community organisations. In the recent budget the government committed $12 million over three years to meet the housing needs of the Aboriginal community through the AHA, with $4.4 million provided in 2002-03. In addition to capital works programs, $3.9 million of recurrent grants will be provided to the Aboriginal community organisations to construct nine new homes, purchase a further 42 new houses and upgrade 60 existing dwellings. Total grant revenue for the AHA in 2002-03 is estimated at $21 million, which includes $11 million allocated to the community housing program for Aboriginal communities in remote South Australia. Staff assist community housing organisations to manage their stock through policy development support and the delivery and design of new houses. This program also includes an upgrade component.

The rental housing program takes an holistic approach to housing assistance to the Aboriginal community in South Australia and manages some 2 085 properties. Services include housing allocation, tenant management, home visits and debt management, while developing and reviewing strategies that enhance the delivery of housing services.

Support is also provided to assist those in housing need to secure and maintain private rental housing by providing bond guarantees and rent in advance. The AHA also manages a home ownership program in conjunction with HomeStart finance for households within the rental housing program. The AHA is committed to providing a range of housing options to its customers, including tenants with multiple and complex needs. Several new initiatives currently under negotiation include transitional housing for single parents in crisis and provision of metropolitan property to house students from regional centres for medical and associated reasons.

I now turn to HomeStart. Through HomeStart finance the government offers a range of home financing products that support low income households into affordable home ownership. It has settled more than 2 422 loans in 2001-02. Approximately 95 per cent of these customers would not have qualified for a bank loan at the time of application. During 2001-02, HomeStart also:

- commenced a pilot program with a carer's home maintenance loan to assist people to modify their homes to improve the quality of life for a carer or dependent;
- established an internal unit for the management and delivery of senior and carer's loans; and
- further reviewed regional South Australian lending deposit requirements in order to provide greater access to home ownership opportunities.

I will now deal with community housing. The community housing program involves citizens in developing housing solutions and encourages local communities to take a more active role in planning and managing appropriate and affordable rental accommodation. Housing cooperatives and housing associations provide greater housing choice. A total of 148 such organisations are registered under the South Australian Cooperative and Community Housing Act 1991 and manage over 3 770 properties. In order to progress the government's commitment to supporting the expansion of community housing, the South Australian Community Housing Authority will be provided with $30.8 million in the recurrent and capital grants for 2002-03. This will fund 193 new houses and upgrade 170 existing homes.

SACHA funds regulate and facilitate the development of affordable community housing within an integrated health, housing and community service system in partnership with community based agencies. Diverse population groups are housed, including low income earners; indigenous households; victims of domestic violence; people who are homeless or at risk of homelessness; some from non-English speaking background; people with physical or intellectual disabilities or mental health problems; frail elderly people; youth; single parents; families in crisis; ex-offenders; and refugees. SACHA also pursues redevelopment strategies in the Housing Trust and other local government community stakeholders. Changes to its act through the Associated Land Owner Program should facilitate an increased housing provision role for church, local government and community groups, and increase the supply of low cost housing.

I would like to comment on homelessness. A major Rann government commitment is the reduction of homelessness by 50 per cent in the next four years. This goal will be addressed through the work of the Social Inclusion Unit, which I and my department will be strongly supporting. *A Place to Live—A Strategic Response to Homelessness in South Australia* is a five-year plan prepared by the department to combat homelessness. It provides for a continuum of services for people who are already homeless and vulnerable, and identifies prevention and early intervention strategies for people considered to be at high risk. Improving access to affordable public and community housing is a major government commitment.

Several pilot programs have been initiated to support vulnerable tenants and reduce the incidence of eviction. Two housing and support programs funded by the commonwealth and the state continue to underpin responses to homelessness. They are the Crisis Accommodation Program, which provides funding for not-for-profit agencies to construct, renovate or purchase housing for emergency and transitional use; and the Supported Accommodation Assistance Program (SAAP), which assists people who are homeless or at risk of homelessness to access a range of support and supported accommodation services.

The four major components of SAAP aim to improve self-reliance, independence and choice for people who are homeless or at risk of homelessness. They are: Families with Children Services; Single Adult Services; Youth Services; and Domestic Violence Services. In 2001-02 recurrent funding of $24.57 million was provided to 48 non-government and community-based agencies, which in turn offered 69 programs to clients. In regional South Australia, $5.34 million was provided, and $1.41 million was distributed to statewide agencies that provide service to both country and metropolitan people.

The supported accommodation program aims to help mental health consumers re-establish themselves in the community. Access to supported housing in many instances can be the main factor in helping them make the transition from institutional care to community living. Four regional demonstration projects are being developed and implemented to provide supported accommodation in Victor Harbor, Whyalla, the Riverland and the South-East. Three other supported accommodation initiatives are also under way in metropolitan Adelaide, involving collaboration between the Housing Trust and other housing providers, community organisations, local government, consumer and carer representatives and the Department of Human Services. They are models based on integrated service delivery to people with complex needs, to enable them to live independently in the community and to experience an improved quality of life.

In conclusion, the activities outlined today will help achieve the government's priorities for families and communities. Strategies focus on the needs of our most vulnerable fellow citizens and provide socially just and practical responses. Access to housing is a basic human right. The State Housing Council within the Human Services portfolio will develop these strategies to ensure that secure, appropriate and affordable housing opportunities are available for all South Australians. We will accomplish our goals through:

- coordination of housing activities across government, the community and industry;
- supporting a strong and viable public, Aboriginal and community housing sector;
- advocating for continued commonwealth funding; and
- working with industry to address the traditional barriers that hinder a vibrant and strong affordable housing market.

As a government, we will promote the important role housing plays in our lives and in our communities. We will build new opportunities and stronger relationships to improve housing outcomes for all South Australians.

The Hon. DEAN BROWN: Thank you very much for that detailed statement: I appreciate those figures. Obviously, we will need time to go through them and calculate how some of those figures are determined, because I suspect that some figures here do not reflect the real figures. But I think you have given us the background to them. What is the government's formal response to the triennial review?

The Hon. S.W. KEY: Obviously, the triennial review has formed the basis of the program that we are looking forward to in the future. As you know as the previous minister, the three major themes were responding to housing need; asset management; and financial viability, and we are basically using that as the background to the way we wish to develop our state housing plan. I am advised that we have made some progress in implementing a number of strategic directions and opportunities that have been outlined in that triennial review. We have been trialling prevention and early intervention pilot projects aimed at assisting tenants with high and complex needs to maintain their tenancies, and those evaluations are under way.

There has been further development of the Better Neighbourhood strategy to provide appropriate levels of housing replacement in areas of high demand. We have been reallocating home renovation expenditure to target dwellings so that they will be held for a longer term, and we have also established improved asset management decision-making processes through the development of a strategic asset group; restructuring maintenance from real estate services divisions; undertaking a review of capital projects division; developing regional asset management guidelines; and beginning the development of an asset condition database.

As the deputy leader knows, there is renegotiation of the Commonwealth-State Housing Agreement for a period from July 2003, so this will be an opportunity for us to use the triennial review recommendations in conjunction with looking at our financial viability. Some of those points I noted in my opening speech. Obviously, to maintain that financial viability there are some major things that we will need to address. We will need to improve, where we can, the Commonwealth-State Housing Agreement funding arrangements. I have had the honour to be at only one of these conferences, but the forecast is that some reductions may be offered in the CSHA expenditure.

We need to follow up on the continuation of GST compensation and also to look at the whole area of the ageing asset base, which will be a big issue for us, and the recognition of the costs of managing a more complex customer base. We are really using the triennial review as a basis for the state housing plan that I noted, as a bit of a blueprint of what we are going to do in the future.

The Hon. DEAN BROWN: As a supplementary question, will there be a formal response publicly from the government on the triennial review? To my knowledge, there has not been a formal response to the parliament.

The Hon. S.W. KEY: There will be no problem with that. I can make that information available as soon as we come to that conclusion.

The Hon. DEAN BROWN: I think I am right in saying that the legislation requires the triennial review to be tabled and requires a formal response from the government within a certain period. I could not vouch for that, but I think there is an obligation to respond as a government.

The Hon. S.W. KEY: I will certainly do that.

The Hon. DEAN BROWN: Earlier the minister gave some figures, and I have done some comparisons with the budget figures of last year, because I know that, under the Commonwealth-State Housing Agreement, the amount of money available is about the same each year. In fact, in real terms, diminishes slightly, as it has done since 1989, because of inflation and the fact that the capital funds have been pegged. I notice, however, that last year it was projected to be 215 new homes and this year the forecast is for 482 new homes. I cannot quite comprehend how, on the same amount of money, more than twice the number of homes will be produced. Also, I ask whether a significant proportion of the capital funds from last year was unspent at the end of last year and which, under the Commonwealth-State Housing Agreement, has to roll forward to the new year, which therefore would be rolled forward to 2002-03.

The Hon. S.W. KEY: I will ask Mary Crearie to clarify that question for the honourable member.

Ms CREARIE: I will have to refer to my briefing notes.

The Hon. DEAN BROWN: I am referring to page 6.33 of the Budget Papers, which shows 482 new houses. I do not quite comprehend how that figure has been derived.

Ms CREARIE: I have not been able to find my paper to refer to, but I can answer the query about the significant underspend on the capital program this year. That was directly linked to problems in the building industry this year with regard to builders' indemnity insurance, and the trust capital program was unable to be completed in the timely way that we had expected. In fact, we had permission to roll forward the program into the coming financial year.

The Hon. DEAN BROWN: Can you give me some indication of what was the underspend? I refer to paper 5 for the Department of Human Services, which shows that it underspent its capital works by approximately 50 per cent. Was a significant portion of that in housing and, if so, how much of the housing money was not spent?

Ms CREARIE: The housing capital program expenditure underspend was $10.9 million below the original budget and, as I said, that was directly linked to the collapse of HIH Insurance and difficulties builders were having in completing the contract, which compounded the problem. The 2002-03 capital works program is $91.6 million, compared to last year's program of $95.8 million, and the difference of 4.2 of the program is completely due to reclassification of expenditure under the AHA (Aboriginal Housing Association) program for 2002-03. Some $3.915 million was transferred from capital to operating to reflect correct accounting treatment of expenditure for Aboriginal Community Housing. In addition to the amount transferred, a further $400 000 has been allocated to the program and not included in the capital figures.

The Hon. DEAN BROWN: I appreciate all that but, because you have acknowledged that the dollar terms are almost the same, that would not account for more than a doubling of the number of homes being built.

The ACTING CHAIRMAN: Is that a supplementary question?

The Hon. DEAN BROWN: Yes—it was a point that I raised earlier, and I am trying to find out why there appears to be this discrepancy in the number of new homes being built with the same amount of money.

The Hon. S.W. KEY: Madam Chair, I am not sure how much of the question you were here for, but the deputy leader asked a question in two parts, and Jim Birch will explain the numbers. We think the numbers that the member is quoting are perhaps the entire housing program numbers rather than the parts that we are talking about.

The Hon. DEAN BROWN: That may well be the case.

The Hon. S.W. KEY: Jim Birch will amplify that matter.

Mr BIRCH: We believe that the numbers to which the shadow minister is referring include SACHA, the Aboriginal Housing Authority and the Housing Trust in total and, in comparing the Housing Trust from year to year, he would be correct. But in adding in the other numbers it makes a difference between the ones that he is talking about. It is the whole housing program.

The Hon. S.W. KEY: I hope that answers the two parts of the question from the honourable member.

The Hon. DEAN BROWN: Yes, it does; thank you. I appreciate that, and I appreciate the way in which the minister has given such useful answers, and particularly in her introduction earlier. Am I allowed to bring in supported residential accommodation? I understand that that comes under this area of housing.

The Hon. S.W. KEY: I would be happy to try to answer a question, if that is your point.

The ACTING CHAIRPERSON: You people have made the agreement. I am just trying to sort through the middle.

The Hon. DEAN BROWN: It is sometimes difficult to know exactly where it sits within the portfolio, but I think it probably sits in this part of it. I had discussions with some of the people from supported residential facilities last year, and they face a difficult situation. The number of SRFs within the state is tending to decline, because the cost of providing accommodation tends to be growing at a faster rate than the increase in the social security payments that these people are receiving, and they pay 85 per cent of their social security payment across to the operator of the SRF. There are people of different backgrounds in SRFs, and some have a much higher level of need than others. Certainly, there were discussions with the SRF association in December with a view to putting some of the rental assistance money that was saved from last year's budget (and which would, therefore, be an ongoing saving) into providing specific packages for people with higher needs living in SRFs, so that they might be able to, say, call in some assistance on a paid weekly basis. That money could be allocated to people almost like an options coordination, but within an SRF, although only for people with an assessed higher need. Obviously, the package is a relatively small one—it might be $30 or $40 a week—but that is very significant in helping to look after people with higher needs within SRFs.

I have again met in the last week with a representative of the SRFs. They made three particular points, and I have raised this, as I promised I would, with the SRF representative. They require funds to provide care for people of various ages with moderate to high care needs, which is the very point that I have just been making. There is no assistance there at all at present and, because people are in an SRF, they are specifically precluded from other forms of assistance—home care—that otherwise could be provided.

Secondly, they require assistance to improve the capital works, and I think anyone who knows at least some of the SRFs around the community realises that they are now getting very old boarding houses and are in need of a significant injection of additional funds. In fact, one of the problems as to why there is a diminishing number of them is that, frankly, they just do not come up to standard, and a number of them have been bulldozed. Will the minister give some thought as to how some sort of assistance could be provided to allow renovation and/or the construction of new SRFs for those people who are clearly having to move out of existing facilities?

The third matter is a viability study to be undertaken by the SRF—and I think that a viability study is under way now, or was under way, at least, into the SRF sector. However, I understand that that study has been delayed, even though I know, from when I was minister, that DHS had put aside the money for the study. Will the minister assure me that the study will be carried out (if it has not been already), and will the results of that study be made available publicly? There are about 2 200 people who live in SRFs—I think that figure is right—and, clearly, those people face an increasingly uncertain future because there are very few alternatives for many of them to get housing.

The Hon. S.W. KEY: It is interesting that the previous minister and I as the current minister have an emphasis on the supported residential facilities area. In the very early days of my becoming minister, I received information—and was very concerned—about the lack of community care services available to residents because of the situations in which they find themselves, which the honourable member has identified. I think it was a couple of weeks ago that I met with the Supported Resident Facilities Association which raised with me all the issues which the honourable member has just raised. I am pleased to say that the committee which the former minister established is one that I am continuing. It is comprised of very much the same people identified by the previous government because of their range of expertise and views for the future about what we need to do in this area.

I have spoken to ministers in the areas of community services and housing—the former minister quite rightly identified that these problems go across a number of areas, particularly the portfolio areas for which I am responsible—and they have identified the same problems. On a state level we are looking at financial viability, which was initiated by the previous government, and that report should be available shortly. We are also looking at the framework to set up a review of the Supported Resident Facilities Act, which should come up shortly. All of this work is about to happen.

I have raised this matter on a national level and I understand that shortly we will have a telephone conference to try to see whether we can come up with an appropriate agenda item for the next meeting of either the Community Services and Disability Ministers Council or the Housing Council. I hope that issue will be covered on both a national and a state level. I am very aware of the fact that not only is limited information known about SRF residents but also we need to come up with a solution for people who sometimes are in good situations because of the generosity and support (particularly in the private sector) of the SRFs in which they reside, but there is also the issue that the honourable member raised about the need for maintenance and improvement of these facilities. This is an area of great importance to me. I am pleased to say that the interest and concern initiated by the former member is being carried on by this government, and I hope to have some strategies for dealing with this issue to report soon.

The Hon. DEAN BROWN: I am pleased to hear that. I thank the minister for her response, and I am sure the SRF Association will be pleased to hear it as well.

Mr O'BRIEN: What is the Income Confirmation Service (ICS) in Output Class 3.1—public housing (pages 6.13 and 6.14)—and why has it been introduced by the Housing Trust?

The Hon. S.W. KEY: The Income Confirmation Service is a national service developed jointly between the state

housing authorities and Centrelink. It will enable all state housing authorities to obtain electronically from Centrelink income details of mutual customers. The majority of public housing customers receive income support from Centrelink. The Housing Trust currently has approximately 50 000 tenants, 42 000 of whom receive a rental subsidy. When I was a member of the Housing Trust board, this was a major issue for a long time, and it is pleasing to see that now, in 2002, we actually have made some advances in this area.

The implementation of the ICS is planned for September/October 2002 and all other states will implement this system. When someone applies to the Housing Trust for assistance—whether it be an application for housing, private rental assistance or a bond guarantee—they are required to provide confirmation of their income. In order to do this, currently they are required to visit or telephone a Centrelink office to obtain an income statement every time they apply for services. The Housing Trust also asks all tenants who are in receipt of assistance to confirm the income of all household members at least once a year or when household circumstances change. This can be difficult for the customer, and delays within Centrelink offices can cause delays in their receiving assistance from the trust or, what is worse, they can lose their benefit or any assistance they are receiving which obviously places them in financial difficulty.

So, there are some real benefits in this system for, most importantly, the customer and the trust. We believe that this system will make the obligation to provide proof of income easier for all eligible customers, especially those who have difficulty in getting to a Centrelink office. We are thrilled that this electronic access to information will ensure that changes to income will be advised on a timely basis. It will lead, I am advised, to administrative savings for the trust, which are always welcome, and it should be better than the service that we have at the moment.

Mr O'BRIEN: What provisions in Output Class 3.1—public housing (pages 6.13 and 6.14)—and Output Class 3.3—crisis accommodation (page 6.16)—are the Housing Trust and other social housing providers putting in place to reduce youth homelessness in South Australia?

The Hon. S.W. KEY: The Housing Trust offers a range of housing services in response to the needs of young people. In terms of my ministerial responsibility in the area of youth, this is very pleasing. There is a particular focus on urgent housing. The Direct Lease Youth Priority Scheme provides priority access to medium term public housing for young people aged between 16 and 25 who are experiencing difficulties in accessing and/or maintaining a tenancy in the private rental market. The minimum lease period is 18 months. The scheme provides young people with an opportunity to work towards stabilising their housing situations.

I have had the opportunity of meeting a number of young people who have benefited from this scheme and said that it has given them an opportunity to do other things that they may not have been able to do because of their problems with housing. This has given them a bit of confidence to do other things. I am advised that last year 235 young people were housed under the direct lease program. That is a good number, but we probably need to try to increase it.

The trust also provides immediate housing for limited periods for individuals or households experiencing acute housing problems. These households normally find other housing options at the end of their lease. In 2001-02, 52 young people were provided with short-term housing under this program. Young people may also apply for long-term public housing. The trust, the Aboriginal Housing Authority and the Community Housing Authority all have waiting lists which target applicants with the highest needs. Applicants in category 1 must be homeless or at risk of homelessness.

There is also financial assistance for private rental market accommodation. Again, in the last financial year, the trust provided 5 928 bond guarantees and 5 153 rent in advance and rent in arrears payments to enable young people to access or maintain private rental housing. The trust also leases 257 properties, through the Supported Tenancies Scheme, to organisations which provide supported accommodation services to young people who are at risk or at risk of homelessness. Organisations supporting young people receive the highest number of properties under the STS program. The trust is currently reviewing the Direct Lease Scheme and other housing services with the aim of improving access and equity for young people. The trust is also working in partnership with Family and Youth Services to facilitate improved access to young people who are under the guardianship of the minister. The trust also has a homelessness working party that is exploring a number of strategies to minimise homelessness, including private rental market incentives and improved use of vacant trust properties. This working party has already identified young people as a major focus for that area.

The Aboriginal Housing Authority has a number of initiatives targeting young people. These include the West Coast Project for Secondary Students. The AHA has recently secured a property which will enable 10 students from the West Coast to live in supervised accommodation and to take up scholarships at college. The project is in conjunction with Port Lincoln Community Council with recurrent funding through the Aboriginal Hostels. The Gladys Elphick Hostel will provide accommodation for female students from rural and remote areas. There is an Aboriginal youth accommodation centre in Parafield Gardens which provides stable accommodation for youth on bail.

The South Australian Community Housing Authority has a focus, through the community housing organisations, on young people. Most of these organisations are large community housing organisation programs. They are supported with recurrent funding to enable skilled housing staff to be employed. In the past SACHA has allocated 32 walk-up flats to Lutheran housing with a proportion to accommodate young people. Aid allocations have gone to developing alternative solutions for housing such as DASH, a housing association which targets its services to young people, particularly the homeless. So, they are just some of the initiatives that we are looking at, and I think that is a very important focus for us to have.

Mr MEIER: I compliment the minister on her earlier statement in which I noted that she hoped to reduce homelessness by 50 per cent: all the best in that. My question relates to that, and it is mentioned on page 6.13 of Volume 2. What assistance is given to people who seek to rent Housing Trust homes to assist them with managing their finances? I say that because in the past 10 years in rural areas we have had specific people in to help farmers manage their finances, and I think that that has helped enormously. Good seasons also make a difference, but if you are getting a certain income you need to manage it. I cite a specific example. Not so long ago I was chatting with a fellow who had hocked some of his

gear: a welder, a tool-kit and a television. The value was between $800 and $1000 and I think he got something like $300 to $400 from Cash Converters. I had a look at the paperwork and I noticed that he was being charged what looked like 25 per cent interest.

I looked more closely and then I noticed that it was 25 per cent per month, which is 300 per cent interest per year. That is higher than what I am currently paying for my housing loan at roughly six per cent: in fact 300 per cent is a lot higher than 6 per cent. I remember when farmers were going broke because they were paying just over 20 per cent. I felt that it was totally outrageous and I tried to point this out to this person, but he said, 'It is only 25 per cent per month. It is not that much.' This person had a Housing Trust home and I felt that it was totally unfair that he was not being given more advice, guidance, assistance and help, because he used his hard-earned money to buy a television, a welder and a tool-kit. Now he has hocked them all. I doubt that he will see them again because he was not able to get the money to pay it back let alone pay the 300 per cent interest on it. What assistance are people who rent Housing Trust homes being given so that they can at least catch up and look to the future to purchase a home at perhaps a realistic rate of less than 300 per cent?

The Hon. S.W. KEY: Particularly as a House of Assembly member I know that this is something that we end up having to deal with in our electorate offices as well, so I understand the question very clearly. I am pleased to tell the member for Goyder that there are a number of programs that are available. I might get some assistance in a minute to amplify some of programs. There is what we call Successful Tenancies, which has a whole lot of support that is available. There have been a number of initiatives and demonstration projects in this area. Part of it is prevention, and I am sure that the member for Goyder would agree that some of these things can be avoided with early intervention, as well as trying to identify people who are at risk in the first place, who have perhaps come from difficult circumstances or might have had to leave their home because of a domestic violence situation. All sorts of issues can arise for people getting into difficulties with eviction.

Today I had the honour of launching a gamblers' kit for use by GPs, because of the connection between that as an addiction and a whole lot of other issues, including anxiety, stress and other problems that people have. The idea is that we try to have a holistic view about debt and financial management. As we all know, one of the other addictions that has had a lot of prominence recently is the area of gambling and its associated rehabilitation.

A number of projects relate mostly to debt, financial management and life skills development. A lot of collaborative projects are in place. Again, I acknowledge that some of these have been in place for quite some time under the previous government, with Family and Youth Services, the police, education and a whole range of non-government agencies. I am advised that up to July this year approximately 133 customers were involved in the successful tenancies program.

A number of projects have been put in place, including the debt management early intervention model, and one example is the work done by the Salisbury Housing Trust and Family and Youth Services which involves supporting tenants with a debt of over $1 000. Also, if people have bills from the emergency services area or for electricity, work has been done so that the organisation that is hoping to receive payment of the bill understands the circumstances and that arrangements have been made for those people. That is one of the services being offered.

There is the Northwest Families project, which involves Woodville and Port Adelaide—another Housing Trust, Family and Youth Services and Port Adelaide Community Health Service project. Again, that is looking at trying to address longstanding problems. Unfortunately, we are now getting into generational problems of families with difficulties, including debt management, disruptive behaviour, eviction and children's school attendance. A whole bundle of issues needs to be looked at.

I am also told there is a financial management project, and this is in various metropolitan and country locations. Again, it is a partnership model between the Housing Trust, Family and Youth Services and the non-government sector. The Supported Trust Tenancies project is mainly located in Noarlunga, Marion, Port Adelaide and The Parks. There is a Housing Trust and non-government sector Southern Junction Youth Project, as well as the Port Adelaide Mission. They are just some of the examples that should be complimented.

There is a focus on improving service delivery on a macro level through the Department of Human Services, and I think there has been some success in trying to make sure we have that collaborative approach between the different services. There is case coordination by the housing support coordinators, and this is another initiative that has proved to be helpful to people at risk in the sorts of circumstances that the member is talking about.

Lastly, there are linkages and protocols. The project called 'Good Practice in Multi-agency Linkages' is trialing DHS with regard to the coordinated delivery of service for people with complex needs. These are the sorts of programs that are in place. I am sure there always needs to be double or treble the amount provided, but they are the projects. I ask Ms Crearie if she has anything further to add.

Ms CREARIE: I think the Minister has given a really good coverage of the range of demonstration projects which we have in place and which are helping people with issues regarding debt and other tenancy matters. On a more general basis, Housing Trust staff do attend training and financial counselling courses, and that would be true also for staff of the Aboriginal Housing Authority. We do have a close relationship with Family and Youth Services.

In fact, in some of our trust offices we have an arrangement where we have FAYS people working on a part-time basis to provide financial counselling services. With respect to our advice to people going into the private rental market, we are very clear in our criteria to advise people not to overcommit in terms of the rental commitments that they take on.

Mr MEIER: In today's issue of the *Yorke Peninsula Country Times*, there is an article which indicates that emergency and supported housing is virtually non-existent on Yorke Peninsula. At the same time, I believe that we have been working on a category basis, namely, categories 1 through 4, for priority in Housing Trust accommodation. Therefore, when I hear that there is no such thing as emergency housing, I just wonder how accurate is that assessment. Is it really in this day and age more based on a person's immediate need versus going on the waiting list and waiting for some period of time?

The Hon. S.W. KEY: I understand the point made by the member for Goyder. We need to look at the whole context of housing. We are now delivering social housing as well as public housing. Obviously there is public housing, but by

'social housing' I mean that we are making sure that those most in need, and those at risk of being homeless or who are homeless, take first priority. It is true to say that throughout the history of the Housing Trust there has always been provision for emergency or crisis housing, and there has mainly been a provision to assist people who are escaping difficult situations such as domestic violence, family disruption or family violence. They have always had a priority, whatever government has been in power at the time.

With the category 1 to 4 system referred to by the member for Goyder, he would know as a local member that when people come to him for assistance with housing there is quite often a need perhaps to advocate the case a little stronger for people to get into category 1 and to be housed more quickly. As much as there are a number of criticisms of that process, I think it has worked quite well where the member of parliament has acted as an advocate.

I am pleased to say that I am finding that where issues of this sort are raised and they can be substantiated by professional certification to say that the person involved is in need of immediate housing, and also with the support of their local member, we have been able to achieve housing for that person. It is a matter of priority. To get onto the priority list, I think there are some fair steps that people need to go through.

My concern in answering this question is that, because of the limited resources, we do need to have a priority list, and that is the way in which the process is working at the moment. I do have some details here of the different demands for Housing Trust accommodation, but I am not sure if that is what the member was asking. I think it was more about whether we would be keeping that category system and what the access would be.

Mr MEIER: I wonder if we could have that incorporated into *Hansard*?

The ACTING CHAIRPERSON: Is it a statistical table of not more than one page?

The Hon. S.W. KEY: It is a statistical table of one page and a quarter. I seek your leave to have it incorporated.

Leave granted.

Social housing waiting lists

Issue

Applicant demand for social housing and allocation activity.

Key points

- Social housing sector comprises three components—SAHT, AHA, and SACHA
  - At 31 May 2002 SAHT waiting list was 29 262 compared to 29 241 in May 2001
    - Comprised 894 category 1; 4 664 category 2; 23 580 category 3 and 124 low demand applicants
  - At 31 May 2002 AHA waiting list was 1 450
    - Comprised 112 category 1; 55 category 2; 1 279 category 3 and 4 low demand applicants
  - At 30 June 2001 SACHA waiting list comprised 974 category 1; 581 category 2; 328 category 3—this information will be updated during community housing data collection for 2001-02
- Social housing providers have made the following allocations over the past 12 months:
  - SAHT has allocated to 4 017 households including 2 027 (50 per cent) category 1; 705 category 2 (18 per cent); 1 275 category 3 (32 per cent) and 10 low demand applicants
    - SAHT also allocated 416 houses to other special programs such as student housing, support tenancy scheme and on arrival migrants
  - AHA has allocated to 239 households including 141 (59 per cent) category 1; 28 category 2 (12 per cent); 68 category 3 (28 per cent) and two low demand applicants
  - As SACHA is not a direct provider applicant allocation outcomes are not available
- Waiting times for those housed were:
  - SAHT
    - 81 per cent of category 1 within six months and a further 15 per cent between six and 12 months
    - 51 per cent of category 2 within six months and a further 16 per cent between six and 12 months
    - 38 per cent of category 3 within six months and a further 11 per cent between six and 12 months
  - AHA
    - 79 per cent of category 1 within six months and a further 13 per cent between six and 12 months
    - 79 per cent of category 2 within 6 months and a further 14 per cent between six and 12 months
    - 68 per cent of category 3 within six months and a further 9 per cent between six and 12 months
  - As SACHA is not a direct provider allocation waiting times are not available.

The Hon. S.W. KEY: I think we need to ensure that the offer I have made to members of parliament, in terms of briefing either them or their electorate staff, should be taken up, so that access to a housing service is more immediate; and, secondly, if members do have any constituents who require assistance—and I know that my predecessor had this system—we will try to assess and assist that person as quickly as possible, particularly in terms of an emergency housing situation.

Mrs REDMOND: I am not sure whether my questions relate to housing, ageing or disability so, if the minister feels that other advisers would be better, I am happy to return to the questions after the dinner break. My first question relates to Budget Paper 3, page 3.10, under the heading 'Human Services', which states:

> Further details on the key portfolio initiatives funded as part of 2002-03 budget are:

and there is a series of them. The one in which I am particularly interested is the very first dot point, 'Additional group homes'. Another dot point, five down from the top, on the following page also relates to additional group homes and to the construction of new group homes for people who require supported accommodation. On the previous page (3.9), I assume that the two references to additional group homes appears because on the previous page there is one operating initiative relating to additional group homes and one investing initiative for additional group homes. I notice that they are being funded as part of the 2002-03 budget.

The first reference to additional group homes does not have anything for the first three years; indeed, there does not appear to be any funding until the year 2005-06, and the other initiative has no funding until three years in. I am just wondering whether the minister can confirm whether that means there is no funding for additional group homes in the current year's budget, notwithstanding the commencement of the statement on page 3.10.

The Hon. S.W. KEY: My Executive Director, Ms Roxanne Ramsey, has identified that this question relates to the disability portfolio, but we are happy to answer that question now if that is of assistance to the honourable member.

The ACTING CHAIRPERSON: Does the honourable member have any housing questions she wants to ask before 6 o'clock?

Mrs REDMOND: I suspect that my other two questions may also fall within the disability portfolio in the sense that they both relate to the table on page 6.23 of Budget Paper 4, volume 2. I also wanted to ask questions about the transfer of 50 Strathmont residents to an aged-care facility and about the ageing in place appearing therein. Do they both relate to disability?

The Hon. S.W. KEY: Yes.

Mrs REDMOND: I am happy to come back to them later.

The ACTING CHAIRPERSON: Does any member wish to ask a housing question? If not, we will proceed with the member for Heysen's question.

The Hon. DEAN BROWN: I bring to the attention of the minister that late last year five units adjacent to the Victor Harbor Caravan Park were purchased by the government. Those units, I think, were vacant by the end of February and I think that the minister will find that they are still vacant. Basically, they are emergency housing for people because there is no emergency housing at Victor Harbor. One tends to see a lot of people coming to Victor Harbor for holidays, or for other reasons, and suddenly they can find themselves without any housing. Could the minister look into making sure that those five units opposite or adjacent to the caravan park become operative so that people can access the homes as soon as possible?

The Hon. S.W. KEY: I may need to provide the deputy leader with some further information, but my understanding and the advice I have just received is that the five units are intended for a project with the Salvation Army and will now be used to accommodate youth on a short-term basis. That is in conjunction with the Southern Junction Youth Services. Two of the units will be managed by the Housing Trust and three by the Southern Junction Youth Services. I do not know whether that answers the honourable member's question but I thank him for raising the matter. I think that those units are now under some sort of supervision.

The Hon. DEAN BROWN: I have some omnibus questions. Should I raise them now or should I do that after dinner because they apply to all the portfolios?

The ACTING CHAIRPERSON: It might be a comfortable time to raise them now and then we can start after dinner with the disability questions: is that all right minister?

The Hon. S.W. KEY: Certainly.

Mrs REDMOND: The minister and I were under the impression that I would get an answer now to the question about the additional group homes.

The Hon. S.W. KEY: We can give an answer now. I will ask Ms Ramsey to do that.

The ACTING CHAIRPERSON: Deputy leader, we can keep your omnibus questions until the end.

Ms RAMSEY: As the honourable member stated, two funding allocations appear in the budget papers: one for the capital, which is in the out years; and one for recurrent funding. They are two quite separate projects. The recurrent money allocated this year will enable us to set up immediately supported accommodation for people with a disability. We will be negotiating with the Housing Trust and SACHA to get the capital and the physical infrastructure to set that up. So, the provision of those group homes is not contingent upon the capital infrastructure.

In the out years there is additional money to build group homes, and we will do that by either purchasing or building facilities. We will, in those out years, need to find the recurrent funding to staff and service those group homes, although there is a process of moving towards community-based care, which is to move those who wish to out of institutions and into community-based living, so that capital can be used as part of that process. However, it should lead to additional community-based supported accommodation for people with a disability, but they are two different funding strategies.

Mrs REDMOND: I understand the nature of the capital and recurrent funding. Is there somewhere in this budget that shows what funding will go into that supported accommodation in the next 12 months?

Ms RAMSEY: The capital funding?

Mrs REDMOND: Either. As I read it I could not see from where that funding was coming for either capital or recurrent in the next 12 months.

Ms RAMSEY: There is provision in the budget this year for recurrent funding for the services—not the building of group homes but for the recurrent staff to run group homes. An additional $1 million is in the budget for that, which will lead to additional supported accommodation for around 40 people. That is new money to go into community-based services. We will be negotiating with the Housing Trust and SACHA to use their facilities. That will mean that we will not need capital money to place those 40 people. But then in the out years, when there is money for the capital build, we will need additional recurrent money to put into capital funding.

The Hon. S.W. KEY: There was a question about Strathmont?

Ms RAMSEY: I am sorry, I cannot recall that question.

The ACTING CHAIRPERSON: We will get onto that after dinner. The members on my left have now had a run of four questions. I think that the deputy leader is indicating that, given we have just a few minutes left before the dinner break, it might be a convenient time for the omnibus questions.

The Hon. DEAN BROWN: That is right. For each of the years 2002-03, 2003-04, 2004-05 and 2005-06, and for each department and agency reporting to the minister, what is the share of the total $967 million saving strategy announced by the government, and what is the detail of each saving strategy? For each department and agency reporting to the minister, what is the share of the $322 million underspending in the year 2001-02 claimed by the government, what is the detail of each proposal and project underspent and what is the detail of each carry-on expenditure to 2002-03 that has been approved? How many reviews have been undertaken or are scheduled to take place within the portfolio since the government was elected; to which matters do these reviews pertain; and which consultant or consultancy organisations have been hired to undertake this work and what is the total cost of these contracts?

The Hon. S.W. KEY: Is that in addition to your famous 69 reviews, deputy leader? This was raised in question time.

The Hon. DEAN BROWN: I didn't carry out the 69 reviews; that is the trouble with that answer. How many of the 600 jobs to be cut from the Public Service will be lost from within the portfolio? Which initiatives contained within the government's compact with the member for Hammond have been allocated to this portfolio? How much will each cost, and will these costs be met by new or existing funding? Finally, how many positions will attract total employment costs of $100 000—that is per position per annum—within all departments and agencies reporting to the minister as at 30 June 2002 and estimates for the 30 June 2003?

[Sitting suspended from 5.57 to 7.30 p.m.]

Minister for Social Justice—Other Items, $9 020 000.

Additional Departmental Adviser:

Mr G. Beltchev, Director, Central and Southern, Metropolitan Health Division, Department of Human Services.

The ACTING CHAIRPERSON: Does the minister wish to make an opening statement in relation to ageing or disability services?

The Hon. S.W. KEY: Yes, thank you; I do. I acknowledge that the government is happy for the opposition to field most of the questions, considering the deputy leader's absence. Thank you very much for the opportunity to introduce the social justice portfolio. I would like to acknowledge my media liaison officer, Anne Hallion, and Sue Bath. This government is committed to making a real difference to the lives of disadvantaged South Australians.

Tonight I want to focus on the long-term challenges involved in achieving that and talk about some of the ways in which the portfolio has begun to tackle those challenges. In a healthy, functioning society all citizens need to be able to shape their own lives and the lives of their families, as well as contribute to the wider community. Many South Australians are prevented from reaching their potential and from contributing to their community by poverty and inequality.

The Rann Labor government is committed to the long-term goal of unlocking the potential of all South Australians so that they are participants in and contributors to their own communities. This commitment—to a genuine equality of opportunity—is the modern Labor definition of social justice. The social justice portfolio provides the means of protecting the vulnerable. The portfolio, through the Department of Human Services, has a particular role in, amongst others, caring for children who cannot live with their natural families; supporting young people at risk; and assisting people with disability to participate in, enjoy and enrich their communities.

The social justice portfolio is a concrete expression of the belief that everyone matters. The problems we deal with have roots and many causes. For example, the problem of homelessness is often the end result of a combination of family conflict, mental illness and substance abuse which can be created or exacerbated by unemployment or financial hardship. These factors can, in turn, be affected by commonwealth economic policy or global economic trends.

The social justice portfolio is concerned with dealing with these complex issues, assisting individuals, families and communities to find better ways of managing the challenging pressures of modern life. The social inclusion initiative of the Rann Labor government is a specific initiative to focus on addressing complex social justice issues. The Social Inclusion Unit is a high profile board, serviced by a secretariat that has the specific responsibility to examine the broad context of social inequalities.

The Rann Labor government does not want just to manage problems but wants in the long run to solve them, beginning with small steps which build a platform on progressive reform. There are a number of obstacles to overcome. The first of these is the magnitude of the problem. There are 216 000 South Australians, including 65 000 children, existing below the poverty line. This level of poverty is much higher in rural areas, with 32 per cent of the households in rural towns reporting incomes of less than $15 000. Poverty and inequality are widespread. They are also deeply rooted in certain population groups and communities. We are all familiar with the groups of suburbs in The Parks area that consistently score in the 10 poorest postcodes in Australia. We are also all too familiar with the entrenched nature of poverty and disadvantage in the indigenous community. It is shocking to think that in 2002 the life expectancy of our indigenous women is 19 years less than that of the broader community or that indigenous men will die, on average, 18 years earlier than other men.

A particular challenge for my portfolio is reducing the over-representation of Aboriginal young people in child protection and the juvenile justice system. These are daunting challenges, not within the capacity of any one department to solve. Therefore, the Rann Labor government is focused on building partnerships internally within government departments and externally with the community. It will be the collaborative efforts and investments of the full community that achieve the changes that the government desires. The partnerships will bring together a range of perspectives and expertise to focus attention on reducing poverty and its effects over time.

The partnerships between social justice and other portfolios, including key partnerships with education, justice, health and housing, are the foundation. The partnership with health and housing is well developed through the role of the Department of Human Services. This department combines health, housing and the community services. It creates opportunities for integration and pooling of resources through a single chief executive, who is jointly accountable to me and to the Minister for Health. This arrangement gives me access to a far greater research infrastructure than would be possible in a stand-alone department of social justice. However, the separation of the health and social justice portfolios ensures that each area gets the level of ministerial and cabinet attention that it deserves.

The integration of health, housing and community services also provides great opportunities for collaboration between community health and community services, particularly in areas of early intervention, mental health and public housing. Another key partnership will be with justice, as many of our clients also have dealings with the police and courts. An effective partnership with the justice portfolio will result in alternatives to detention that will keep families together, keep young people away from hardened criminals and save enormous amounts of government time and taxpayers' funds.

The partnership with non-government agencies is also essential. There is a range of large and small non-government agencies that receive funding from the Department of Human Services. In addition to the funding received, these agencies invest further resources into the programs they deliver, using the contribution of volunteers' energy, ideas and financial donations. The Working Together process provides a framework through which the department can discuss and resolve issues with its non-government partnerships. My predecessor (Hon. Dean Brown MP) developed Working Together, and I congratulate him for this initiative. I intend to strengthen this framework as an indispensable part of building a more just South Australia.

Working Together was created to redress some of the damage caused by the cycles of competitive tendering that had soured relationships and imposed unreasonable demands for compliance on non-government agencies. The ongoing operation of Working Together enables government and non-government agencies to work together constructively on solving problems, instead of arguing the terms of their relationship.

Another key partnership is the partnership with families and communities. The government recognises that the family, in all its forms, is the major informal institution in our social structure. Positive, healthy families underpin confident and stable communities. While children and young people do have independent rights, their health and wellbeing is

primarily promoted through caring and functional families. The importance of participation is another key theme of this government and this portfolio. There can be no partnership without participation. Families, non-government agencies and communities will not see themselves as partners unless they feel they can genuinely participate in the decisions that affect them.

A good example of this approach is the government's response to the issue of increasing violence in indigenous families. This response has focused on community-developed local action plans, which begin with regional forums. The first regional forum on Aboriginal family violence was conducted in Ceduna on 12 and 13 June this year. The second challenge confronting the portfolio is the need to manage the effects of broader social and economic trends that are sweeping across society. These include the effects of globalisation, such as the growth of the working poor, through to demographic changes such as ageing. The ageing of the population has implications for social justice.

By 2051 it is predicted that the proportion of the population aged over 65 years of age will reach 26 per cent, or double the level of 1997. This places a great challenge on government to have in place effective and appropriate health service infrastructure to meet demand. Not all the effects of an ageing society are negative. For example, the scarcity of young people is likely to lead to their being more highly valued. Youth unemployment will not be tolerated, as it represents a waste of scarce productive capacity. Also, because of the relatively small number of young people, it will be possible for government to have a major impact on employment and school retention policy. However, this still leaves the problem of how to manage the increased demand for health and support for elderly South Australians.

The key strategy here is prevention. If people grow old alone, if they lack adequate nutrition and exercise, or if they have a lack of stimulation, they are much more likely to require government support. If, however, people remain active, eat well and participate in their community, they are more likely to remain independent and healthy. One of the best ways to avoid the negative consequences of ageing is to build a socially just South Australia. In this case, social justice is a commonsense investment in the future, rather than a radical theory. Realising this investment will require close collaboration between the health, education and social justice portfolios.

Although preventive strategies will assist in minimising the hardship and cost of ageing to individuals and to the community as a whole, there is still a need to invest in services to support older South Australians. The 2002 budget outlined a number of initiatives in this regard, including:

- An additional $16.5 million over four years for the Home and Community Care program. This brings the total funding for HACC to $163 million over four years. The additional funds will be used to resource early and rapid intervention and preventative strategies to assist older people and the disabled, along with their carers, to maintain healthy and active lifestyles within the community.
- The allocation of $2.63 million to complete the construction of the $5.75 million aged care facility at Northfield.

The third challenge facing social justice is the legacy of neglect of public and community services. This government is committed to rebuilding services as a major direction. In the social justice portfolio this rebuilding of services has taken two forms. Where possible, we have increased funds to services that are struggling under high levels of demand. One example of the government's rebuilding services policy is the increased funds to the Gamblers Rehabilitation Fund. Problem gambling continues to adversely affect some families in the community, with increasing numbers of people needing to access support services. The funding of these programs has not kept pace with need.

The state government has responded by releasing an additional $4 million over four years for the Gamblers Rehabilitation Fund. This will assist in providing additional counselling and rehabilitation services, reducing waiting times and improving access to Breakeven counselling services that are in demand by people with gambling problems and their families. Community education programs informing people of the consequences of problem gambling and providing alerts to encourage those affected, their families and friends to seek help earlier, will be supported through the fund. Research into problems associated with gambling will also receive funds.

Another area where the Labor government is beginning to address years of neglect is that of youth at risk. For some years, community organisations have pointed out that young people do not receive a response from the government until they are in crisis. The allocation of $500 000 to employ more youth workers, support young people to stay at school and fund youth drug support programs is a first step in rebuilding services for young people. Other areas where the Labor government is beginning to redress years of neglect are disability services, where $1.8 million has been allocated to the budget for 10 new group homes.

This will include accommodation at Port Lincoln and Mount Gambier for people with intellectual disabilities and accommodation in the metropolitan area for people specifically with Prader-Willi Syndrome. The injection of this funding should help in reducing the waiting list for accommodation. The state government will continue to provide $6 million for unmet needs as part of the Commonwealth-State Disability Agreement. Our rebuilding in some areas cannot begin until functionality and roles have been redefined. We need to take some time to rethink our directions and be certain that each initiative is consistent with our overall goal and conforms to our comprehensive reform agenda.

In March 2002 the state government announced a major review into child protection in South Australia. The review, chaired by Ms Robyn Layton QC, is to report to government on effective strategies to improve the provision of child protection services in this state. The terms of reference for the review are established and a comprehensive discussion paper has been widely distributed. Public consultation is occurring. Written submissions were forwarded to the review by 28 June this year.

However, as I mentioned during the passage of the child protection legislation, I am prepared to arrange for late submissions from members who would like to contribute to the review. A broader reform process of the whole of the social justice portfolio is also under development to provide a comprehensive review of the whole service system. However, the implementation of this process will be mindful of the review fatigue in the department, and the broader community services sector.

The fourth challenge to achieving social justice is the complex and interrelated nature of disadvantage. It is common to find disadvantage occurring in a mutually reinforcing cocktail of problems. Youth homelessness, for

example, often begins as the result of family conflict or sexual abuse. It can then become intertwined with substance abuse and health problems. A response that treats the whole person rather than a series of individual problems is required for sustainable change. Integration focuses on identifying holistic approaches and solutions.

A good example of an integrated approach is the Port Augusta Aboriginal Families Project. This project has been developed by the Port Augusta Family and Youth Services, the South Australian Housing Trust and the Port Augusta Hospital to assist Aboriginal families who are confronted by multiple problems. This project is making a measurable difference to the lives of Aboriginal families. Formal evaluations have identified the prevention of drift to alternative care, repayment of debt, return of children to the education system, discharging of criminal justice orders and so on.

The fifth challenge to the work in my portfolio is how to influence the commonwealth instead of simply reacting to it. The commonwealth is a key player in social justice issues in South Australia. Its income support and employment policies all impact on South Australians and on the Department of Human Services. Some of these impacts are positive, such as the jointly funded commonwealth-state programs like the Home and Community Care Program; the Commonwealth-State Disability Services Agreement, which received $6 million in the July budget; and the Supported Accommodation Assistance Program. The challenge for the social justice portfolio and the Department of Human Services is to negotiate these agreements on the most favourable terms possible to South Australia.

This requires the policy and research capacity to mount cogent arguments to both the commonwealth and state agencies. I would also like to use the policy and research capacity in a more dynamic way to influence other commonwealth policies. For example, the increase in breaching of people on Centrelink benefits inevitably increases hardship and drives people to seek financial counselling and assistance from state agencies and state funded bodies. If we had monitored these impacts, we would have evidence to argue for changes to the policy even as it was being introduced. However, because we did not monitor the impacts, we have not been able to press for changes as effectively as we may have been able to.

Another avenue for influence is participation on ministerial councils. I was recently appointed as the representative of the Community Services and Disability Ministers' Conference to the Ministerial Council on Gambling. This appointment provides access to the commonwealth Minister for Family and Community Services as well as the opportunity to work in concert with other states and territories to resist policies that are manifestly ineffective or inequitable. I would like to acknowledge here the efforts of my predecessor in the national gambling policy, which I believe assisted my appointment in this council.

I am very proud to be associated with this new portfolio. I believe that this can be the start of a long process of reducing poverty and making the people who use our services feel empowered, respected and full members of our society. But no-one is more aware than I am of the size of this challenge, the limits of the resources available and the number of things that can go wrong in realising this goal. So, although I have high hopes, these hopes will be built on small beginnings. I will focus the portfolio on achieving a series of small successes over time and build momentum for fundamental change. For a long time the social justice services—agencies such as Family and Youth Services with its role of child protection—and other units providing a range of small anti-poverty programs have struggled with society's most difficult cases.

For over two decades, there has been a widespread and profound fatalism about the ability of this portfolio, and government in general, to do anything more than manage these problems as crises. In many ways, the agencies for which I am responsible are seen as the end of the line; the last stop in a downward spiral of self-reinforcing disadvantage. In fact, the statutory work of my portfolio—for example, child protection—has led to the concept of 'the agency of last resort'. I believe that we may have an opportunity of changing this by harnessing new energy and optimism through social inclusion. Not only will we protect the vulnerable and support those in need, we will also launch them into full participation in society. I would at this stage like to acknowledge the work of all the employees in DHS for which I am responsible through the portfolios that I have had the honour of being given. Their work is appreciated, and we want to make sure that we maximise the outcomes from that work.

The ACTING CHAIRPERSON: Member for Goyder, in view of the illness of the deputy leader, is there an opening statement, or do you wish to proceed with questions?

Mr MEIER: No, I do not have an opening statement, but I would take this opportunity to thank the minister for her words and to compliment her on that statement: it was most appropriately said. I also wish to thank her for acknowledging the efforts of her predecessor, the Hon. Dean Brown. I think it is rather ironic that the shadow minister for disability services has a disability this evening: he has a pinched nerve in his leg, which he has had now for two weeks and which does not seem to be improving. In fact, as Opposition Whip I instructed him go home when he indicated that he was in considerable pain. This may mean that there will not be quite so many questions because, whilst he briefed me on some of the questions, he felt that some of them were more appropriate for him to take up with the minister personally. My first question relates to the Fleurieu Volunteer Resource Centre. I am given to understand that the centre has received $13 000 per annum in the last few years, I assume. Can the centre expect to receive an annual grant and, if so, how much? Is there any increase on the $13 000 that it has received in the last year?

The Hon. S.W. KEY: I am pleased to report that there are a number of services in the southern Fleurieu Peninsula of which I can advise the member. In particular, with respect to the service that I mentioned before—the Home and Community Care program—following the presentation of the commonwealth budget, and subject to the appropriate bill being passed in federal parliament, the commonwealth HACC offer is estimated to be $58.6 million, to be matched by the state contribution of $36.5 million. This will bring the total HACC funding in South Australia to a $95 million figure, which is recurrent. Obviously, this will translate into the different regions, and at least $1 million of the HACC funding is allocated specifically to the Frail Aged Carers' Support Service in the southern Fleurieu. Because of the awareness of the increase in age of older people in the southern Fleurieu subregion of the Hills, Mallee and the southern planning area, it is acknowledged that services and support systems will need to be put in place to assist that

particular population. That is certainly part of our planning in the HACC area.

In 2001-02, the Department of Human Services funded a project called A Better Social Planning Model for the Development of Retirement Villages in the Southern Fleurieu Region of South Australia. This project was looking at developing and documenting a social planning model, and also a process of approval for retirement villages and other developments and supports in that region. There also has been a project called The Moving Ahead Project, for which some $7 000 was allocated, which was auspiced by the Victor Harbor council, which looked at (and I quite like this term) the positive ageing task force. The member is nodding, so he also obviously likes that term.

The HACC Amending Agreement looks at the differences in regions and responds to those differences in a positive way. Having been through the first round of HACC funding and the auspicing documents, I am pleased to say that, on my reading of them, there appears to be a real emphasis in regional areas, and the Southern Fleurieu seems to be well represented in the allocations.

In the disability area, through the options coordinator, about $210 000 per annum has been set aside to look at case management issues as they arise, particularly on Kangaroo Island. Under the Intellectual Disability Services Council, there is an allocation for the southern area of $148 200 per annum for various day options and respite services. I think the member will agree with me that the respite issue has been raised with all of us by constituents.

In the area of housing (and some of this was discussed in terms of my previous portfolio), there is a crisis accommodation program. I mentioned the $1.3 million that was allocated to a boarding house project in Victor Harbor. As I understand it, SACHA is spending $557 000 on building six units associated with that boarding house project. Community housing is looking at six units under construction in a joint venture with senior citizens at Yankalilla at a project cost of $589 000 (at this stage). I mentioned the Victor Harbor project, which is being coordinated by SACHA. On Kangaroo Island, three units have recently been completed at a project cost of about $320 000, and at Port Elliott 10 units were opened by me on 5 July with the assistance of the local member and former minister. The cost of that project was $1 million. So, considerable resources have been put into this area. I mentioned before the work with the Southern Junction Youth Services that was being looked at in the Victor Harbor region as well. Those are some of the projects that are being looked at. They are seen as Southern Fleurieu achievements.

Mr MEIER: I take it, therefore, that the Fleurieu Volunteer Resource Centre can expect to receive its $13 000-plus this year?

The Hon. S.W. KEY: I will defer to Roxanne Ramsey to answer that question because she is closer to the actual operation.

Ms RAMSEY: I will need to know the funding source. I think it is probably the Family and Community Development Grant program. If I could ascertain the funding source, I could be a little more confident in my answer. If it is the Family and Community Development Grant program, the funding is likely to be recurrent so that it rolls over. If it was a one-off grant, I would need to understand what the conditions of that grant were before I could confidently answer the question. If further details could be provided, I could answer your question.

THE ACTING CHAIRPERSON: Minister, would you like to take that question on notice? Would that be the simplest way of dealing with it?

The Hon. S.W. KEY: If that reply has not answered the honourable member's question, I am more than happy to provide further details. As Ms Ramsey said, we probably need a little bit more information about the source.

Mr Meier interjecting:

The Hon. S.W. KEY: The member is asking me about the term which I used and which, I must say, does appeal to me. It is the 'positive ageing task force'.

Mr MEIER: It certainly does appeal to me. In fact, it reminds me of a Bob Dylan song. I cannot recall the title, but in the lyrics he sings:

Ah, but I was so much older then, I'm younger than that now.

I think that applies to many of us. I love those words. My next question relates to HACC funding. I note on page 6.52 of volume 2 of the Portfolio Statements (and the minister referred to this in her opening statement) that there is state matching of HACC—$3 million. That is indicated as an actual variation. I assume that means that it is an increase. In her statement, the minister said that it was an extra $16 million over four years. If that is so, I would like to check whether the $3 million is the first amount of that increase. I assume that $3 million will grow in line with the CPI over the following three years. Is my assessment correct?

The Hon. S.W. KEY: The point I made in my opening statement was that the state budget for 2002-03 for HACC funding is $3 million, with $16.5 million over the next four years. So, that is the funding for 2002-06 inclusive. This is a positive situation for South Australia. As the member would know, the state contributes about 40 per cent of this funding under a joint commonwealth-state initiative. The state will fully match this offer with approximately $36.5 million, bringing the total HACC funding for South Australia to $95 million. That is an $8.4 million increase over the 2001-02 funding.

Mr MEIER: My next question also relates to page 6.52—the Commonwealth State Disability Agreement (CSDA) to which the minister referred in her opening statement. It indicates that there is an extra $8.835 million. The shadow minister for disability services pointed out to me that under the previous government an extra $6 million was put in last year and an extra $6 million in the year before. I think he indicated that that was as a result of an agreement with the commonwealth. It would therefore be rather interesting and surprising if those two amounts of $6 million (and that may not have been from the commonwealth; let us assume it was an extra $6 million from the state) suddenly increased to $8.835 million. Is that increase really only $2.835 million rather than the stated amount of $8.835 million for the coming year, or was there a carryover from the previous year?

The Hon. S.W. KEY: I will ask Frank Turner, our funding expert, to answer that question.

Mr TURNER: I refer the member to page 3.9 of Budget Paper 3—table 3.10. On the second line there is an amount of $8.8 million for additional state funding for disability services. That comprises a continuation of the unmet need money, which is the $6 million referred to, plus growth money for disabilities being the balance.

Mr MEIER: I take it therefore that, whilst $6 million extra was provided last year and the year before, in fact, this year it is an extra $8 million-plus.

Mr TURNER: No. The previous funding was only provided on a two-year basis in the forward estimates. Prior to the budget the forward estimates did not in fact reflect any continuation of that previous $6 million. So the decision in this budget was to continue on that previous $6 million and to provide the growth funding that was required.

Mrs REDMOND: There are just some things that I want to clarify in the budget papers. I refer the minister to volume 2 of Budget Paper 4, page 6.23, Output Class 5: Accommodation and Support. There are two items there on which I seek clarification, the first being:

- Create more community accommodation places, with a concomitant reduction in the number of residential places in institutions: 50 Strathmont residents to move to aged care facility.

I assume that those people would be of an age where they would normally be fitting into an aged care facility and have been in Strathmont for some time, reached a certain age and they are going in. Do they then have to go through the same sort of ACAT assessment to be placed into an aged care facility, or do they in any way usurp a position?

The Hon. S.W. KEY: As indicated before the break, Roxanne Ramsey, who is the Executive Director, will answer this question.

Ms RAMSEY: They are people who are eligible for aged care places and will need to go through an ACAT assessment, if they have not already done so. They are people who have reached the age where they are eligible for aged care and require aged care and, in fact, most of them are quite severely disabled, so they are aged and disabled. Historically a lot of those people would probably not have lived to this point, so it is actually something that is relatively new in the disability services, where we are required to provide aged care services to people with a disability.

Mrs REDMOND: Part of that answer makes me happy because I know that in some states, previously at least, there had been situations where young people with a disability were placed into aged care facilities, which was inappropriate. I am pleased to hear therefore that the people you are placing are aged. Are any special arrangements made in terms of catering to their disabilities once they are placed into an aged care institution?

Ms RAMSEY: Yes. The services will still be provided by the Strathmont Centre, so they are people who have expertise as well as experience in caring for older people with disability. One of the processes that Strathmont Centre is going through is not just identifying the residents from Strathmont who are suitable to move to the aged care facility, but also working with staff to identify which staff would like to accompany a lot of the aged people. In fact, over the last couple of years aged people tended to be located in the two villas. That accommodation will be closed and those people will be moving to Strathmont. So, apart from physical changes, they are effectively just going with staff they know—the relatives have worked with staff—and they are really just moving to much improved physical accommodation.

Mrs REDMOND: I seek clarification about a dot point in the same table on page 6.23. As I understand 'ageing in place' the essence of it is that you may perhaps be in a hostel and, as you grow more infirm, rather than being shifted to a nursing home, arrangements will be made to accommodate you in that place. So you stay there, even though the care provided is nursing home care and eventually, I suppose, even palliative care. Does that extend back in the other direction into the community so that ageing in place will take place in the home or a standard retirement village that might be commercially operated, rather than ones that start at hostel stage?

Ms RAMSEY: Increasingly people are being accommodated in community-based accommodation. It is certainly something that is a preference for the disability services as well as most of the people concerned. There are, however, people who have lived in institutions for most of their lives and, in a sense, it is a bit cruel to move them unless they wish to be moved. So, they are moving through the institutional setting but, as they die, we are not replacing the beds in the institutions but tending more to move people into community-based care.

As they age, we are expecting that the services will be accommodating them and they will be ageing in place. We will probably have to have enhanced support services, not because of their disability but because of their ageing. It is a relatively new phenomenon for us that we in the disability area are now needing to accommodate not just the disabled but the ageing. We are also working quite closely with aged care services—the non-government services—to assist them in understanding the needs of people with disabilities, and they are very open to this, so that we do not have disability institutions or nursing homes for aged people so much as people with disabilities who are able to move into generic nursing homes. They often need additional support—extra support—but should be able to access generic nursing home accommodation.

Mrs REDMOND: On page 6.24, there is a table entitled 'Output 5.2—Accommodation and support for people with disabilities, which deals with the costs. The costs for the year just ended shows that the average cost per government-provided place in an institution was $67 671, compared with the cost in a group home of $38 410, and that indicates that it is significantly cheaper to provide group home accommodation than institutional places. But the targets for this current year then left me confused because, whereas the average cost per government-provided place for an institution has been reasonably significantly increased, the targeted cost per place for a group home is significantly reduced. I wondered whether there was some explanation as to why that would be the case.

The Hon. S.W. KEY: I am advised that it depends on how the counting is actually done to account for that service. We can either give you an answer now or I can provide some further information.

Mrs REDMOND: I am happy to take it on notice. On page 6.25 in the second table, Output 5.4, the figures given for the estimated result and the target for next year for the number of offender bed days in remand and detention remained the same. There is a little explanation at the bottom saying that it was a provisional estimate only due to current data not being available, but it was to be available in early July. I assume that is why there is no change in those figures from last year's result to this year's. But, given that the statement was that those figures would be available in early July, can I get some new figures? Again, I assume you may have take this on notice.

The Hon. S.W. KEY: I am more than happy to make that available when it is available to us. I do not know if we will be able to reach the deadline that has been set by the estimates committee: we may need a bit of an extension on that time. If you are happy to take my assurance that I will provide that information, we will certainly do that.

Mrs REDMOND: I am happy with that. You mentioned the regional forums regarding domestic violence in Aboriginal communities and the fact that you held the first one at Ceduna. As it happens I am reasonably familiar with the Aboriginal community in Ceduna. Can I ask whether that included Koonibba and the surrounding area? My experience of Aboriginal communities on the West Coast generally is that one needs to take a great deal of care to make sure that you make cars and meals and all sorts of things available to actually get community participation in most events. Even the distance of 40 kilometres from Ceduna out to the Aboriginal settlement would not be easy for many Aborigines to overcome in those communities. I wonder how far-reaching is that, or will there be separate regional forums for those more outlying communities?

The Hon. S.W. KEY: My information is that it was conducted in Ceduna, as I said. I do not have any details about how far the network went for that particular forum. That might be something on which I will need to seek further information. I hope that is okay. I am advised that other forums are also to be held, admittedly not in the same area but at Oak Valley and Port Lincoln. So, a number of forums are planned for that region. I am not sure that I can answer the question further.

Mrs REDMOND: Places like Oak Valley and Yalata are very much related, but they are long distances apart and, if it is held only at Oak Valley, Yalata might miss out because it is 200 kilometres from Ceduna and 300 from Oak Valley.

The Hon. S.W. KEY: I am not sure of the answer to that question, but we will certainly investigate that. I am happy to make the information available.

Mr MEIER: Just as in the Housing Trust we have seen a significant shift over the last few years from the Housing Trust sector to the private sector, so in the disability sector I believe that may be the way we have to go in the future. I was disappointed when, in the last 12 months I think it was, I raised with the previous minister an application from a person in my electorate who was happy to build some three or four units in her backyard to house disabled persons. She actually had a close association with one of the disabled groups. The answer came back, 'No, it is a private enterprise venture and no government funding is available.'

Is any thought being given to seeking to move in that direction, so that the government perhaps will not have to provide all the accommodation for the disabled, and that some arrangements can be made with the private sector to provide assistance to build appropriate accommodation?

The Hon. S.W. KEY: I just know through my own experience in the electorate and also now as minister that there are a number of requests to come up with some more flexible living arrangements for people with disabilities. One of the striking things particularly in the community cabinets that I have attended with the CEO and the Executive Director is the request that accommodation be made available for people with disabilities. One of the reasons for that is, as I mentioned earlier, that our population is getting older; a lot of parents and carers out there are also getting older; and they are really concerned not just about respite care but about the future for their dependants and the people for whom they care.

So, as we have said in different parts of tonight's questioning, we are investigating opportunities for joint partnerships, and one of those involves looking at the private sector. South Australia, particularly through the Housing Trust, has had quite a long history of joint ventures and joint partnerships. This is one of the positive attributes of having all these portfolios under the one minister. It encourages the housing portfolio to sit down even more than they do now with the disability and ageing portfolios, as well as the Family and Youth Services and Community and Youth Services areas.

Those sorts of proposals have been put to me already, and we are investigating them and following them up. I think with the very good record that both the Aboriginal Housing Authority and the Community Housing Authority have had, there are some great models available for there to be different forms of accommodation, particularly for people with different or complex needs. They are the sorts of things we are looking at.

The member mentioned the non-government sector. There are a lot of projects, and I have had the pleasure recently of opening some of these projects where the non-government sector, the church sector in particular, has been putting forward accommodation models for people with different needs. I think this is the way of the future, and if people do have proposals I am very keen to hear about them to see how we can maximise this idea of people living not only comfortably and securely but also with the sort of support they need. If we are going to be serious about deinstitutionalising people with issues and problems, these are the sorts of alternatives that we need to research and fund properly.

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

ADJOURNMENT

At 8.22 p.m. the committee adjourned until Wednesday 7 August at 11 a.m.