HOUSE OF ASSEMBLY

Tuesday 22 June 2004

ESTIMATES COMMITTEE A

Chairman:
The Hon. R.B. Such

Members:
The Hon. D.C. Brown
Ms F.E. Bedford
Ms L.R. Breuer
Mr E.J. Meier
Ms E.M. Penfold
Mr P. Caica

The Committee met at 11 a.m.

Department of Human Services and Department for Families and Communities, $1 838 751 000
Administered items for the Department of Human Services and Administered items for the Department for Families and Communities, $166 349 000

Witness:
The Hon. L. Stevens, Minister for Health, Minister Assisting the Premier in Social Inclusion.

Departmental Advisers:
Mr J. Birch, Chief Executive, Department of Human Services.
Mr G. Tattersall, Director, Financial Services, Department of Human Services.
Mr P. Gardner, Acting Executive Director, Corporate Resources, Department of Human Services.
Mr. R. Michael, Executive Director, Corporate Resources, Department of Human Services.
Mr P. Jackson, Director, Asset Services, Department of Human Services.
Dr D. Filby, Executive Director, Strategic Planning and Policy, Department of Human Services.
Ms R. Ramsey, Executive Director, Country Services, Department of Human Services.
Mr G. Beltchev, Director, Major Projects, Department of Human Services.
Mr B. Dixon, Executive Director, Aboriginal Services Division.
Mr C. Lemmer, Chief Executive, SA Ambulance Service.

The CHAIRMAN: Welcome to Estimates Committee A. The estimates committees are a relatively informal procedure. There is no need to stand to ask or answer questions. The committee will determine an approximate time for consideration of proposed payments and to facilitate the change-over of departmental advisers. Have the minister or the lead speaker sorted out a timetable?

The Hon. L. STEVENS: Yes, we have: until 4.30 this afternoon.

The CHAIRMAN: Changes to the committee membership will be notified as they occur. If the minister undertakes to supply information at a later date it must be submitted to the committee secretary by no later than Friday 23 July. The minister and the lead speaker can make opening statements, preferably brief. There will be a flexible approach to giving the call for questions—approximately three questions per member. 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 relate to lines of expenditure in the budget papers. I do not ask members to list those unless they stray from the topic because it takes up a lot of the committee's time. Members unable to complete their questions can have them included in the House of Assembly *Notice Paper* as questions on notice. There is no formal facility for tabling of documents, however, documents can be supplied to the chair for distribution. Statistical material no longer than one page can be incorporated in *Hansard*. All questions are to the minister and not to the advisers.

Any questions involving advisers must be through the minister. I point out that television coverage is allowed from the northern gallery during estimates. I declare the proposed payments reopened for examination and refer members to the appropriate budget statement and portfolio statement lines. Minister, would you like to make a statement, please?

The Hon. L. STEVENS: Thank you, sir. I welcome everyone to today's session. I look forward to a positive opportunity to talk about health services. In this budget spending on hospitals and health services by the South Australian government will be increased to a record $2.659 billion in the forthcoming financial year. This represents 27 per cent of the state budget. New spending measures over the next four years total $432 million. Health remains the state government's number one priority as we reform and rebuild our services through the implementation of the Generational Health Review.

Demand for health services continues to grow. From July 2003 to March 2004 there was a total of 188 331 admissions to the metropolitan public hospitals. This number represents nearly 8 550 more patients than at the same time the year before. During this period, an additional 652 elective surgery procedures were undertaken compared with the year before. However, on the demand side, an additional 705 new patients were also identified as requiring elective surgery. This demand is not only in the metropolitan area but it is also evident across the state. Health is not just about hospitals, it is also about helping people stay out of hospital, and we are increasing funding for that as well.

New initiatives receiving funding in this budget for the next four years include:

- $239.275 million for increased costs and demand in metropolitan hospitals;
- $27.765 million for the Clinical Information System;
- $20.528 million for improved care options to reduce the number of people who need to go to hospital or reduce the duration of their hospital stay;
- $2.5 million towards the $14.5 million Flinders Medical Centre Cancer Care facility—a joint initiative with the Flinders Medical Centre Foundation—which is a project that, as the committee may remember, was announced but not funded by the former minister;
- $13.811 million to provide 24-hour mental health crisis intervention, registrar support and expansion of community based support. This funding will commence in 2005-06;
- $4.257 million to fund additional employment costs for nurses in country hospitals;

- $1.703 million to increase transport assistance for rural patients;
- $2.802 million for supported accommodation at Catherine House which, as members probably know, receives people exiting from Glenside Hospital;
- $5.427 million to cover health system cost increases; and
- $4.17 million to fund structural reform within health services.

We recognise the pressure that our hospitals are under to do more each year. This budget includes $12.5 million in extra funding over the next four years to meet the increasing demands for elective surgery and dental work. A total of $8 million will be allocated over the next four years for elective surgery. This is in addition to the extra $9.5 million allocated over four years in the 2002-03 budget for elective surgery: it builds on the extra $5 million allocated in March this year to undertake more than 1 000 extra surgical procedures.

This budget also includes an extra $4.5 million over the next four years for dental treatment, and this is in addition to the extra $8 million over four years for more dental work that we announced in the 2002-03 state budget. While the waiting lists for general dental care have fallen from 90 000 in 2002 to 62 000 by December last year, there is still a long way to go to bring down the lists which grew to over 100 000 under the previous government after the Howard federal government scrapped the Commonwealth Dental Scheme in 1996.

Mr Chairman, the Flinders Medical Centre (which I know is dear to your heart) is an emergency-driven hospital. Last financial year it treated almost 50 000 patients in its emergency department, through which more than 16 000 people were admitted to the hospital. The Flinders Medical Centre is to get an extra $30 million over the next four years to improve patient care in and the performance of its emergency department. The Flinders Medical Centre, through its Redesigning Care project and with the support of the state government, has been transforming the emergency department since last winter. This new funding will further support this initiative and will be used to employ more staff, open more beds and increase the physical capacity of the state's busiest emergency department. It will target efforts to make the Flinders Medical Centre's emergency department less crowded with shorter waiting times.

Mental health services are a priority, and I have already mentioned an extra $13 million over the next four years for crisis intervention and the expansion of community-based support. In addition to that extra funding, this budget locks the capital required to reform our mental health services into the forward estimates. This includes:

- $7 million to develop a 20-bed aged acute mental health facility at the Queen Elizabeth Hospital;
- $7 million to develop a mental health facility at the Women's and Children's Hospital;
- $6.5 million to develop a 30-bed adult acute mental health facility at Noarlunga Hospital;
- $2.8 million extra funding to establish 40 new adult acute and 20 new aged acute mental health beds at the Lyell McEwin Health Service;
- $1.6 million initial funding for construction of a 40-bed secure forensic mental health facility replacing the existing facilities at Hillcrest and Glenside;
- $1.6 million for expansion of the mental health facility at Modbury Hospital to 25 beds; and
- $1.2 million initial funding towards a 30-bed rehabilitation mental health facility.

Finally, I want to mention the new governance arrangements in metropolitan Adelaide that will apply from 1 July to the delivery of our health services. Members of the committee would be aware that from 1 July 2004 the Department of Human Services will be split into two departments and a new Department of Health will be created. This will provide the focus to deliver the government's commitment to implement the Generational Health Review and rebuild our health services. Also from 1 July 2004, the new metropolitan regional structures, comprising the Central Northern Adelaide Health Service, the Southern Adelaide Health Service and the Children's, Youth and Women's Health Service will take over responsibility for the governance of metropolitan and statewide health services. These new organisations will have responsibility for approximately $1.3 billion of capital assets, over $1.5 billion in recurrent annual expenditure and provide services to the majority of South Australians through the endeavours of 13 000 staff.

We are implementing the recommendations of the Generational Health Review to reform governance and the way that we plan and manage the system. We are building better services to shift the balance towards primary health care, as well as allocating the new $20.5 million over four years for improved care options to reduce the number of people who need to go to hospital or to reduce the duration of their hospital stay. We are developing better support systems, such as population based funding and long-term work force planning, which we need to do in conjunction with the federal government; and we have an extensive program for public health law reform. This is a record health budget and I look forward to today's proceedings.

The Hon. DEAN BROWN: I look forward to today's estimates because I believe that the estimates is a chance to find out the truth behind all these rather glossy announcements; to find out what is in the government's budget; and to look behind many of the announcements made by the minister and the government. Let me give some examples: the Flinders Cancer Centre which was announced today. That was approved and the money signed off by cabinet by the former government.

The Hon. L. STEVENS: There was no money.

The Hon. DEAN BROWN: Money was available. Money was allocated in Treasury, formally approved by cabinet, and the minister knows that. What happened is that, on coming to office in early 2002, this government immediately cancelled the $2.5 million for the Flinders Cancer Centre. Consequently, that cancer centre has been delayed for 2½ years because of the actions of this government. I welcome the cancer centre. The government also failed to announce that, according to their own budget, there is no funding commitment for the $2.5 million (or for the expenditure) until the year 2006-07. That is three years away from where we are currently. If members wish to look at the facts, I refer them to Budget Paper 4, Volume 3, page 2.29.

There is a different story behind each of these government announcements, for example, the one on mental health facilities. The minister has just referred to this massive capital works program for mental health facilities in exactly the same way as she did in her press release on the day of the budget. What she did not say was that her own budget documents (again on the same page to which I referred) show that not one dollar is allocated to those projects in this coming financial year, 2004-05. In some cases, not one dollar has been allocated for those projects next year; and, in the case of the Modbury Hospital, not even one dollar allocated for the

year after. In fact, no construction is due to start on these announced projects again until the year 2006-07. They are a mirage out into the distance. If you look at the facts, that puts an entirely different spin on it.

I refer to the capital works program as a third example. I highlight the fact that, if members look at the budget documents, they claim an increase of $35 million in the capital works program. This also appears in many of their press releases—an increase of $35 million in the capital works program to build new hospitals. The budget allocation for this coming year is almost exactly the same as the budget allocation for last year: there was no $35 million more. The budget documents show that the government failed to spend $35 million of last year's budget, or this current year's budget—2003-04. There was no increase in the capital works program. In fact, South Australians have been dudded $35.5 million for this present year, and all that is happening is that this money is being spent next year.

The budget shows that the allocation for capital works for building new hospitals is the same next year as this year. In fact, it actually shows that for medical equipment, which is a crucial area, there is a reduction next year, even though the AMA has been arguing very strongly for an increase in funding in that crucial area which deals with the quality of medical care. The second broad area I wish to address is the issue of the extent to which the government has tended to hide major disasters and areas where there is a risk to public safety and where they have failed to take action. I briefly just touch on what occurred at the emergency department at Flinders Medical Centre where, in March last year, it was found to be unsafe and increasingly unsafe. It was not until I did an FOI of the documents that we found out that this information had been sent on by the hospital last year. In fact, they did a study at the end of the year which found the hospital emergency department to be grossly unsafe.

The second example is the Mount Gambier hospital, where an independent report by Stokes—

Members interjecting:

The Hon. DEAN BROWN: I am sure, Mr Chairman, that you will protect me from these inappropriate interjections.

The CHAIRMAN: I realise the member for Finniss is quite sensitive. He has been bruised in this place a few times, so I do not think that he needs a lot of protection. However, members should not interject.

An honourable member interjecting:

The CHAIRMAN: Order! The member for Giles is out of order.

The Hon. DEAN BROWN: We heard the minister in silence, and I do ask that I be heard in silence. A crucial study found that the situation in the emergency department at the Mount Gambier hospital was dangerous—and that was the word which was used. The minister sat on that information for seven weeks before sending it to the board of the hospital to take action. The third case to which I wish to refer is one which I have raised today in the media; that is, the sale of imported honey into South Australia which contains nitrofurans. This imported honey tends to comes from South Africa. Nitrofurans in a food substance are banned in Australia. This was removed from the shelves of supermarkets in New South Wales on 5 May this year.

It has been removed from the supermarkets by the Canadian government and it is found to be dangerous. The Canadian government said that they removed the substance in March. At that time, they issued a statement saying that its concerns related 'to potential carcinogenocity and genetoxicity of the drug as well as the potential of the drug to cause antimicrobial resistance': in other words, the development of superbugs. A month later, the Canadian government issued a further statement, which states:

> Consumption of foods contaminated with nitrofurans may impose a human health risk related to the inherent toxicity of the drug and the potential to cause allergies.

The New South Wales government moved on this. I point out that the minister's food safety officers were warned of this about six months ago. There has been a series of meetings with them. As late as 11 May this year—I have the test results here—a honey product was bought at Woolworths at Port Pirie. It was sealed by the store manager and sent off for testing at the Advanced Analytical Australia Pty. Ltd. testing laboratories, which is a NATA accredited laboratory. It was found that there were significant levels of the metabolites of nitrofurans in the honey (4.5). This was a home brand honey.

The CHAIRMAN: Order! The member is not allowed to display the jar.

The Hon. DEAN BROWN: I'm not; I just used it as a reference.

The CHAIRMAN: The member needs to put it out of sight because it is against standing orders.

The Hon. DEAN BROWN: This product was withdrawn from sale in New South Wales at the beginning of May. Once again, we find that the South Australian government has been slow to move to protect the health of the public. I am concerned that, despite warnings in a letter to the minister (which I have sighted) at the beginning of this month and a letter to the Premier, nothing has been done. As I said, it was raised with the department six months ago, and it has been raised repeatedly with the department since. I believe that action needs to be taken.

The question that I think needs to be answered by the government is why they did not remove this product from sale, because it contains a banned substance as outlined by the Australian and New Zealand Food Authority (ANZFA).

The Hon. L. Stevens interjecting:

The Hon. DEAN BROWN: I will come to my questions in a moment. The minister had longer than I have had so far for her opening statement without interjection. I challenge the government as to why they have not removed this product from sale to protect people in South Australia and why they have not made sure that they have followed up what has occurred in New South Wales so that South Australia does not become a dumping ground for a product which is banned from supermarket shelves in New South Wales. The federal government has moved to stop the import of this product, but there is a considerable quantity of it currently available.

Perhaps the minister might like to answer that as a first question. Why has the department and she been so slow in taking action to have this imported honey which contains a banned substance withdrawn from sale in South Australia, and what action will she now take, because I believe that, at the very least, there ought to be a voluntary recall of this product in South Australia. There may be other brands as well. I have the test results for one brand here, but I know that there have been numerous tests carried out on honey products which are available for sale throughout Australia. I believe that any potential product—

Ms Bedford interjecting:

The Hon. DEAN BROWN: I have the figures here.

Ms BEDFORD: You might like to share them with us.

The Hon. DEAN BROWN: I have shared the one that came out of South Australia. The others back up what I have

already outlined: that these products contain this substance. There were 12 samples collected around Australia that showed that this product contained unacceptable levels of this substance. No level of this substance is acceptable.

Ms BEDFORD: How long have you known that?

The Hon. DEAN BROWN: It was brought to my attention last week when I was on Kangaroo Island, where they produced the results. That is my first question to the minister.

Additional Departmental Adviser:

Dr K. Buckett, Director, Population Health, Environmental Health.

The Hon. L. STEVENS: I am pleased to have an opportunity to address the shadow minister's first question. My department is aware of this matter, and I will ask Dr Kevin Buckett, the Director of Population Health, to explain in detail what has happened in relation to that matter.

Dr BUCKETT: The department has been aware of this issue for some time. We are aware that nitrofurans have been reported in some honey mostly originating from Argentina. The chemicals in question are indeed carcinogenic. Quite a lot is known about the nature of these chemicals. There is no maximum residue limit set for nitrofurans in honey; therefore, any level is a technical breach of the Food Standards Code. However, Food Standards Australia New Zealand (FSANZ), which sets the food standards, has reported on a health risk assessment for nitrofurans in honey. This information is available on their web site. They report that there is no health risk associated with the consumption of honey containing nitrofurans at the levels that have been found.

They are found in very small amounts in imported honey. Nevertheless, there is a technical breach of the standard and, on that basis, the New South Wales Food Safety Authority elected to write to some of the major supermarket chains informing them that there was a technical breach. I assume that those food chains then elected to take the product off the market. This action has not been undertaken by other jurisdictions in Australia.

The approach South Australia has taken is that, as this product does not represent a health risk, a food recall from the shelves is not warranted. If there was a health risk, we would take very strong action to ensure that any product was removed from the shelves straightaway. In the absence of any health risk, we have elected not to go down that path. However, in concert with our colleagues in other jurisdictions, we have worked on developing a management strategy. The Australian Quarantine Inspection Service is—and has been for some time—inspecting all imported honey into this country, and any product found to contain nitrofurans is not allowed into the country. Through this action, the department believes that public health and safety is guaranteed. There is no economic demand on shops and others, the health risk is fully managed, and the problem is in the process of being solved.

The Hon. DEAN BROWN: Before asking my next question, I must comment on the fact that the Canadian government (also on the web site) has issued a health warning. It says that there is a health risk, and I have quoted what it has said. I should have thought that any banned substance would warrant a voluntary recall, which is exactly what I have called for.

The Hon. L. STEVENS: Mr Chairman, can I make a comment, or is that a—

The CHAIRMAN: No, the member has not finished his question.

The Hon. DEAN BROWN: Therefore, there should be, at the very least, a voluntary recall of this product, as was done in New South Wales, as I indicated, at the beginning of May—I think it was on 5 May. The Canadian government went further and ordered the withdrawal of the product completely. The Australian government has said that it will try to stop any imports. The trouble is, though, I understand, that the Australian government, at this stage, is testing only bulk imports and is not testing packaged imports. I understand that the brand of the product to which I am referring is packaged in Denmark from honey imported from Argentina and sent to Australia as packaged honey, which is not being tested.

I argue that any banned substance in a food ought to be required to be withdrawn. The Canadian government found that there was a health risk and set out the basis for that health risk. I would have thought that anything that tended to encourage bacterial resistance to an antibiotic was a potential risk in the broader sense, but also they say that it causes allergies, is carcinogenic and gene toxic. I would have thought they were significant issues indeed, particularly where the products is probably consumed in reasonable amounts by children in our state. My next question is in relation to Budget Paper 4, Volume 2—

The Hon. L. STEVENS: I rise on a point of order, Mr Chairman. I am not sure whether the next question will move off this topic altogether. In summing up and making the comments, the shadow minister raised a number of other issues which I would be very pleased to be able to put on the record—

The Hon. DEAN BROWN: I have not yet asked a question; I am about to ask my questions.

The Hon. L. STEVENS: I was wondering whether those questions are in the same vein, or whether we would be moving onto something else.

The CHAIRMAN: Order! We will find out. The member for Finniss.

The Hon. DEAN BROWN: My question refers to page 7.110. In formulating the budget for 2003-04 and the anticipated expenditure in 2003-04 and then in terms of what the budget is in 2004-05, the minister has indicated that the major hospitals have run up a debt of about $35 million.

The CHAIRMAN: Order! In fairness, can the minister respond? There were certainly implied—

The Hon. DEAN BROWN: Mr Chairman, I have not asked a further question. I reserve my right for this to be my second question.

The Hon. L. STEVENS: The member does not want the answer.

An honourable member interjecting:

The CHAIRMAN: Order! I think some people have been on something more than honey!

The Hon. DEAN BROWN: I just want to reserve my right to my second question.

The CHAIRMAN: In fairness, I think the member put it almost as a question, and I took it that way. I think the minister should be able to respond on the honey question.

The Hon. L. STEVENS: Thank you, sir. I appreciate your intervention, because food safety is not something we take lightly for political point scoring. It is really important that we have an opportunity to get all the facts on the table. I will refer again to Dr Buckett.

Dr BUCKETT: The two questions I picked up were about the Canadian risk assessment process and its national body. Of course, every sovereign state has a right to have its own risk assessment process, and ours in Australia clearly differs with that of Canada. We always take the lead of our own statutory authority in Australia, which is the Food Standards Australia and New Zealand organisation. The second point is that nitrofurans are not a banned substance; they are present in a range of foods. The issue here is that no maximum residue limit has been set and, under that condition, according to the Food Standards Code, any level of that substance found in a food is unacceptable and therefore the food should not be available. It is not that the substance itself is banned, but no residue limit has been set. So, it is a technical breach of a food standards code, not a safety issue, as far as Australia is concerned.

The CHAIRMAN: I wonder whether the minister's adviser, Dr Buckett, could indicate what other food products contain this substance.

Dr BUCKETT: Nitrofurans can be found anywhere where proteins have been burned. As I understand it, in this case they are a breakdown product of antibiotics. However, nitrofurens are a fairly common chemical and can be found in a number of products such as heavily burnt meat, for example.

An honourable member interjecting:

Dr BUCKETT: Yes.

The Hon. DEAN BROWN: Before I ask my second question I highlight the fact that I have a statement here, issued by Food Standards Australia and New Zealand on 10 December 2003, which says:

> Any food products found to contain nitrofurens will not be permitted for sale in Australia.

Full stop!

Ms Bedford interjecting:

The Hon. DEAN BROWN: Well, black and white. I will repeat that, 'Any food products found to contain nitrofurens will not be permitted for sale in Australia.' And they went on to say, 'It is a banned veterinary chemical within Australia.'

Ms BEDFORD: Veterinary chemical.

The Hon. DEAN BROWN: Yes, but it comes through the bees.

The CHAIRMAN: Order!

Mr CAICA: I rise on a point of order, sir.

The Hon. L. STEVENS: Can we have the document tabled that the shadow minister has—

The CHAIRMAN: Order! There is a point of order by the member for Colton. I ask people not to shout. I am refraining myself, because there is a direct feed to the headphones of *Hansard*, and we might be talking about health via honey, but I can tell you the health of *Hansard* via the headphones is not good if you shout.

Mr CAICA: I might be presuming that the deputy leader was to move on to his next question, but I raise two points first, that the document that he was referring to be tabled, and secondly, that the minister be given the opportunity to respond to comments made by the—

The CHAIRMAN: Order! The member for Finniss does not have to table it. He can if he wishes, but he does not have to.

The Hon. DEAN BROWN: It is a statement issued by the food authority, and anyone can go to the food authority and get that statement as of that date, and I have given the date when they made that statement.

The Hon. L. STEVENS: So, you are not prepared to table it?

The Hon. DEAN BROWN: I am happy to produce the quote I gave to the house, yes.

The CHAIRMAN: He can circulate it if he wishes.

The Hon. L. STEVENS: Thank you.

The Hon. DEAN BROWN: My second question relates, as I said, to page 7.110, and the minister has already indicated that the major hospitals have overrun their budget this year by about $35 million. I would appreciate knowing what is the anticipated figure for which the hospitals have overrun their budget for this year? I understand that an assurance has been given by the department that the public hospitals will have that debt picked up for them. I understand in some cases that an undertaking has been given in writing to some of them (although I have not seen it), but I understand that they have been told that that debt will be picked up. Will that debt of $35 million, or whatever it is, be picked up as part of next year's budget, so that they will not have to carry it as a debt into next year's expenditure?

The Hon. L. STEVENS: As the shadow minister may remember, I answered this question on 31 May. It was asked of me in the house by the shadow minister on that date, and I will put that on the record for people again to hear. At April 2004, the debt of the metropolitan public hospitals for 2003-04 was $30.5 million, not $35 million, and not $61 million, either, which is what we inherited, as the shadow minister would remember.

The final end of year result is contingent on the distribution of $30 million in additional funding that was approved by cabinet in December 2003, and I will hand over to Jim Birch to provide us with some extra details on that answer.

Mr BIRCH: The projections for the end of the year which were contained in the mid-year review were determined at 31 October 2003. Those projections have since changed, and in some instances have improved in some hospitals, and in some instances have deteriorated. The shadow minister, I think, asked whether all hospitals and health services would have their debt expunged by 30 June this year. At this stage it is not possible to determine that, as we are still in negotiation with the Department of Treasury and Finance about the end of year position. However, the overall departmental—that is DHS—position as indicated in the mid-year review has continued to track consistently, in which case we would envisage a positive outcome for health services and hospitals by 30 June. However, it is not possible for me to indicate hospital by hospital, or health service by health service, at this stage whether all hospitals will or will not have their total year debt expunged by 30 June. That is different to accumulated debts from previous years which still stand on the books as doubtful debt which arise from 2000-01, 2001-02 and 2002-03 and which have, in fact, decreased from 2000-01, from an accumulated debt of $61.1 million to a 2002-03 debt of $54 million.

The Hon. DEAN BROWN: You did not answer the specific issue that I raised which was, firstly, what is the projected figure at the end of this financial year? I heard that the minister repeated what she had said in parliament earlier, but I was interested in knowing what the projected figure is at the end of this current year (2003-04). Secondly, where—because it is not covered—there is an explanation in the budget that talks about variations from budget 2003-04 to estimated result 2003-04, that is not covered. There is something that talks about the variation between estimated outcome 2003-04, and that is why I referred you specifically

to that page, and 2004-05, where it talks about deferred expenditure. So, I am asking specifically whether this is being picked up under the first category on the top half of that page, or on the bottom half of that page? If it is being picked up on the bottom half, why has it not been referred to, because it is a very significant variation indeed? That is the clarity for which I am asking.

Mr BIRCH: I just wanted to check with the Director of Finance before I answered this question. My understanding (and I believe this is correct) is that the $30 million that was referred to by the minister as additional money allocated in the mid-year review has yet to be allocated to the Department of Human Services and is likely to be allocated in the next seven to 10 days (prior to 30 June) and, therefore, does not appear in the budget papers at this point: it is held within a Department of Treasury and Finance contingency line. I believe that issue will substantially cover the deficits you are referring to. Notwithstanding that, the total Department of Human Services projected end of year deficit exceeds that $30 million, and further discussions will occur between now and 30 June to attempt to resolve that issue.

The Hon. DEAN BROWN: Before I go to the next question, I will say that it was known at the time of the budget, because I had asked questions in this parliament about it. I am surprised that it has not been picked up in the budget documents because it refers to much lesser amounts and, clearly, it is a significant liability.

I now wish to pick up two points. On the same page it refers to fringe benefits tax expenditure of $11.8 million deferred from 2003-04 to 2004-05, so there is an example where it picked up a smaller amount and referred to it. It also refers, of course, to the $35.5 million of capital not spent in 2003-04, but I have referred to that already.

It also refers to misclassification of expenditure, and this is picked up in two parts. It is picked up in the variation for 2003-04 to 2004-05, but it is also picked up in the variation at the bottom of the page between 2003-04 and estimated results for 2003-04. The figure at the top is $14 million and the figure at the bottom is $67 million, so we are looking at pretty significant amounts. My understanding is that the effect of that, in accounting terms, is that expenditure, both in 2003-04 and 2004-05, has been overstated as a result of that misclassification. I know that sort of mistake can be made, but my understanding is that that is the impact (from what is said here) of effectively saying that it has resulted in increased revenue and increased expenditure, which would therefore reflect as a higher level of expenditure than actually occurred by those amounts of $14 million and $67 million. Therefore, what is the impact of that—and I presume it is reflected mainly in the major metropolitan hospitals—on stated expenditure for the year? I must say that $67 million is a fairly significant amount for this past year, and the figure for the coming year is $14 million.

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

Mr BIRCH: Clearly, I will not answer all that question, and I would like to refer the question on FBT to Mr Tattersall. We may have to come back to the shadow minister, given the complexity of that question, to see whether in fact he answers it adequately or we break it down into its parts. I will ask Mr Tattersall to answer.

Mr TATTERSALL: The misclassification that is referred to in the documents refers to a correction of a classification area that first occurred in 2001-02. It involved some expenditure by DHS being incorrectly recorded as grant and subsidy payments to agencies when it should have been recorded as an intragovernment transfer (and I refer to Budget Paper 4, Volume 2, page 7.57). The impact in 2003-04 is $67 million, but there is a further four year impact in 2004-05 of $14 million, so those two figures in the budget statements are connected, as you have pointed out.

The consequence of that is that in 2003-04 the estimated final result includes a correction that reduces grant and subsidy payments by $67 million, but that is equally offset by a matching increase in intragovernment transfers of $67 million. The bottom line expenditure budget total is unaffected. The full year effect in 2004-05 of the correction is similarly to reduce grant and subsidies by a further $14 million, offset by a matching increase in intragovernment transfers of $14 million. So, that explains the link between the $67 million and the $14 million.

Because the correction has taken effect in 2003-04, the estimated final 2003-04 budget and the 2004-05 budget are comparable in structure, and the increased expenditure can be demonstrated to relate to the decisions by government about the various initiatives that were announced in the budget. It also includes some provisions for the indexation of the budget base.

So, that is impacting on the Department of Human Services. Intragovernment transfers reflect the funding provided by DHS to incorporated health and disability units to undertake their activities, so there must be some corresponding adjustments for changes in the classification for the budget statements for the budget entity shown in the book as incorporated health and disability units. I refer to Budget Paper 4, Volume 2, page 7.104.

In 2003-04 the revenue for intragovernment transfers has increased by $67 million, and the budgeted expenditure using those funds has similarly increased by the matching amount of $67 million. There is a further full-year effect of $14 million. Again, because the adjustments have been applied to both 2003-04 and 2004-05, the underlying increase of $143 million in the expenditure budget between those years does reflect the initiatives that have been approved by government, including indexation. A lot of complexities are in amongst all of that and, if you wish, I can arrange for a more complete response.

The Hon. DEAN BROWN: Yes, because of the potential significance of this, I would certainly appreciate and take up that offer. I think that what you have confirmed is what I asked, which is that gross expenditure and gross receipts have escalated but that the net result at the bottom has not changed. I was specifically asking whether, in fact, gross expenditure and receipts have therefore been escalated, because my understanding of what has been said there is the consequence, but it does not have an effect on the bottom. It does not need to be made up suddenly by Treasury, or something like that, as a potential loss.

I would appreciate working through that in more detail so that we can see where it has an impact because we are talking about fairly significant amounts of money. How much of the nurses' enterprise bargain has been included or factored into the estimates for each of the next three years, and what is the total cost—

The Hon. L. STEVENS: Mr Chairman, as a point of order, how many questions does the shadow minister get before the other side has a go?

The CHAIRMAN: I think that the Deputy Leader is on his fourth question. We will compensate later. We may as well finish this question now.

Members interjecting:

The Hon. DEAN BROWN: I thought it was for the opposition to ask the questions. Can I have an answer to that question?

The CHAIRMAN: Sure.

The Hon. L. STEVENS: Could the shadow minister repeat the question, please?

The Hon. DEAN BROWN: How much of the nurses' EB has been factored into the forward estimates that we have before us in this budget document for each of the next three years? So, how much for each of the next three years and what is the total cost of the EB? I understand that it is a three-year EB and, therefore, what is the total cost of the EB for the full three years? How much is in here already, and what is the total cost of what has not yet been factored in?

The Hon. L. STEVENS: Before I ask my officers to answer the detail of that question, I would like to congratulate my colleague the Hon. Michael Wright. Certainly, he negotiated with the ANF very successfully. As health minister, I am absolutely delighted with the result, and I know that the ANF is delighted with the result. With respect to that enterprise bargaining agreement, not only has there been a significant increase in wages but also significant gains in terms of retention of nurses. As people would know, we are facing a critical nurse shortage, something that, unfortunately, was left in abeyance for us to deal with when we came to office.

We really were well behind the eight ball in terms of other jurisdictions in this and other countries that had got on with things. We have had to claw back lost time. This enterprise bargaining agreement between the union and the government will, we believe, help us in terms of both attraction and retention of nurses in the public sector, and of course that is exactly what we are after. I am so very pleased that this time we have an enterprise bargain that has been fully accepted and funded by the government, which is quite different from the one that we inherited when we came to office.

At my very first meeting with the ANF—probably within the first month of my becoming minister—I discovered from the union, and then my department, that the enterprise bargaining agreement that had been negotiated by the former minister had significant sections unfunded. The key components of the offer that has been accepted and agreed to are: a 3.5 per cent enterprise bargaining increase operative from 1 October 2004 and 2005; a 3 per cent nursing specific special increase from 1 July 2004; a further 1.5 per cent nursing specific special increase payable from 1 July; a 5 per cent increase, consisting of a 3.5 per cent enterprise bargaining increase and a 1.5 per cent nursing specific special increase operative 1 October 2006; qualification allowances; an average of three days per week at registered nurse level 3 with clinical duties (working time to be set aside for non-clinical duties); cash incentives for rural and remote nurses—and I know that the members for Giles, Goyder and Flinders would be very pleased to hear that; paid maternity or adoption leave of eight weeks, which can be shared if both partners are employees of the Department of Health; in charge allowances payable to an RN1 who is designated in charge of a ward when no higher-level nurse with clinical responsibility is rostered; consideration of standard 10-hour night shifts to be progressively implemented over the life of the agreement; an increase in night duty penalty from 15 per cent to 17 per cent; and significant increases to on-call allowances. We have, I think, an historically good EB agreement with nurses in this state—one which we believe will complement our commitment and resolve to dealing with the nurse shortage so that we have the people we need to provide the health services that we need now and into the future. For the detail of the question I would now call on Mr Beltchev.

Mr BELTCHEV: Again, this may be a question that would be best answered with a supplementary written brief, because there are some complexities with the figures, and it involves some input from Treasury. My understanding is that the estimated cost of the EB outcome in 2004-05 is estimated to be $56 million in round figures, increasing in 2005-06 to $108 million, increasing again in 2006-07 to $155 million, increasing further in 2007-08 to $167 million. The construct of the budget estimates, as they stand at the moment, includes some provision for future EB outcomes. They are estimated to be as follows: in 2004-05, $25.3 million; in 2005-06, $51.6 million; in 2006-07, $73.8 million; and in 2007-08, $79.5 million. That leaves an approximate budget impact that is not yet reflected in the budget estimates, because the decision has been taken since the budget estimates were compiled. That budget impact that is not yet reflected in the budget is estimated to be in 2004-05 $31 million, rising in 2005-06 to $56.5 million, to almost $82 million in 2006-07, and $87.5 million in 2007-08.

The Hon. DEAN BROWN: That is exactly what I was after. Thank you; I appreciate that.

Ms BREUER: I refer to Budget Paper 4, Volume 2, page 4.74 regarding the delivery of health services. Can the minister provide the committee with details of the hospital avoidance and demand management strategies being implemented by the government including initiatives such as the home supported discharge from hospital, admission prevention strategies, and chronic disease management?

The Hon. L. STEVENS: Thank you, member for Giles. I am delighted to give the committee details of these very important initiatives—initiatives that are absolutely spot-on in terms of major recommendations from the Generational Health Review. Today I have outlined plans which are aimed at reducing hospital admissions from emergency departments and general practice and, as I said before, respond directly to the findings of the Generational Health Review. I add, for the interest of the member for Giles and other country members, that 12 per cent of the money for these services will go to country South Australia. The country members can keep that in mind as I explain what this is about.

As to hospital avoidance, the Department of Human Services has piloted a number of projects aimed at reducing hospital admissions from emergency departments and from general practice. These alternatives to hospital projects were: GP Home Link East from the ACH group, GP Home Link North with Helping Hand Inc., and the Emergency to Home Outreach Service from Flinders Medical Centre. In 2002, a $1 million boost was allocated to expand these hospital avoidance initiatives, which we talked about last year. This extra $1 million in funding, allocated by the government, was used to develop the Metropolitan Home Link Service. The Metropolitan Home Link Service is a metropolitan-wide service aimed at reducing hospital admissions from both hospital emergency departments and general practice. It is governed by a collaboration (partnerships, again) of non-government and government community-based providers called the Advanced Community Care Association.

The DHS has also provided in funding to RDNS in 2002 to pilot the acute in-residential care living project, which aims to reduce hospital admissions from nursing homes. As a response to the 2003 Generational Health Review final report

and the success of the department's established alternatives to hospital initiatives, a very detailed business case was developed to expand and develop these programs further. This used a detailed economic model to simulate over a 10-year period cost, effect, capacity and the interrelationship of the strategies.

From the simulation, it was recommended that the following strategies be implemented: first of all, home supported discharge from hospital; secondly, prevention of admission from hospital emergency departments; thirdly, prevention of hospital presentation and admission from nursing homes; fourthly, prevention of hospital presentation and admission from emergency departments; fifthly, chronic disease management. I might add, in listing those strategies, they are of course all done in the context of improved patient care.

The total funding received for 2004-05 as part of the state budget is $4.33 million, and the total funding received over four years is $20.5 million. The business case strategy is built on a substantial level of state funding, which provides care within the community and avoids the requirement for hospital admission wherever possible and wherever, of course, appropriate, and in consultation with a doctor. The Metropolitan Home Link Service provides short term and rapid response services to persons in need to enable them to remain in their homes, people who would otherwise have presented or been admitted to a hospital. This service is provided from hospital emergency departments and general practice. State funding, allocated to Metropolitan Home Link Service for this year, is $2.1 million.

Metropolitan Domiciliary Care provides care to frail elderly and/or disabled persons and their care givers. This care enables many people in need to remain in their own homes, rather than being admitted to a hospital. Care is also provided to many people who have been discharged from hospital, but who, without such support, would likely be readmitted. State funding allocated to Metropolitan Domiciliary Care in 2004-05 is $19.5 million. Commonwealth funding through the Home and Community Care Program, allocated to Metro Dom Care for the next financial year, is $20.9 million.

RDNS provide home and community nursing and allied health to clients and carers which supports them in maximising their health and quality of life. By providing clinical nursing services for people at home, or in the community, a number of potential hospital admissions are avoided. That is exceedingly good for the people themselves, as well as for the hospital system. State funding allocated to RDNS in 2004-05 is $7.8 million, and commonwealth funding through the Home and Community Care Program, allocated to them in 2004-05, is $14.2 million. There are also a number of other joint commonwealth and state funded programs providing care within the community that also assist in avoiding unnecessary hospital admissions. $17.9 million is to be provided for other HACC programs in country regions for 2004-05, for avoiding unnecessary hospital admissions, and $22.1 million is to be provided for other HACC programs in metro Adelaide for next year.

Going back to the $4.3 million that I talked about this morning, in relation to alternatives to hospital care, of which 12 per cent will go to country, this will enable us to fund 7 000 additional packages of care every year. A package of care can last for up to a week. This includes 2 400 packages to support on-time discharge from hospital.

To explain that a little, often we have people in a hospital who could be discharged if there was support available for them in their homes. In the past, if that support is not there, for instance they may not have family that can come by and check them, or there may be some other reason why they are isolated in the community, these people have had to remain in hospital. It is not particularly beneficial for them, and probably not beneficial for them in their recovery. They would obviously get the care of the hospital, but they could be at home, and we all know that if people can return home it is generally their preference, to be in familiar surroundings. This will put that care in place, so that when people can leave an acute hospital they can go home with a care package around them to provide that care at home. This is better for them and it is certainly better for the hospital, because it frees the bed for other people requiring that acute care to have it.

There are also 3 300 packages to support people in the home after a visit to an emergency department. This, of course, is something that Metropolitan Home Link have been doing already, but this will just further increase that capacity. Somebody may go to an emergency department, they may have something like perhaps a fracture of an arm, or whatever, then get treated in the emergency department, and, again, if that person could go home with support, that would be their preference. We have found that if that support does not exist for them they end up being admitted to the hospital. Again, that plugs into that situation where a person in that case can then return home with a package of care around them in their home, in conjunction with their GP.

As well as that, there are 1 000 extra packages for people who have visited a GP and, more appropriately, require home support instead of hospitalisation. Of course, the GP who will have access to how to link into these services will then be able to broker with the services a package of care around those clients to have them supported and cared for in their own home. This is very exciting. Work has been done on this in other countries, in particular, New Zealand. I will ask my chief executive to provide some examples, but there have been stunning results in the improvement of care, and health systems have been able to free up beds to enable more people to receive acute care in hospital.

Home support could provide a range of simple measures such as: cooking meals, assistance with showering, medication management and nursing care such as wound dressing or assisting someone to attend a GP follow-up appointment or even arranging for a GP to visit the home. This will build on services such as the metropolitan homelink service, which I mentioned. This morning, I spoke to a person who is receiving these kinds of services and her GP. The GP was asked whether a busy GP would be able to do all of these extra things. His answer was that programs such as this make the work of a GP much more efficient and effective because of the options and the level and type of care which will lead to better patient recovery. So, GPs are particularly keen on this program.

Finally, we will also provide an extra 350 packages of care in the first year of the Advanced Nursing Home Care program. Some people in nursing homes do not have to go to hospital if advanced nursing care can be taken to them. When a frail aged person from a nursing home is admitted to an acute hospital, the experience is very traumatic, it is a shock to their system. They may go into hospital for a particular reason, but when they come out they have often gone backwards in terms of their general level of health and physical capacity. We are working on how we can take

appropriate care to people in nursing homes so that they do not have to go through the trauma of an acute hospital stay. The Advanced Nursing Home Care program has already been trialled successfully.

We will also provide an extra 375 packages of care in the first year for chronic condition management. As members would know from their own constituents, people suffering chronic conditions undertake many trips to hospital. Some of these trips can be avoided if worsening symptoms can be detected and treated in time. We need to get in early and nip things in the bud. Profiles of patients most frequently hospitalised will be examined to develop plans of intensive individualised management and care of people most at risk of worsening chronic conditions.

What is of great importance is the enthusiastic cooperation that has been shown by our partners in this program. The Advanced Community Care Association has worked with us for a long time to put this program together, and the other significant partners are general practitioners. We are keen to work with them in every way that we can in terms of these innovative primary health care responsibilities. We see GPs as our major partners in putting into practice many of these new measures so that we can keep people healthier and provide better care and have better outcomes for them and the system in general. I will ask the Chief Executive to nominate someone who can talk about the excellent results that we know these programs provide.

Mr BIRCH: I am happy to speak on this. The minister referred to projects in New Zealand. On the South Island, a GP organisation called Pegasus Health Care has been the most impressive. With the use of hospital avoidance monies and some funding that we would call primary health care funding they have been able to establish arrangements for patients who would normally be seen in accident and emergency departments or admitted to hospital, particularly for chronic disease, to be treated in their own home with fairly complex tests being conducted in GP practices. That has resulted in significant reductions in A&E attendances and hospital admissions on the South Island of New Zealand. This study was undertaken in many different regions of New Zealand, and they have had the most impressive results.

I think it is pertinent to mention one of the major issues that has resulted in the need for hospital avoidance strategies, and that is the explosion in chronic diseases and the need for better management of chronic disease in the future. I refer to two particular diseases, one of which is hypertension. In the US, particularly Kaiser Permanente and Veterans Health Care have estimated through a random international study that only about 27 per cent of citizens receive proper hypertensive care according to best practice. In South Australia, some work has been done at the University of Adelaide, and it is estimated that approximately 25 per cent of Australians receive proper hypertensive care.

The resulting problem is clear; that is, most people who do not get proper hypertensive care end up in accident and emergency services or are admitted particularly late at night, which causes congestion within the hospitals, when it is an avoidable admission. The end result is that we have modelled the impact by 2011 upon the public hospital system in this state, in the event that we are unable to successfully have primary health care and hospital avoidance strategies. It was the fundamental issue upon which the Generational Health Review was pinned. There will be need to be over and above in the forward estimates to 2011 an increase of nearly $450 million if we do not address the excessive numbers of people who are entering the hospital system and who could otherwise be treated either through the mechanisms mentioned by the minister or through general practice.

The lessons we need to learn from this are to collaborate with the commonwealth and also, where possible, seek to pool funding. Some impressive early work is being undertaken, particularly in the south of Adelaide, where there is also a difficulty with work force and the availability of GPs, which can also be enhanced by these initiatives.

Mrs PENFOLD: I think this is a wonderful initiative. However, on the Eyre Peninsula, with my 10 hospitals, we are finding that fewer specialists are being sent to Eyre Peninsula, and therefore, as the minister has said, a huge amount of trauma is being caused by my people travelling long distances to catch aeroplanes or travelling eight to 10 hours on the bus to come to Adelaide. It would seem to me that it would be best if those people did not have to travel and that the specialists visited the region. When people come to Adelaide to see specialists, they then suffer that major trauma (as mentioned by the minister) and they are often sent back too soon in order to empty the beds in the city hospitals, which causes major trauma in my hospitals and for families in the region. I am curious to know why, when about 33 per cent of the population live in the regions, the regions receive only 12 per cent of the funding.

The Hon. L. STEVENS: I will ask my Chief Executive to give the detail on that question. However, in terms of country areas and the whole issue of country health services, as recommended by the Generational Health Review, to the greatest extent possible, we have to try to put services as close as possible to where people live. Of course, that is balanced with the critical shortage we have in relation to work force across all disciplines of health, which is compounded by the problem of how you get the work force to move out of city areas into country areas. We are endeavouring to try to put those services, to the greatest extent possible, where people are living. In relation to the 12 per cent, I think the member said that 33 per cent of people—

Mrs PENFOLD: Approximately 1.4 million people live in South Australia, a third of whom live in the regions. Of course, I have 10 hospitals in my electorate, and it would seem to me that the specialists need to visit my hospitals, which would cause a lot less trauma. I think that is occurring less frequently rather than more frequently under the minister's government. Evidently I have only 12 per cent of the funding allocated, yet I think our need is greater.

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

Mr BIRCH: This is one question where we may need to come back to the honourable member with a specific brief. I do not have a specific brief on this issue, so I am recalling from my own memory of the statistics. My understanding is that, whilst the honourable member is correct in saying that country health services on the ground receive a smaller percentage of expenditure versus the total population, if she takes into account all country people treated within a public health system in this state, my recollection is that the total expenditure spent on country people from all health services in the state correlates very closely and, indeed, may actually exceed, the level of country allocation based on a population basis.

However, I am happy to take that question on notice and provide the honourable member with a very specific allocation. The honourable member is correct in saying that the amounts spent within the country regions themselves do not

equate to the per capita population basis. However, when you consider the total health services provided in metro, or at statewide services to country people, it equates very closely.

Mrs PENFOLD: It costs $300-odd just to travel backwards and forwards on the aircraft from Port Lincoln, and that has been included under 'Patient assisted travel'. You cannot call that a health service; that expense should be separated from any cost that could be attributed to my patients.

The Hon. L. STEVENS: We have just advised the honourable member that we will provide her with the detail she requires. I reiterate the comments made by the Chief Executive in his answer, and advise that we will get the detail for the honourable member.

Ms BREUER: I refer to Budget Paper 4, Volume 2, page 7.92, which talks about country health services and, in particular, the patient assisted transport scheme. Following on from the remarks made by the member for Flinders, I note the announcement of an extra $1.7 million over four years to fund the PAT scheme. Will the minister advise how much money is allocated for the coming year and how many claims are expected, as this is of considerable interest to country members?

The Hon. L. STEVENS: This is, of course, an issue of access to health services to people from country South Australia. As people would know, it is an access program for rural and remote South Australians who are unable to obtain medical specialist services at a local level. The scheme is not means tested and it is an important equity program for country residents faced with health problems. There is an increasing demand for the service. It is estimated that in 2003-04 there will be 35 000 claimants based on current trends, which is an increase of 8 000 from 2002-03.

In 2003-04, benefits totalling around $4.8 million are being paid directly to claimants. Increasing demand and cost pressures are being driven by many factors such as the consequences of the drought in some areas; an ageing rural population contributing to this upward trend; meeting the needs of the disadvantaged; more advanced travel payments have been approved; as well as the need to process an increased number of direct payments for accommodation costs. Regular on-site PATS services have been established at the Royal Adelaide Hospital's social work department, and the cancer council through Greenhill Lodge, to provide direct accommodation payments and personal benefit advice to clients. In 2004-05 it is expected that the increase in claims trend will continue at the present rate of about 24 per cent per annum. Estimated claims for 2004-05 are approximately $38 000, with an additional $410 000 being allocated to the PATS budget to meet that demand.

Whilst PATS benefits do not generally cover travel for dental treatment, assistance has been extended to cover medically compromised patients who are referred for dental services by a medical specialist. The planned, innovative, multi-user, web-based claims management system will more effectively deal with the workload, and is due to be in service in the first half of 2004-05. Financial assistance for referrals initiated outside the public health system, for essential treatment not available in South Australia, are now considered on a case-by-case basis.

The government is obviously trying wherever possible to address work force shortages in country areas. It is something that we are not alone in having to contend with here in South Australia. I guess what is different for us, compared to states like New South Wales and Queensland, is that we do not have the big population centres outside the capital cities. Essentially, we have got Adelaide, with much smaller regional centres than the eastern states, and then scattered populations.

We are looking at ways—particularly with the new services at Mount Gambier Hospital with the links to both the Royal Adelaide Hospital and the Queen Elizabeth Hospital—to enable sustainable coverage of surgery and anaesthetics. We will be examining this very carefully in terms of whether this is a strategy that we will be able to look at in conjunction with the provision of resident specialties in other parts of South Australia. Again, we are talking to our clinicians: the Clinical Senate will look at these matters in relation to how, with a decreasing work force, in terms of specialties and in terms of dental care and nurses, we can more effectively take services to the country areas, because we know that when we talk about health services in country areas and access to them, transport issues are always significant.

The Hon. DEAN BROWN: In the budget papers, on the PATS scheme, in 7.50, it shows that in 2002-03 the actual result was $27 000 claims on PATS. The cost was $6.27 million. For this coming year, you are expecting to increase the number of people by more than one third, from 27 000 to 38 000, but you have actually budgeted less money—only $6 million. I cannot see how you can deal with one third more people. In fact, it is more than that, it is about 38 per cent more, with a reduction in funding and when you have got inflation as well.

The Hon. L. STEVENS: I will take that on notice. We will have a look at those figures and provide an answer for the shadow minister.

Ms BEDFORD: On the same budget document, page 7.89, referring to child and youth health. Can you provide to the committee further information on the program called Every Chance for Every Child, which was launched in November 2003 to provide home visiting services for newborns, and how this service will operate in the budget year 2004-05?

The Hon. L. STEVENS: I would be delighted to. Every Chance for Every Child was also a policy initiative arising directly out of the recommendations of the Generational Health Review. It was one of the government's priority areas for implementation in its First Steps Forward document, and I might remind the committee that it was at estimates last year that the government announced its response to the Generational Health Review and First Steps Forward, and this is one of the major planks of policy reform for South Australia.

There are three main parts to the program, Every Chance for Every Child: firstly, a Universal Home Visiting program, which I will talk about in detail in a minute; secondly, a sustained home visiting program and support program for families requiring extra support in terms of the parenting of their child; and, thirdly, developing community capacity in terms of support for families, and support for parenting in all its forms.

In relation to the funds asked about in the question, the funding allocation of the universal home visiting program for 2003-04 was $690 000, and the following has been achieved to date. The roll out of the universal home visiting program by Child and Youth Health is near completion and 98 per cent of families across the state with a newborn child are offered a home visit by, at the moment, Child and Youth Health—and, of course, the new organisation when it joins in about 10 days' time. A memorandum of understanding currently exists between most of the birthing hospitals in South

Australia and Child and Youth Health regarding involvement in the universal home visiting program.

The feedback that we have had in relation to that has been extremely positive. Child and Youth Health has indicated that it has had the highest-ever enrolment onto its database of newborn children. Upwards of 95 per cent of newborn children are now enrolled and on the books for us to be able to track and, I guess, monitor in terms of the health of our young people into the future. Funding allocation for the second component, the sustained home visiting component of the home visiting program, for 2003-04 was $2 million. The following has been achieved to date. Implementation of this component through Child and Youth Health has commenced, with more than 80 families in the outer northern and southern metropolitan areas of Adelaide currently being visited.

The roll-out of this service for families living in Port Augusta, Whyalla and the Riverland is presently being planned, with 100 families expected to be enrolled by 30 June 2004. That is very pleasing and, in particular, we will look at how this program pans out, is adapted and worked through in terms of Aboriginal families so that it is culturally appropriate and gives the improvements that we want to see in terms of support and development of Aboriginal children and also their parents and wider family groups. The completion of a culturally appropriate model for Aboriginal families for the sustained home visiting component is under way, with 23 per cent of families already enrolled being of Aboriginal descent.

Funding allocation for 2004-05 includes $790 000 for the universal home visiting program and $3 million for the sustained home visiting program. This funding will be used for the following. Obviously, the universal home visiting program for all children born in South Australia and their families will be continued—and I might add there has been an increase in births. People have heard about our program!

Ms Bedford interjecting:

The Hon. L. STEVENS: I am not sure. I do not think it is that well known but, who knows? Anyway, we have had a very pleasing increase in births in South Australia and, of course, all those new babies will be visited and will have access to our programs. There will be: continuation of the roll out of the sustained home visiting component of the home visiting program within the designated areas and to other South Australian metropolitan and country regions to support up to 900 families by the end of 2004-05; enrolment and participation of 100 per cent of Aboriginal families with a new child living in the sustained home visiting designated areas; the implementation of culturally appropriate strategies for Aboriginal families with young children; the implementation of evaluation strategies for the home visiting programs; and utilising the information gathered during the first year of the program.

In addition, the department of health will monitor the implementation of the action plan for Every Chance for Every Child. It will ensure research and evaluation of all of the initiatives—because we need to base what we do on evidence and what works. The department will also facilitate the development of a whole of government framework regarding Every Chance for Every Child initiatives. In particular, we will work with the education department, and I will be delighted to do that with the Hon. Jane Lomax-Smith and also the Hon. Jay Weatherill. We will have the help, support and activities of Jennifer Rankine (the member for Wright), who has parliamentary secretary responsibilities in early childhood health and also early childhood education: she will assist in this work across government.

A consultative group comprising the Director of the Major Projects Unit, the CEO of Child and Youth Health, the CEO of the Women's and Children's Hospital, the Project Director of Every Chance for Every Child and representation from the regional health services is being established to oversee the operational management of the program in the transition phase of the regional health services and the department of health. It is envisaged that, once the structures within the new Children, Youth and Women's Health Service and the Department of Health are finalised, the Children, Youth and Women's Health Service will become responsible for the operational management of this framework.

I am certainly enthusiastic about this program. I think that, as we proceed, we have a real opportunity to make a significant difference to every child in this state. The new amalgamated organisation will have operational responsibility for this program. Certainly, in terms of the service agreements that we will be signing with them (and also our expectations of what they intend to do with the money they get from us), significant parts of that will be directed towards outreaching their services and supporting primary health care right across South Australia so that, indeed, every child in this state does get every chance to reach their full potential.

In relation to the third part of the program (capacity building), it has been very pleasing to be able to support some very important community-based programs over the last year. In particular, I mention a program which is based at Salisbury North Primary School and which is done in conjunction with a non-government organisation called Good Beginnings. That program does some extremely important parenting support work in the Salisbury North area. It reaches out and provides extra parenting support for parents who have had some difficulty managing that role. We have also been able to provide a significant boost of funds to a program called Hope for the Children, which the member for Florey would know operates in the Modbury area.

That program was commenced and is sponsored by Rotary, and we are very pleased to be able to work in partnership with Rotary. I would like to reiterate to the committee that, in all the work that we do, there is a constant desire on our part to form partnerships with others, whether it be with groups such as Rotary, the commonwealth government, other non-government organisations, local government, the private sector or GPs. It is about all of us focusing on the result that we want, breaking down the barriers that exist and working to problem solve our way through so that we can get better streamlined services for the people who need them—in this case, the children of South Australia.

Mrs PENFOLD: As a supplementary question, of all the electorates in the state, my electorate has the most Aboriginal children. Minister, you said that 100 per cent of Aboriginal students living in this home visiting area would be getting this new service. That would be very pleasing, but I would like to know whether that includes the electorate of Flinders. I did ask the minister, the Hon. Jane Lomax-Smith, whether the Ceduna junior school could have a health clinic. I have not received any response from that request. The minister did not seem to think that was possible, but, while we are doing that junior school, I would certainly appreciate that being looked into.

I think it is an opportunity that should not be missed. I would like to know whether this home visiting area, in which 100 per cent of Aboriginal students will be getting this

service, includes Eyre Peninsula, where the greatest number of Aboriginal children in any one area are to be found.

The Hon. L. STEVENS: I might ask Ms Roxanne Ramsey to talk about the honourable member's particular area, but in terms of sustained home visiting I will ask George Beltchev, who heads our major project unit and who has taken lead responsibility in relation to this program, to answer the honourable member's question.

Mr BELTCHEV: The universal home visiting program is being rolled out for every child born in South Australia. I emphasise that it is a voluntary program. The service is offered. It is not a service that is provided unless the family accepts it. At the moment special arrangements are being discussed about how that will be best provided, particularly in the remote areas of the state and in particular in the Aboriginal communities in the Far North. Certainly, 100 per cent is a realistic program ambition. In terms of the sustained—

Mrs Penfold interjecting:

Mr BELTCHEV: Now. These discussions are occurring now.

Mrs PENFOLD: Yes, but you said that 100 per cent of Aboriginal students are eligible for this sustained home visiting area. Am I getting those at Ceduna and Port Lincoln?

The Hon. L. STEVENS: There are three parts to this.

Mrs Penfold interjecting:

The Hon. L. STEVENS: This is sustained.

Mrs PENFOLD: What I am particularly interested in is Ceduna and Port Lincoln for the students.

The Hon. L. STEVENS: I will ask Mr Beltchev to talk about the sustained home visiting designated areas. They are the areas where we said that 100 per cent of Aboriginal families with a new child would receive this service.

Mr BELTCHEV: At present, the sustained home visiting program is resourced to be able to service the northern and southern metropolitan areas and three country areas: Port Augusta, Whyalla and the Riverland. That voluntary service is for new-born children and will be provided for up to two years. The total number of new-born children who will be serviced by this program with the available $3 million a year is estimated to be 900. That is just over a third of the target population. In relation to those designated areas (northern metro, southern metro and the three country areas), 100 per cent of Aboriginal children will have that service offered to them.

Mrs PENFOLD: That means that 50 per cent of Aboriginal children in my area will not get this sustained home visiting.

The Hon. L. STEVENS: At this time, that is correct. The government will endeavour to roll out this program in future years. You have to understand that we have already put $16 million towards this program. We are developing it and rolling it out as the years go by and, at the moment, that is where the program is in terms of sustained home visiting in country areas. Your existing services will still continue and also the community capacity building part of this overall program is still available to other areas. In terms of the health centre on the primary school site, that is a different matter, and I am happy to get Roxanne Ramsey to talk about that.

This program is aimed at newborn children, not school-aged children. The whole issue of siting health and education facilities together is something at which we are looking because many programs which existed when I was a principal of a school (which was at a time when health and education worked very well together at local levels) have disappeared over the last 10 years or so. This government is faced with the job of re-establishing those tried and true things that were very much part of the system in earlier times.

Mrs PENFOLD: The school at Ceduna is a junior primary school and it is next to the kindergarten. My feeling is that, if I could involve the parents, particularly the mothers, then we would be able to access them when they are pregnant and their babies when they are born. It would be a good opportunity to spread that information amongst their friends and perhaps make a meeting group. I ask the minister to look at it. I am very disappointed that an area such as mine, where I think the need is great, has not been included in this program.

The Hon. L. STEVENS: Yes; I guess that you would have been really disappointed that that did not happen during the years when your party was in government and it had the opportunity to bring in such a program. However, this Labor government is making this a priority: it has started on the job and it will not give up. I will ask Mr Jim Birch to answer the question.

The CHAIRMAN: Can I just remind you not to shout into the headphones of Hansard, who may need a visit from a professional if they keep getting that in the head.

The Hon. L. STEVENS: Sorry, Hansard.

Mr BIRCH: I think that it needs to be made very clear that there are three or four key programs in this area. Some are run by DECS and some are run by the new Department of Health; the one to which we refer in the component mentioned by Mr Beltchev is the universal home visiting program. Prior to the universal home visiting program commencing, a range of different existing services, including those on Eyre Peninsula, provided antenatal and postnatal care. The universal home visiting program is simply a mechanism to ensure consistency across the whole state and that no children fall between the gaps. You are correct in saying that the linkage between pregnant women, the early years and kindergarten is critical.

The sustained home visiting program is based on an assessment by child health nurses who visit all people who volunteer that those parents have a particular need for parenting support for a variety of reasons, and we estimate that about 40 per cent of the population of newborns will access that program. It has always been intended that the sustained home visiting program would become a universal program. However, it is very important that—and I refer you to Professor Victor Nossar who is a national expert in this area—we actually test this amongst a number of different population groups to ensure that it works well. At this stage, it is very positive, particularly for Aboriginal families, whereas programs provided to traditional non-Aboriginal families are not as suitable for rural and remote Aboriginal families.

There is also a third area, the early childhood and literacy programs of DECS. We are now linking the Every Chance for Every Childhood program into those programs. I would have an expectation that we would progressively roll out this across the state, subject to funding, because it is not a terribly expensive program when you consider the benefits. We would be more than comfortable to check with what DECS is intending to do in relation to its early childhood, kindergarten and pre-school areas, particularly on Eyre Peninsula, to see what opportunities there are in relation to linking with our universal home visiting program.

Mrs PENFOLD: I think that it could also be included with food and nutrition, as there are opportunities to teach cooking and hygiene in my kindergarten.

The Hon. L. STEVENS: Absolutely. I reiterate what Mr Jim Birch has said: we will definitely do that. Of course, that is exactly what we need to do. It is about a holistic and community-based approach. It is about involving the people in determining their needs and developing those programs around them. As I said before, the new organisation in the Children's, Youth and Women's Health Service will also have specific lead responsibility to look at innovative primary health care approaches in conjunction with DECS and other departments so that we can try to achieve more than has ever been achieved in this state.

The CHAIRMAN: We are out of time. I ask the minister and her advisers to keep their answers shorter after lunch, because I think that one question took 23 minutes to answer.

The Hon. DEAN BROWN: Mr Chairman, I back up what you have just said, although in fact the first question took 26 minutes to answer. I appreciate the point that you make.

The CHAIRMAN: It is important that we keep answers short and, while the chair cannot dictate that, in fairness to everyone, we should try to keep the answers short.

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

Mr CAICA: Minister, I refer to Budget Paper 4, Volume 2, programs S6 and S9, relating to the operation of metropolitan and country health. Will the minister provide the committee with details of the patient safety framework and monitoring systems that have been implemented to ensure quality and safety in our health systems?

The Hon. L. STEVENS: I would be delighted to answer this question from the member for Colton.

The Hon. DEAN BROWN: What page was that on?

The Hon. L. STEVENS: I think he said Budget Paper 4, Volume 2, S6 and S9. I do thank the honourable member for the question because safety and quality are critical issues in our health system and much is being done to ensure that we have the highest standards possible. To focus on safety and quality and manage this process, Professor Brendan Kearney was appointed as the Executive Director, Clinical Systems. A 'Patient Safety Framework', a document outlining the government's plan for improving safety and quality in the South Australian health system, has been produced.

An Advanced Incident Monitoring System (AIMS) has been implemented statewide and this allows local health service levels a statewide centralised management of events if adverse events and near miss events occur in our health system. Incident Reporting to Improve Systems (IRIS) is a project that complements the Advanced Incident Monitoring System. This has been effective in increased reporting of adverse events by health professionals, which is what we need to happen, and focuses on improving processes to prevent future occurrences. This one includes a toll-free 24-hour hotline for clinicians to report adverse events. We encourage that of course.

Root Cause Analysis Training (Patient Safety Training), a method of investigation to identify health system deficiencies that are not readily apparent, has been provided to more than 500 members of the health care team through eight courses since April 2003. These are just some of the initiatives that have been implemented, in addition to the government's commitment to alleviating overcrowding at the Flinders Medical Centre Emergency Department and the redesign of processes at the Royal Adelaide Hospital Emergency Department, which I might add is occurring with very positive results.

I would like to ask Professor Kearney, who is present today, to provide the committee with some details of the programs which include: clinical practice improvement; patient evaluation of hospital services; the introduction of a statewide patient safety newsletter; and implementing AHMC's April 2004 National Health Reform Resolutions relating to safety and quality in health care.

Prof. KEARNEY: Thank you, minister. South Australia has put together a framework for patient safety which I believe is the equal of any in Australia and equivalent to those at the forefront of safety in health care internationally, and we were early to do this. There are a number of key elements to that framework. The first is a common clinical information system that, in the Australian context, South Australia is unique in having a system called OACIS that supports clinical information.

This means that the electronic record that is available is a medical record with medical, nursing and allied health notes and is fully transportable between sites and accessible within the whole system. It allows not only for better recording of key patient data but also accumulative reporting of all investigations—laboratory, radiology and so on—and makes this information readily available to any doctor, nurse, or allied health specialist treating the patient at any time of the day or night. It also provides for timely and accurate discharge information to general practitioners, which is a key in the continuing management of patients.

Another key element which is unique within the South Australian system is the incident monitoring system. This system was developed out of the Royal Adelaide Hospital, but has been rolled out and implemented throughout South Australia, both metropolitan and country hospitals, and it provides for voluntary reporting of adverse events. The international literature shows that the more adverse events are reported voluntarily, the safer the system. This year we expect over 6 000 adverse events to be reported, but we know that that can increase substantially, and we are encouraging clinical staff to report more and more adverse events so that it forms a foundation of knowledge about problems within our system which we can then address.

The minister mentioned that we complement the incident monitoring system with a system called IRIS, and that is a 24-hour telephone system encouraging particularly doctors to report, because we find that doctors are not as good at reporting events voluntarily as perhaps other health care staff. It is interesting that this AIMS system (which has been developed in South Australia) has now been adopted nationally as a standard to be implemented and to be rolled out.

The next key part of our framework is the safety assessment code, which is a risk management code compliant with Australian standards for risk management. It categorises the frequency and severity of adverse events and allows staff to assess whether there is a potential or actual serious harm and to take appropriate steps to investigate and to take actions from such an investigation. This code covers events affecting patients, visitors, staff, and plant and equipment within hospitals. Again, it is something that has been developed in South Australia and is now being applied nationally.

The other key competency is that following the assessment of the severity of an adverse event is the technique of root

cause analysis. We have trained in excess of 500 senior clinicians throughout our system in this technique, and we continue to train them. Root cause analysis is a system that is used generally in industry. It has come late to the health-care industry, but obviously the aviation, mining and motorcar industries use these kind of techniques as basic to their manufacturing systems, and we are now in the process of rolling out this kind of system quite quickly within our health-care system. It involves teams not involved in the adverse event. It is multi-disciplinary, and it has a very structured process designed to analyse the contributing and causal factors involved in an event and to come up with implementation plans based on the literature surrounding those kind of events. The next phase of the program is the implementation and monitoring of those implementation plans and reviewing whether they have been successful.

We have also instituted a national sentinel event reporting program that looks at eight of the most serious causes of adverse events. This covers wrong side surgery, abduction of infants from hospital, death or attempted suicide within a hospital or under care, retained instruments, and a range of other programs. We have centralised reporting of this system, and that is contributing to a national database which we hope will give us a better program to prevent and manage these kinds of adverse events. We have a number of aggregated approaches including infection control, falls, burns, pressure ulcers and medication errors which affect the very common but serious adverse events occurring in our system. These projects aim at quantifying and addressing those problems.

In addition, we have looked to involve consumers heavily in the safety and quality program, and we have asked each of the major hospitals to have a consumer committee that focuses on safety and quality. They are involved in not only feedback from the consumer but also in considering the findings of the root cause analyses and their implementation. We are also piloting a project around open disclosure. This is a form of saying sorry when an obvious adverse event occurs but without admitting negligence.

The Hon. DEAN BROWN: I am happy for a prepared answer like this to be inserted. We have now been on this question for 10 minutes. Whilst I appreciate what Professor Kearney is saying, it is important, I think, that prepared material like this can be circulated.

The CHAIRMAN: We need to keep questions and answers tight, otherwise it makes a mockery of the whole estimates.

The Hon. L. STEVENS: In his comments earlier today, the shadow minister specifically referred to the lack of attention to safety and quality given by this government. He cannot have it both ways. Professor Kearney is answering a question, but he wants us to stop giving that information about the considerable work that is being done.

The CHAIRMAN: It is important to give the answer, but I think that before lunch some answers were going for over 20 minutes, so I ask you to be as concise as possible.

Mr CAICA: I am particularly interested in what Professor Kearney was just about to say, and that is the mechanisms by which sorry can be said, because we know from the Health Complaints Bill that this can avoid a lot of litigation further down the track. I would appreciate it if Professor Kearney could finish on that aspect.

The CHAIRMAN: Perhaps the professor could consolidate the answer. If there is additional information, that can be provided subsequently.

Prof. KEARNEY: Briefly, regarding open disclosure, South Australia is to be one of the key jurisdictions involved in the implementation of this program nationally. We are selecting three hospitals within the metropolitan area and one hospital in the country. The aim of this program is not to avoid negligence claims but to more openly discuss issues so that, when things go wrong with patients, the hope is that we can minimise the number of claims by communicating better about processes without admitting negligence. We want to try to improve the quality of communication and health-care outcomes. The other major program that we have is a continuous practice improvement program that is unique to South Australia. It is designed to give senior clinicians the skills to evaluate their clinical care.

The Hon. DEAN BROWN: I turn to page 7.50 of Budget Paper 4, Volume 2—grants to country hospitals and regional health services. Taking into account the tables on the previous page, it will be seen that there has been an increase in federal funding for country hospitals of $2.7 million. As far as state government funds are concerned, the allocation to country hospitals dropped by $5.6 million from $173.7 million in the estimated results for 2003-04 to $168.1 million. That is a drop of 3.2 per cent in the estimated outcome for this year. That is astounding when you consider that there will be inflation and that the health inflator is invariably about 6 per cent. Some of that is wages. We have heard earlier today that approximately half of the money for wage increases for nurses is already covered in the budget estimates.

Country hospitals report to me that they have had to have an effective cut of 3 per cent per year for the last two years. This will now be substantially more than 3 per cent, because of inflation. Whilst there might be some supplementary money for wage increases, that will erode this amount even further, and I know this is causing enormous concern amongst country hospitals. Can the minister say whether it was a Treasury decision as to what would be allocated to country hospitals and health services for 2004-05, and on what basis did Treasury make that decision?

The Hon. L. STEVENS: Will the shadow minister please advise what page he is working off?

The Hon. DEAN BROWN: Page 7.50, Program S3: country hospitals. I do not think the minister needs the program to answer that question.

The Hon. L. STEVENS: Let me be the judge of that. I will make a couple of comments and then hand over to the Chief Executive. There was an issue in relation to the two figures quoted by the shadow minister, and the Chief Executive will refer to that matter. In relation to the country health budget, an extra $8.7 million has been allocated this year for the country health regions. I have talked about the extra PATS money of $1.7 million over four years. The increased nursing allocation is $4.2 million over four years; and of the dental services new money allocated in this budget, the country will receive $990 000, which is 22 per cent of the $4.5 million statewide figure. This morning, I talked about the hospital avoidance money, and also the $8 million increase over four years for elective surgery in metro hospitals, 10 to 15 per cent of which will be spent on country patients. We must not forget that in October last year the government allocated an extra $20 million over four years to country health regions. I will now hand over to the Chief Executive.

The Hon. DEAN BROWN: My question is really one which the minister has to answer.

The CHAIRMAN: Order!

The Hon. DEAN BROWN: Can I repeat my question, because it is quite specific? Was it a Treasury decision as to what would be allocated to country hospitals and health services for 2004-05 and on what basis did Treasury make such a decision?

The Hon. L. STEVENS: The shadow minister has been the minister, and he knows what the process is for allocating budgets. That is all I will say about that matter.

The Hon. DEAN BROWN: I want an answer to the question.

The CHAIRMAN: Order!

The Hon. L. STEVENS: The member has already had an answer.

The CHAIRMAN: Order! The member for Finniss cannot demand an answer to anything, and the chair cannot make the minister answer in a particular way. The minister chooses to answer in accordance with what she thinks is appropriate.

The Hon. L. STEVENS: It is a quite ridiculous question; the member knows the answer. I also draw people's attention to page 7.92, Program S9: Country Health Services, and the table, 'Summary statement of financial performance'. At the bottom of that table is a little footnote which states:

> The country net cost of service for regions in 2004-05 is forecast to increase by $8.7 million above the equivalent budget for 2003-04.

That is what I was searching for when the shadow minister was quoting some figures in the table earlier. The Chief Executive will explain that discrepancy there. That footnote clearly explains the $8.7 million that I have just mentioned.

The Hon. DEAN BROWN: I must correct that point. My question actually related to the estimated result for 2003-04 and not the estimated budget. I have worked on the government's own figures of the result for this current year, and there has been a cut of 5.6.

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

Mr BIRCH: There is some supplementary information in relation to interpreting the budget papers that is worth the shadow minister and other members being aware of, particularly in relation to country. The budget papers do not include allocations yet to be made to country which are incorporated in other lines of the budget papers, specifically against other programs. The shadow minister mentioned earlier the nursing enterprise bargaining agreement, which has not yet been fully funded in the budget papers. However, there are other funds in mental health where it is expected that a proportion of the new mental health programs which will be rolled out not only in the forward estimates beyond this year but also within the current allocation that exists in the base of the department in the Mental Health Unit a proportion will be rolled out to country. Further, the Every Chance for Every Child Program, which is contained within the budget papers in a central line this year but will be provided next year through Children's, Youth and Women's, will also be included as a country program, and HACC funding in 2004-05, which is also to be rolled into the country, is included within a central line.

The other really difficult issue for the department is that, on a case mix or a strictly case workload basis, the country would be struggling on a purely scientific basis to get significantly more money. In fact, Roxanne Ramsey has figures that demonstrate that country activity is declining, of which I am sure the shadow minister is aware. There are a number of minimum volume country hospitals for which we are required to maintain the level of funding. It is not possible to transfer funds from those into other areas where there are population increases. But in general the amount of activity that is decreasing across country, in terms of the number of in-patient separators, is about 2 per cent, the equiceps. In emergency patients, it is 1.8 per cent WOS, which is weighted outpatient separation, and nursing home patients are declining by 1.2 per cent. So, there are declining activity pressures at the same time as we have additional dollars going into country, that we need to take into account.

Ms RAMSEY: The only thing I would add to that, with the services in the country, is that it is the community-based services and the services outside of the acute setting that we are needing to build up, and that is represented in the activity figures, which have seen a slight increase in out-patients but a decline in in-patients.

The Hon. DEAN BROWN: I do not think my question has been answered, and basically it was: have they allocated money to the country based on a population basis, and is this the impact of allocating money according to that?

Mr BIRCH: The population based funding model has not yet been introduced. It will be shadowed for one year from 1 July and will come into play on 1 July 2005. Therefore, we are not implementing allocations within the health department budget on the basis of population.

The Hon. DEAN BROWN: My second question relates to the ambulance transfer costs in country hospitals. There are 46 country hospitals, I think, and I would appreciate knowing, for each of those 46 hospitals—and I appreciate that you cannot provide the answer today, but if you could provide it to the parliament with other relevant information—what is the total ambulance transfer costs for 2003-04 for each of those country hospitals in terms of their budgets, and to what extent have they exceeded those costs in the current financial year of 2003-04? The country hospitals are saying to me that the costs have increased by 22 per cent on an equal service basis over a two-year period, and the *Government Gazette* would reflect that. For instance, I have some costs here that show that in 2002-03 the category 1-3 hospital transfer would cost $506, and for 2004-05 it will cost $618, and similar increases have occurred in other areas.

What is the specific transfer budgeted figure for this year? What has been the over-run, because many of them have complained of substantial over-run? What supplementation of hospital budgets is occurring from head office to take account of this 22 per cent increase in ambulance transfer costs for a service over a two-year period, because hospitals have indicated to me that, in effect, they have had no adjustment. Their budgets had about a 1.8 per cent increase this current year and so therefore if they have had a 22 per cent increase in ambulance costs they have had to absorb that cost into their budgets. I am asking, therefore, what supplementation, because if you have a 22 per cent increase in costs over a two-year period—and it is a significant cost in each hospital—then you are consuming a significant amount of that hospital's resources into ambulance transfers, which provides no benefit to the patients within that country area, except they get to Adelaide.

The Hon. L. STEVENS: We will get the detail of that question for the shadow minister. I know that there has been some money set aside. I will ask Jim Birch to respond and then maybe also Chris Lemmer.

Mr BIRCH: We will get the detailed information back to you because we will not be able to provide that today. However, I think it is worth providing this information. Mr Lemmer can provide information about the specific fee

increase which occurred with the South Australian Ambulance Service which was the subject of budget supplementation to the department for flow-on to the regions for accounting for that fee increase. It was a substantial increase but then from thereon in I understand CPI will provide, but Mr Lemmer can actually provide the details. I can give you the amount by regions during 2003-04 which were allocated in relation to ambulance transfer increases, dollars by region: metropolitan area, $485 000; Eyre, $8 000—and this is not the total budget but the increased supplementation—Hills/Mallee Southern, $74 000; Mid-North, $13 000; Northern and Far Western, $38 000; Riverland, $57 000; South-East, $21 000; and Wakefield $60 000. We can provide the information that you have indicated earlier which I think included whether there were any specific over-runs against that during the year.

The Hon. DEAN BROWN: You have indicated an amount of $60 000 there for Wakefield as supplementation. I am able to indicate that one hospital has had to cancel surgery now for eight weeks, and is one of the hospitals in that area. It is anticipating that they will be over their budget for hospital transfers, just the ambulance costs, by an amount of about $40 000. It would appear that most of that money will be swallowed up very, very quickly indeed.

If that reflects one hospital, I wonder what it is like when you pool all the hospitals within that one region: it would exceed that quite considerably. The hospitals report to me that they are over budget—and significantly over budget—when it comes to ambulance transfer costs, and that obviously takes into account any supplementation which has occurred, which is clearly inadequate.

Mr LEMMER: There were really two elements to the increased cost in ambulance transport to hospitals, particularly regional areas. The first was the 2002-03 increase in fees of 17.6 per cent, which was a once-off increase and a result of having to recover a budget savings strategy which had been built into the forward estimates for the outsourcing of the ambulance cover scheme. That was eventually rejected by the federal Minister for Health and, as a result and to recover the loss, fees were increased by 17.6 per cent. If ambulance cover been outsourced, members in the ambulance cover scheme would have been able to take advantage of the 30 per cent health insurance rebate available to all ambulance cover members who get their benefits through registered private health funds. The ambulance service is excluded from that, which applied additional cost pressure to the ambulance service and also makes the scheme exceptionally uncompetitive. The increase in 2004-05 will be 3.8 per cent, which is in line with CPI, or in line with inflation.

The Hon. DEAN BROWN: But 2 per cent is the inflation rate—or 1.9 per cent?

Mr LEMMER: Yes, in line with the health inflation factor, which is 3.8 per cent. Also, during 2003-04, the Ambulance Service introduced a third tier of charging. Previously, we had only two charges—one for emergency and one for elective. In 2003-04 we introduced a third tier, so we had an elective tier, a mid tier and an emergency tier charge. When we introduced that we recognised that it would have some impact on regional hospitals particularly but, because at the same time we changed the way in which we triaged patients, it was impossible to do an exact correlation of how the accounts under the new triage system would equate to the old system. As a result of that, the supplementary figures that the Chief Executive (Jim Birch) read out earlier relate to the revised triaging that has taken place in the last 12 months. That had nothing to do with the 17.6 per cent increase. That was a separate supplementation for the triaging change.

The Hon. DEAN BROWN: Was there any supplementation for the 17.6 per cent increase?

Mr BIRCH: We can provide those figures specifically.

The Hon. DEAN BROWN: My next question relates to the Royal Flying Doctor Service. The Royal Flying Doctor Service, as we all know, operates a retrieval system across the state, and some of that goes into Adelaide at present, and some goes into Port Augusta, as everyone understands. Certainly, a significant amount of it goes into Port Augusta, and an aircraft and personnel are based in Port Augusta.

Presently the Royal Flying Doctor Service has a review under way by an external consultant who is looking at all the issues and, in its latest letter, the Royal Flying Doctor Service President and Chief Executive Officer indicate that they are now looking for an increase in funding and that the state government is willing, perhaps, to pay additional funding to the Royal Flying Doctor Service to maintain existing medical retrievals at Port Augusta so that the operation will remain the same.

Is that a fair assumption as to what is implied in this letter? If so, what commitments have been given by the state government and what amount of money is likely to be involved as part of that commitment?

The Hon. L. STEVENS: I think that the shadow minister would need to seek the answer to the question of what is implied in the letter from the people who wrote the letter. I have answered a question in parliament already in relation to the government's position as made clear by the Premier when he wrote to the Prime Minister in relation to the Royal Flying Doctor Service and its operations in Port Augusta. I will reiterate the last sentence of his letter to the Prime Minister, as follows:

> I urge you to join me in calling on the board of the Royal Flying Doctor Service to preserve existing operations in Port Augusta in the interests of Outback people.

As the shadow minister has stated and as is also in the letter, no decisions have yet been made by the board of the Royal Flying Doctor Service, so we will be, I am sure, having discussions with it once it has made that decision. Any other comments are hypothetical and speculative at this point.

The Hon. DEAN BROWN: With due respect, I will read the appropriate part of the letter, as follows:

> The board commenced this review process with the sole aim of ensuring that we could continue to deliver as a minimum the same standard and same level of service delivery. The foundation of this review is not about funding and, up until now, the review has been conducted under the premise that our resources from government were fixed. Our previous representations to the government for additional funding suggested no reason to assume otherwise. The Premier seems to have indicated that this may not necessarily be the case, and the board is pursuing this matter.

How can you have a review? Funding is a crucial part of that, and that has been acknowledged throughout this letter. I am simply asking: is the minister willing to ensure that additional funds are put into the Royal Flying Doctor Service to maintain the existing service? It would appear that the Premier has indicated (whether or not the minister is aware of it) that the government would be willing to look at what additional funding might be needed to maintain the service.

The Hon. L. STEVENS: My understanding is that the only official comments the Premier has made in relation to this matter appear in this letter to the Prime Minister. My comments stand. When the board makes its decision in

relation to its services, I am sure that, as a funder (and the federal government as a funder), we will need to talk with it about what decisions it is making to its service provision as a result of what its review reveals. That is all I can say.

The Hon. DEAN BROWN: First, this letter goes beyond what the Premier said in his letter to the Prime Minister. Frankly, one must ask: why drag the federal government into this? We know that hospital to hospital transfers are covered by the state government under funds provided by the state government, some of which, of course, include federal funding. Hospital to hospital transfers are done by the state government. We know that 45 per cent of the funding for a retrieval not from a hospital is provided by the state government and 45 per cent by the federal government.

If one puts the two together one can see that the overwhelming majority of funding comes from the state government. It is therefore a state government decision, and that is why I am asking this question. Is the state government willing to put in additional resources to maintain the existing services out of Port Augusta and based at Port Augusta?

The Hon. L. STEVENS: The question is completely premature. We do not even know the outcome of the deliberations. I believe that it will have some result from its review fairly soon. I cannot comment any further about the Premier's comments. On a previous occasion I have given the house the Premier's words to the Prime Minister. That is the government's position. We now need to wait to see the results from the board of the Royal Flying Doctor Service, which is an independent board. I do not think it has even got its response from its reviewers but, when that occurs, I am sure that it will have discussions with us.

The CHAIRMAN: Earlier the minister referred to a shortage of nurses. It is probably more accurate in my judgment to refer to a shortage of trained nurses who want to work as nurses, but maybe that will change a little with the new EBA. In the minister's outline of that EBA there did not seem to be any reference to changes in the flexibility of working hours for nurses. I just highlight that point; the minister might like to comment in a moment. The main point I want to make relates to the shortage of nurses, as you put it. However, on the other hand, if one looks at the statistics (and I am not picking on the Flinders University, I am just using it as an example), this year there were 1 400 applicants for 200 positions for the Bachelor of Nursing degree.

In the enrolled nursing program (this is just one campus of TAFE) there were 200 applications for 20 positions, and, of course, that is now a diploma course in TAFE. I think that for midwifery there were something like 500 applications for 20 places. I realise, minister, that you do not control the universities or TAFE, but, in terms of your position as minister, what is happening in relation to trying to address that obvious lack of enrolment at the universities and TAFE to provide sufficient nurses? As part of the answer, the minister might like to comment on the fact that some hospitals are telling me that they are likely to have fewer enrolled nurses.

They say that if they are going to employ nurses they might as well have registered nurses. Other people are telling me that there are too many chiefs and not enough indians, which I take to mean that there are not enough enrolled nurses and too many registered nurses. There are three aspects to what I have put to the minister.

The Hon. L. STEVENS: Mr Chairman, would you mind summarising those three aspects?

The CHAIRMAN: First, there is the statement that I believe there is not a shortage of nurses but a shortage of trained nurses who want to work as nurses. I did not hear in the EBA detail any change to the working hours for nurses. People with young children often raise that point with me. I do not know which matron years ago came up with a 7 o'clock start. However, has the issue of flexibility of hours been addressed so that not only mothers but also fathers can accommodate family responsibilities yet work as a nurse? That was the first part.

The second part was that we have a shortage of nurses, as you have put it, yet we have a huge number of people who want to be nurses but who cannot get the training. They cannot get into either university or TAFE, so we seem to have what, in effect, is a paradox. We also have some people within hospitals saying, 'We are going to employ fewer enrolled nurses because if we are going to employ nurses we might as well have registered nurses.' Other people are telling me the opposite: that there are too many chiefs, meaning too many registered nurses and not enough enrolled nurses. I do not know whether you want to comment on any of that.

The Hon. L. STEVENS: Yes, I will comment briefly, and then I will ask the Chief Executive to make some further comments. In relation to the flexibility of working hours, I want to make one comment about one particular area with which I am very familiar and then I will leave Mr Birch to answer more fully. Just a couple of months ago I launched a new model of midwifery practice operating out of the Women's and Children's Hospital called Midwifery Group Practice.

This certainly made the working hours of nurses and midwives more flexible—for midwives, in particular—resulting in much improved patient care for women throughout their pregnancy and after the baby is born. That was a special arrangement negotiated with the ANF to free up the nurses to work outside of shifts and to do quite a different working week so that they could be available to the mothers under their care at a whole range of different hours. That is extremely good, because that met needs on both sides of the equation: primarily, better care for the mothers, but it also gave flexibility of working hours to the midwives, which has been very satisfying for them professionally. So, that is a very good program, and we want to extend it to other hospitals. Mr Birch will speak more about the other issues of flexibility.

In relation to the shortage issue, and the TAFE and university places, it is incredibly frustrating. I remember when our first big shortage hit us, in our first year of government, I think, when we were actually forced to close beds in the metropolitan area because we just did not have the nurses to staff them. We were pleading with people to consider nursing as a profession and, of course, lots of people put it down on their choices, only to get knocked back by universities and TAFE who were not providing the number of places that we needed. It is a very problematic issue.

The state government itself, out of its nursing recruitment and retention package, has actually paid for nursing places. Perhaps Mr Birch can give us the exact number of places, but we certainly paid for some. Of course, that is really a stopgap issue, because the responsibility for nursing training places is not the state's: it is the federal government's responsibility for university and TAFE funding. This is of great frustration not only to me but to all health ministers across Australia. We have been extremely frustrated in our efforts to actually engage the federal Minister for Education, the Hon. Brendan Nelson, in relation to the seriousness of the health work force

crisis. It is not only in nursing: of work force shortages across Australia, 13 or 14 of the top ones are in the health professions. Nursing is the largest work force, but it is right across the board.

In the health work force the issues of training, and the way we fund our universities, mean that we are not actually producing the numbers of health professionals needed to provide the care that we need in this country in the short, medium and long term. There is another health ministers' conference in Hobart in July, when this matter comes up again. It is a source of great frustration that we cannot seem to get any serious commitment or effort by the federal government in engaging in this crisis. We will find ourselves at a point where we cannot provide the care that we need to provide. The issues of the mixtures of enrolled nurses and registered nurses I will leave to the Chief Executive.

In rounding off what I have to say, when John Menadue was here, he said many times that he thought the most significant issue facing all of us in terms of health care service delivery was the work force—that it would force us to look at new ways of arranging the care of teams of people, and of doing things differently. For instance, I notice that the minister in Victoria has today announced a new midwifery arrangement—a birthing arrangement with midwives rather than obstetricians. She actually said that one of the reasons for this was that they could not get the obstetricians. We have our own problems.

The same issue exists at the Queen Elizabeth Hospital, where there are shortages. This work force shortage is going to drive reform and the way we deliver our care in a way that probably nothing else has. Mr Birch, would you like to fill in?

Mr BIRCH: I think your first question related to the number of nurses who were not working within the public or private health care system, but were still available to be employed. I can obtain the actual figure, but I believe that the number of nurses who are actually on the register but not actively working within the public or private health care system is now at a record low. That demonstrates that we, along with the private system, are being quite successful in attracting nurses back into the system.

Regarding the second issue of flexibility of hours, it is a commonly held myth that the public system is not actually flexible with hours and that only the private system, or nurses through agencies, can have flexible hours. At least one of our teaching hospitals at the moment has nearly 60 to 70 per cent of its nurses working less than full-time hours, and they are on quite flexible hours. Whilst there are pockets of inflexibility, about which we are concerned, there is a substantial amount of flexibility in the number of hours that are being worked by nurses and midwives.

The issue of the higher education sector is complicated, and we are working very closely with the universities in this respect. One of the complications is the announcement that nurses would be exempt from the 25 per cent increase in HECS. This was seen to be a positive announcement and, on the face of it, it is. However, from a university perspective, we have to avoid the risk of the universities decreasing the number of nursing places because they are unable to increase the HECS fee by 25 per cent. Nursing is actually quite an expensive course per annum to operate because of its technical nature.

At this stage, I am pleased to say that the universities that we relate to, largely, in nursing—Flinders University and the University of South Australia—are certainly not intending to decrease the number of places, but we need to be mindful of that. We have a small number of undergraduate nursing places which we purchased for the last year and which will flow on to this year involving 40 additional undergraduate nursing places—15 at Flinders University and 25 at the University of South Australia. We are hopeful that we will be able to support a new course which would start from the beginning of 2005 at the University of Adelaide and which will have a higher level of clinical placement content.

The other issue of which we were very conscious during the enterprise bargaining negotiations was the question of enrolled nursing versus registered nursing ratios. The Australian Nurses Federation, I think it is fair to say, was quite keen to have a minimum level of RNs employed within our hospitals. We were able to resist that, because we felt that that flexibility of being able to employ enrolled nurses in a variety of situations was quite important. Finally, the other area which we will be very keen to pursue in the new financial year is how we can extend nurse practitioner roles within both rural and metropolitan areas. Over time, that will not only increase the responsibilities of registered nurses but it should also increase the responsibilities of enrolled nurses and make them more valued members of the staff.

In 2004-05, we have the third year of the roll out of the nursing and midwifery recruitment strategy, and the key focus in 2004-05 of the $2.7 million a year program will be recurrent funding for existing programs, which are refresher programs for nursing and midwifery, clinical post-graduate scholarships for nurses and midwives and educational programs, particularly including VET within schools, which I think was your particular focus in relation to TAFE. We would wish to be more involved with TAFE, because we believe that there is a current imbalance between the number of people who are able to gain access to TAFE Certificate Level 4 nursing and our needs for the future. We will be maintaining the existing nursing cadetship program in country areas, the nursing clinical leadership program and also, as I mentioned, the nurse practitioner project.

Finally, we are working with the universities—and we do not have an answer to this at the moment—to try to overcome the drop-out rate; that is, even though there are just over 1 000 registered nursing places, at the end of three years, regrettably fewer than 400 graduate. One of the reasons for that is that nursing is used as an entry point for other courses and, after the first year, people move on. However, we have to address that substantial drop-out rate from that course, because as you have correctly indicated, the rate of year 12 applicants for nursing vastly exceeds the number of available places.

The CHAIRMAN: Just quickly on that last point, I think dentistry and medicine have addressed that drop-out rate, which as you say is quite high for nursing, by putting people through a shock introduction. The dental students-to-be are told that they will have blood and spit and everything all over them, and half of them walk out. I do not think that a similar approach is taken for nursing, and people get half way through the program and find out that they do not like the sight of blood.

The Hon. DEAN BROWN: I have a point of clarification. Mr Birch indicated that there were 40 RN positions. As I understand it, that is the same 40 that was negotiated and agreed to in 2001, which means that they are now in their third year: 25 at the University of South Australia and 15 at the Flinders University. The two schools of nursing have made the point to me that no additional positions have been funded over and above those negotiated in 2001 when I was

minister. So, no additional RN positions have been funded by the state government. I understand it is the third year of the program put in place then. The statement that the government has funded a lot of extra positions is not the case at all, is it, because the only ones that are funded are the 40 originally funded and negotiated at $5 000 a position?

Mr BIRCH: I am happy to provide that information, but I do not believe that to be correct. The honourable member is correct in relation to the program to which I am referring. I know personally that I negotiated in my first year increased funding for the Flinders University over and above the base, and also for the University of South Australia. However, I do not recall the exact numbers and I am happy to provide that.

The Hon. DEAN BROWN: They tell me that there has been no increase over and above those initially negotiated. I am asking the question to clarify that point.

Mr BIRCH: I also know that I personally negotiated with the University of Adelaide the funding allocation for the commencement of their course in 2005, and we are hopeful that their council will agree to the commencement of that course in 2005, which is actually the point Dr Such raised. It has a higher level of clinical work load which, hopefully, will address some of those practical aspects. I stand corrected, but I am happy to provide information out of session on that.

Mr HANNA: Minister, I have a question about one of the most well-used facilities in my local electorate, and that is the Inner Southern Community Health Service. For many years, members of the community and I have been concerned about the relatively shabby state of accommodation that they enjoy. Is there anything in terms of planning—projections, estimates, anything at all—in respect of those facilities and how they might be improved, or, indeed, relocated?

The Hon. L. STEVENS: I thank the member for the question. I am aware of the issues in relation to that health service. We are considering it in terms of the future capital works programs. We do not have an allocation for it at this point. That is not good news for you in particular in relation to that health service and those facilities. Again, I have to say that we have significant demands on the capital works programs in terms of the backlog on the big metropolitan hospitals and the mental health sector, which have been put into the budget this time. We know it is an issue for the near future.

Mr HANNA: I acknowledge the good news in relation to Flinders and the proposed cancer care centre. My second question relates to program K1 in respect of Aboriginal social services. I have a couple of questions about services on the APY lands. In some ways, this is not the most important question, but I want to ask about housing for health workers on the lands. Following a recent visit by the Aboriginal lands committee to the APY lands, one of my personal observations was that there is difficulty in attracting and retaining health workers for the various clinics established on the lands. Obviously, those people require housing. The Aboriginal Housing Authority is stretched to the limit, and it is probably not appropriate for that body to provide the housing. Is there funding in the health budget for housing for these workers, because this is crucial to attracting people not only to go there but to stay?

The Hon. L. STEVENS: I have been to the lands only once a number of years ago, but I intend to go again in a month or so. This is a critical issue in attracting people to work there and to deal with a whole range of other issues. My advice is that in 2003-04 as part of an $11.96 million allocation over four years, $2 million was set aside for DAIS to provide staff housing. I will ask Jim Birch whether he can provide some more information about that.

Mr BIRCH: This is a significant problem in relation not only to health workers but all workers on the AP lands. The amount indicated by the minister is correct. However, it is not for me to release information regarding what is happening in terms of the task force which is currently under the auspices of the Department of Premier and Cabinet, but (under Bob Collins) it is examining how to allocate funding for the coming financial year, and I know that housing for workers is a significant issue which the task force hopes to address.

Another area of which I think members need to be aware is that—and we are not always able to do this—occasionally the commonwealth and the state include in grants to the Nganampa Health Service a one-off allocation to assist with housing. That is not universal; it does not happen with all grants. Therefore, it is not sufficient to adequately provide for housing. However, the task force, on which we have representation, is looking seriously at this issue, because we simply cannot recruit people to the lands—or, indeed, Nganampa and APY and other agencies—without providing adequate housing. That partly answers your question, but I think there is more information to come from the Department of Premier and Cabinet on this in due course.

Mr HANNA: Supplementary to that, is the minister or Mr Birch able to advise what the process is going to be? Assuming the task force says, 'We need more houses on the APY lands', is it then up to the task force or the Department of Premier and Cabinet to go to the health department and say, 'Can you find another $2 million?' How is it going to work for the remainder of this year as the task force identifies what needs to be spent?

The Hon. L. STEVENS: I will ask Dr David Filby, who is a member of the task force, to address your question.

Dr FILBY: The capital costs associated with housing are provided by DAIS. In a sense, they borrow the money publicly to build the houses and bill us an annual recurrent amount to repay it. So, we have to find about $50 000 a year out of our recurrent budget and give DAIS enough warning to build a house for non-local employees.

Mr HANNA: My third question relates to funding for the patient assisted transport scheme on the lands. This is one of 100 questions that I could ask about the APY lands and the health services there. I am informed that the Nganampa Health Service receives about $500 000 a year from the department for the patient assisted transport scheme. However, the actual costs involved are about $600 000 a year. Therefore, $100 000 is essentially coming out of other parts of the Health Council budget. Is the minister able to verify that and provide some assurance that this problem is being addressed if there is this funding gap which I have identified?

The Hon. L. STEVENS: I will ask Mr Jim Birch to address that question.

Mr BIRCH: The actual figure that I have, which is a little bit dated—it was prepared about six to eight months ago—is that for 2003-04 they required about $176 000. There was a $176 000 gap between the funds that they had available and the cost of patient administration transfer.

Mr HANNA: That's what I am suggesting.

Mr BIRCH: We allocated in the current year 2003-04 an additional $100 000 to partially fill that gap, which leaves $76 000. The question of Nganampa's funding for 2004-05 is still under consideration. That is also part of the task force's consideration, because the allocation out of which this came was the $1.65 million that was allocated to the lands

this year, which expands out to about $2.1 million next year. So, there is further consideration as to whether that gap will be bridged this year, and I cannot answer that question at this stage.

The Hon. L. STEVENS: However, we will take that question on notice.

Mr HANNA: I am simply glad to be reassured that the minister is aware of the issue and is considering it.

The Hon. DEAN BROWN: No doubt, the minister is aware of the report commissioned by Premier Bracks of the Victorian government and undertaken by the Allen Consulting Group concerning the possibility of setting up a joint commonwealth-state national body called the Australian Health Commission. Has the minister seen the report that has been prepared?

The Hon. L. STEVENS: I am certainly aware of work being done in relation to possible reforms to the Australian health care system, but I have not seen the report. At the last meeting of the Australian health ministers, we received a detailed briefing by Professor John Dwyer and other clinicians about similar matters in terms of the reform of the Australian health system. These issues are very pertinent and, as the shadow minister probably knows, the Australian health ministers spent a number of months (probably 12 months or more) setting up I think nine or 10 different groups to focus on various health aspects of health reform across Australia. We took a very active role with the then federal minister (Senator Patterson) in relation to the need for this reform. Unfortunately, when the final negotiation for the Australian Health Care Agreement came to the crunch, the commonwealth pulled back on almost all parts.

Health reform and the surrounding issues are continuing to occupy our agenda. In fact, I will ask Dr Filby to comment because he chairs the officials group in relation to health reform. People are probably aware that the Hon. Tony Abbott continues to make statements in the media about the commonwealth's taking over the state health system and the need for that reform, but he has yet to flesh out these statements in any shape or form. It may well be that health reform will be on the agenda of premiers at the COAG meeting to be held at the end of this week: it is certainly something that we are interested in discussing. In South Australia, the Generational Health Review by John Menadue has outlined where we have to go nationally. However, we need everyone on board. It requires more than press releases: it requires all of us to work through the issues seriously.

In relation to the initial question about the report by the Bracks government, I think my office received a draft of that report. However, that matter remains an issue for discussion at premier level at the Council of Australian Government meetings. In conclusion, we would welcome serious discussions with the federal government in relation to how health could be delivered more effectively. We all face the same challenges in relation to the unsustainability of current health systems—the duplication and waste of resources that can occur when different levels of government do not work together in a seamless fashion.

When I was in Canada last year, we looked very closely at health reform. They have been able to progress this issue quite significantly. They have a great advantage because they do not have the very big divisions of responsibility as we do, particularly in relation to their general practitioners. Considerable gains could be made by seriously addressing health reform in this country. I will ask Dr David Filby to inform the committee about where we are in relation to health reform.

Dr FILBY: Briefly, as the minister indicated, for the last three years now substantial work has been undertaken in almost a dozen areas. However, it is fair to say, as the minister has indicated, all that has happened within the existing program structures and framework. The next phase of the reform might relate to a little more structural reform and structural alteration across the health system.

The Hon. DEAN BROWN: My next question relates to page 7.79, Budget Paper 4, Volume 2 and is specifically in relation to the intensive care beds at the Lyell McEwin Hospital. Last year, the minister announced as part of the budget announcements that there would be 15 new intensive care beds, but that funding was being provided to provide staff for 10 of those 15 beds. I received a telephone call a couple of months ago from a member of the public to indicate that they had direct links into the hospital through a partner who was an employee, and that at that stage only two of the 15 beds were operating. If you look at the performance of hours achieved in intensive care, it is 8 040 hours for the year. It does not take much to realise that one intensive care bed operating 24 hours a day—which it is—will provide well over 8 000 hours per year. So, on average, less than one bed has been open for the last year. How many of the 15 beds are currently open, and how many of the coronary care beds are operating as well?

The Hon. L. STEVENS: I will hand over to Ms Jenny Richter, who is currently Acting Executive Director, Metropolitan Health, to address the question.

Additional Departmental Adviser:

Ms J. Richter, Acting Executive Director, Metropolitan Health, Department of Human Services.

Ms RICHTER: The intensive care unit was not planned to be fully operational in the first year. The beds were commissioned in January, and it has taken some time for the unit to be fully staffed with both medical and nursing staff. The beds have not been fully utilised from day one, and we would expect that there will be a gradual ramp-up over a 12 to 18 month period of time as nursing and medical staff become available.

The Hon. DEAN BROWN: I appreciate that but my question was quite specific. How many of the beds are currently operating?

Ms RICHTER: The beds are fully funded for 50 per cent utilisation; 100 per cent utilisation is available right now, as of January this year, but they are not fully utilised, and this report reflects what has actually been provided, not what has been funded, in relation to hours.

The Hon. DEAN BROWN: Which means that about one bed on average has been used?

Ms RICHTER: That is what the data is showing.

The Hon. DEAN BROWN: So, for the last year, and if it is since the beginning of January it is two beds for half the year?

Ms RICHTER: It is important for you to realise that it is a combination ICU/HDU unit, and not every patient in that unit will be caught up in these figures.

The Hon. DEAN BROWN: Regarding the coronary care unit, how many of those beds are open and operating as coronary care beds?

Ms RICHTER: There were 10 beds in that unit and they also became available in January. Again, there has been a period of ramp-up for them to be fully utilised, but funding is available for those beds to be fully available.

The Hon. DEAN BROWN: How many of the beds are actually being operated?

Ms RICHTER: I will have to take that question on notice as to how many are operational right now. Again, it depends on the number of patients requiring care.

The Hon. DEAN BROWN: Thank you.

The Hon. L. STEVENS: The committee needs to be quite clear that the funding is in place for those things to be operational.

The Hon. DEAN BROWN: My next question relates to Budget Paper 3, page 2.9, on the capital works. There is a line under savings initiatives which shows that the capital works program has been reduced or rescheduled over the next four years to save $20 million. Which projects have been affected by this rescheduling and this cutting of $20 million from the capital works program over the next four years? I would like a list of all the projects involved, and how much money is affected by each project, and what is the impact of the withdrawal of those funds on each of those projects.

The Hon. L. STEVENS: I am quite happy to answer the question but I would like to make a couple of comments—

The Hon. DEAN BROWN: I appreciate that you might have to get the information.

The Hon. L. STEVENS: Yes, we will have to. However, I would like to make a couple of comments about capital works before I start. The shadow minister made some comments earlier on today about slippage of capital works. I think he said there was $35 million under.

The Hon. DEAN BROWN: That is what your budget papers show. The specific reference to it in the budget papers is on page 7.110: a reduction in the capital works program of $35.5 million for 2003-04.

The Hon. L. STEVENS: Okay. The shadow minister may well be aware that, I think it was towards the end of last year, the government made an announcement in relation to having to reschedule capital works because of the over-heated market that we were facing. We found that the building market was so full that our tender process sometimes had only one company tendering, and that prices were going over the roof. There was a rescheduling of capital works in relation to that, and that certainly affected some health programs as well as capital works in other areas.

I want to put on the record that our $35 million pales into insignificance if we remember the 1999 effort of the former minister when he became the king of slippage with, I think, $76 million. It featured on the front page of The Advertiser with a particular rebuke from an angry premier, John Olsen. I quote:

> . . . has ordered each department to explain why the money lies idle when it should have been used.

Of course, the biggest underspender was the human services department, $76.2 million. That was presided over by the former minister at a time when the building market was not anywhere near as overheated as the situation in which we find ourselves at the moment.

Mr VENNING: It was buoyant.

The Hon. L. STEVENS: Buoyant. Thank you, member for Schubert: I was looking for that word. The shadow minister talks about our having reduced capital works, but I draw attention to the fact that, in February, $120 million of new money was put into the capital works program of this government in terms of the new funding to be applied to the Queen Elizabeth Hospital's redevelopment. Of course, since coming into government, we had to do that for the Lyell McEwin and Queen Elizabeth hospitals because we found that the latter stages of those hospitals were not funded by the previous minister—as, I might add, we found to be the case with the Flinders Medical Centre research facility, which we have now placed in the forward estimates. I am going to say this because, of course, the shadow minister took the—

The Hon. DEAN BROWN: I have a point of order, Mr Chairman.

The CHAIRMAN: Order! There is a point of order.

The Hon. DEAN BROWN: The question is quite specific and, if we are going to get through a reasonable number of questions, we need to stick to the questions asked. It is a legitimate standing order of this house that answers deal with the question asked.

The CHAIRMAN: I take it that the minister is finalising that point.

The Hon. L. STEVENS: I certainly am, and I will ask Jim Birch to deal with the specifics in relation to the capital works budget.

Mr BIRCH: I think that the best answer to this is that we would need to come back with some specifics. I think there were two questions. One related to the reallocation of the program in relation to the budget papers regarding priority initiatives, and we will take that on notice. The second issue, though, that I would like to come back to after further consideration is the point made about a $35 million reduction.

I note the page to which the shadow minister is referring, and we would like to come back with an answer to that question because we believe that is a combination of slippage and new allocations, and not a reduction in the 2004-05 capital program. We would like to come back with a specific answer rather than make an off-the-cuff remark today. It is certainly my understanding that our total capital works program has not been cut by $35 million in 2004-05. It is a combination, I think, of slippage, plus new allocations. We would like to come back with an answer.

The Hon. DEAN BROWN: I think you misunderstood what I said. The capital works budget for health for the current year (2003-04) was about $130 million, but the budget documents show that you are estimated to spend $95 million of that. Then the budget documents say that there is $130 million for the next financial year (2004-05). I have seen various press releases and everything else talking about the $35 million increase in the capital works program. The fact is that it is not an increase. The budget for the current year is $130 million and the budget for next year is $130 million, which is exactly the same amount. If anything, if there was an honest statement, it would say that there had been no increase to take account of inflation. The fact is that, because it was underspent by $35 million, of course the allocation is going to be higher next year, budget compared to reality.

The point I was making was that the budget for both the years is identical so, regardless of all the press releases put out talking about the $35 million increase in capital works for hospitals (and we are talking about hospitals, not housing and everything else thrown in where there has always been traditional underspend, which is where I think the minister was getting confused earlier), there has been no increase in funding at all. If my logic is wrong, please tell me, because the budget papers are wrong.

The Hon. L. STEVENS: We will take that on notice.

The Hon. DEAN BROWN: I have a quick supplementary question in terms of the capital works program. The Kangaroo Island Aged Care Anchusa extension of six units is

going ahead. Am I correct in understanding that that is funded through a HomeStart loan?

The Hon. L. STEVENS: We believe it is, but we will confirm that.

The Hon. DEAN BROWN: That is what the hospital notifies. That was cancelled but apparently it was reinstated two years later.

The Hon. L. STEVENS: We will take that on notice.

The CHAIRMAN: The situation regarding foetal alcohol syndrome has very serious consequences, as you know, for those affected by it: they can suffer physical defects and often mental retardation. Whilst we do not want to have a witch-hunt of the mothers, what is the department doing to try to reduce the incidence of this very harmful syndrome? My concern has been heightened by recent interaction with some of the professionals in the southern area (where my electorate is), who tell me that many people in the core groups which interface with the police, schools, FAYS and so on in terms of antisocial behaviour are affected by this—of course, people with mental illness and so on are affected as well. In particular, what is the department doing to try to address this awful problem in relation to its effect on children?

The Hon. L. STEVENS: First, I agree that it is a significant issue and one of great concern. It is an issue that has been discussed nationally in terms of the Interministerial Council on Drugs. I know that some work is being done nationally on that program. I am also aware that the Women's and Children's Hospital is dealing with the matter. However, I will have to take that question on notice, but I will undertake to give you a full briefing. I certainly hope that, with our new emphasis—Every Chance for Every Child—on early childhood development and getting to mothers before they give birth, we will be able to deal with this issue in a more comprehensive way and, certainly, in partnership with local communities. I agree that it is a significant issue. The Chief Executive has some information, but, Mr Chairman, we will tidy this up with a full response.

The CHAIRMAN: Another issue of interest to me is prostate cancer awareness. Some silly people think that if you advocate for men's health you must be against women's health, which is silly and a nonsense. I support and want to see healthy men and women. What in particular is the department doing to promote prostate cancer awareness? I realise the difficulty in diagnosis and all of that, but what is happening in terms of awareness amongst men in the community?

The Hon. L. STEVENS: I will have to take that on notice in terms of a full response, but can I say that, in terms of a primary health care response to prostate cancer and prostate issues in relation to men's health, it is very significant. For people to say that to be pro-men's health is to be anti-women's health is complete nonsense. We need healthy men, women and children. We need to focus the community more on primary health care and, with our help and encouragement, people taking responsibility for their lifestyle in terms of exercise, diet and lifestyle so that we are all as healthy as we possibly can be. I will take that question on notice.

Before I hand over to the Chief Executive, I might add that some work was done recently in relation to men's health (and prostate health was part of this) by the University of Adelaide. Some very good work has been done in terms of primary health care initiatives that need to occur, and we will make sure that that is part of the response that we make to you. Mr Birch will provide some extra information.

Mr BIRCH: I cannot provide information on prostate cancer.

The Hon. L. STEVENS: No; all of the issues.

Mr BIRCH: I was going to respond to the Kangaroo Island issue raised by the shadow minister. That is a loan, but it is not a HomeStart loan. The reason that HomeStart is involved is that HomeStart has established the loan and repayment criteria for the Department of Human Services, but the funds come from our capital program, which replaced the initiative that was originally a HomeStart initiative, as you might recall, two or three financial years ago. We have a program with a number of the agencies which were seeking loans and which were public hospital agencies to provide for capital funding, borrowings and repayments similar to a HomeStart loan, and Kangaroo Island is one of those.

The CHAIRMAN: My third question relates to screening on the West Coast, which is funded by the federal government through the Division of General Practice. It has a program to assess every child, and I know some of the professionals working in that area. Has the minister and her department given any thought to the screening of school-aged children in the metropolitan area? I believe that this practice, which used to occur, has merit. Some people say, 'Well, why don't you go to your doctor?' Well, a lot of the people in the community do not, and people often pay a heavy price for that lack of early assessment. I know that it involves DECS, but I ask whether this issue could be looked at so that we get early intervention and treatment in terms of not only learning disabilities but also physical aspects.

The Hon. L. STEVENS: What sort of screening are you thinking about?

The CHAIRMAN: It is a comprehensive screening on the West Coast and includes learning disabilities, which come within the education portfolio. However, it is funded by the commonwealth, and I would be keen for the minister to approach the federal Minister for Health and Ageing (who funds that program) to see whether he will fund a program in the metropolitan area which goes beyond simply learning disabilities but which also looks at physical wellbeing.

The Hon. L. STEVENS: As a general principle I think that is excellent, and I will give an undertaking to do that. Again, it gets back to taking on board Every Chance for Every Child and meaning it, and forming the partnerships with people who have the funds, and that includes, obviously, the federal government. I will give an undertaking to do that.

Mr CAICA: I refer to the capital investment statement in Budget Paper 5 and ask the minister to provide the committee with details on the progress of the redevelopment of our major metropolitan hospitals, including the completion of previous stages and new stages now funded by the government to complete the projects.

The Hon. L. STEVENS: I thank the member for Colton. I know that he is particularly keen on issues relating to the Queen Elizabeth Hospital, but I will talk about all of them. The government has, as I have said, committed funding to complete major reconstruction projects at the Royal Adelaide Hospital, the Lyell McEwin Health Service and the Queen Elizabeth Hospital, as well as building new mental health facilities at the Flinders Medical Centre and the Repatriation General Hospital, all of which had carried over from the previous government. Of course, the two mental health projects were announced many times by the previous government but not funded. As I just mentioned, the Lyell McEwin Health Service and the Queen Elizabeth Hospital were only half funded when we took over government, which

has caused such a concentration of metropolitan capital works.

We have been unable to pursue projects such as the Barossa Hospital—of which the member for Schubert constantly reminds me. I will not forget, but I have to do these metropolitan ones first; then we will clear things a bit and get on with it.

In relation to the Royal Adelaide Hospital, the $78 million stage 2-3 redevelopment is nearing completion, providing a major upgrade and an expansion of critical care, emergency, imaging, theatres and associated clinical facilities. Completion is expected in April 2005 despite earlier delays resulting from substantial latent conditions found on-site and delays resulting from industrial action. The new emergency department, the ICU, HDU, and the burns unit have been successfully completed. The Royal Adelaide will now move into the $118.1 million stage 4 of the redevelopment. This—

The Hon. DEAN BROWN: I rise on a point of order: I have grave concerns that we are about to go into a long diatribe going from hospital to hospital when some of these were actually opened some two years ago. I think I am right in saying that the emergency department at the Royal Adelaide was opened about two years ago. Firstly, a lot of it is already published in paper 5. Can we have a very brief summary or, if need be, a more detailed reply in writing to the committee later?

The Hon. L. STEVENS: You have had a long time.

The CHAIRMAN: I ask the minister to be reasonably brief without curtailing her main points.

The Hon. L. STEVENS: Well, the member for Finniss has had his shot. It is ours now.

The CHAIRMAN: The chair is aware that over time all groups in here have various tactics to try to take up time, but I think, in fairness, if the minister can make her points it would be beneficial.

The Hon. L. STEVENS: The Royal Adelaide will now move into its stage 4 of $118.1 million, which includes a major upgrade of site infrastructure and services, wards and clinical service facilities. I do not think I need to say much on the Queen Elizabeth Hospital, except that the $120 million stage 2 will now proceed. The steering committee, which we announced back in February, has been working solidly, and they are starting the development of the brief for the project, which is expected to be completed by December this year.

Regarding the Lyell McEwin, the completion of the $91.2 million stage A is expected in December this year. The $32 million stage B, providing a new 60-bed mental health unit and other clinical facility upgrades, will now proceed. Master planning is well advanced. The only issue out there at Elizabeth, opposite my electorate office, is lack of parking. We are doing our best, but it is very difficult when you have a very crowded site in a residential area.

In relation to the Flinders Medical Centre and the Repat, in addition to these works the Flinders Medical Centre Mental Health project—that is, the Margaret Tobin Mental Health Centre—was approved by the Public Works Committee last year.

Mr Caica interjecting:

The Hon. L. STEVENS: Thank you very much—a good committee. That has a total funding of $14 million, $12.3 million of which was from the government while $1.7 million was from Flinders University. Construction of the first phase involving the relocation of Flinders Medical Centre's Environmental Services Department was completed in April this year. The tender for the main stage to construct the mental health facility is expected to be called in July, with completion targeted for December 2005.

At the Repat, the $9.8 million project will provide a 30-bed aged acute mental health facility. This was also approved by that terrific committee—the Public Works Committee—at a total cost of $9.8 million. Tenders for construction are planned to be called shortly, with the construction completion targeted for September 2005. The new Barossa Hospital, which I will never be allowed to forget for one minute, is something that—

Mr Venning interjecting:

The Hon. L. STEVENS: Well, we do acknowledge the need for that hospital, and I have done that on a number of occasions. However, the member for Schubert should remember that we are providing the sustainment works required at that hospital. As I have said to the member for Schubert, it is a real pity that his own government was unable to put a priority on his hospital, and it was a real pity that his own government was unable to deal with the metropolitan hospital upgrades year after year over eight years. I think he should actually say something to the person sitting on his right hand side, because that is where the issue of the Barossa really had its inception.

Mr CAICA: I refer to Budget Paper 4, Volume 2, page 7.48, which deals with funding for non-government health services and, in particular, the supply of blood and blood products for South Australia. Minister, can you inform the committee of the steps that have been taken to ensure continued access to blood and blood products to meet growth and demand and to ensure that the Australian Red Cross Blood Service can comply with new donor haemoglobin standards mandated by the Therapeutic Goods Administration?

The Hon. L. STEVENS: Thank you, member for Colton. The 2004-05 budget provides an additional $3.939 million for the blood sector representing the Department of Human Services contributions under the commonwealth cost share arrangements for the supply of blood and blood products by the Australian Red Cross Blood Service with plasma processing at CSL Limited, the purchase of imported products such as recombinants, the management of national projects and administration through the National Blood Authority, plus local and national safety and quality programs. Further growth in the use of recombinants is rejected while major policy changes are subject to national decision at the Australian Health Ministers' Conference. I invite Professor Kearney to provide the committee with some further details.

Prof. KEARNEY: Thank you, minister. There have been a number of developments and improvements in the blood service and they will continue. The new automated computer system for haemovigilance has been installed in South Australia as a pilot site and is established. We have successfully implemented the new TGA requirements for collecting blood from people with higher haemoglobin levels, which was a restriction on the number of people able to give blood.

We have increased the number of units that are leucodepleted, that is the white cells are removed from the blood to be transfused, because that is one of the major sources of blood transfusion reactions and infections. That has increased substantially this year. As the minister said, we have increased the number of people on recombinant factor 8, and the recent senate inquiry into hepatitis C has recommended a further roll-out of that, but that will be a national decision and South Australia has made provision to comply with any

national decisions that are made. South Australia has implemented a Bloodsafe project which puts Bloodsafe nurses in all of the major hospitals and, as the result of that, we have reduced the number of adverse events from blood use, but also have improved the usage of blood supplies and reduced wastage by better monitoring and usage of blood.

One of the major issues that has been facing us has been the availability of immune globulin, or IVIG as it is commonly known, and we have worked hard to develop or convince the national authorities to have an age based distribution and supply arrangement with respect to IVIG, because there is a national shortage. We may have to look at importing that product. The growth in use over the last year has been of the order of 20 per cent. We are assured, despite the concerns that with our management plan to round IVIG, that we can continue to supply the community of South Australia with IVIG.

Ms BREUER: I refer to Budget Paper 4, Volume 2, page 7.45, Environmental Health Management, and in particular I refer to the Port Pirie lead program. Can the minister provide the committee with information on the purpose and the terms of reference for the review into the Port Pirie lead program, which was announced on 16 January 2004?

The Hon. L. STEVENS: I thank the honourable member for Giles for this question, because it is certainly a very important matter for Port Pirie. The review into ways to improve Port Pirie's lead program has been initiated to make sure the program is as effective as it can possibly be. The lead program was established in 1984 to try to minimise the exposure of children in Port Pirie to lead. It now leads the world in understanding how children become exposed to dust contaminants and developing original strategies to protect them.

Funding to continue the lead program is provided in the budget and, while the program was extensively reviewed and revised in 1993 and again in 1998, it is now appropriate to seek new ways to improve its services through this latest review.

When the program began in 1984, blood levels in 98 per cent of young children in Port Pirie were above the acceptable national goal. That has been significantly improved with a drop to 53 per cent, which is a great achievement, but more work needs to be done. This review is to see how we can improve the program even further and do even better. The lead program tests the lead levels of all Port Pirie children under 7 years of age and works with the children and their families to reduce exposure to lead if their blood lead levels are high. The first meeting of the review panel was held on Wednesday 16 June, and the panel will meet regularly for the next three months: Dr Ted Maynard, chair of the Lead Program Steering Committee, Mrs Linda Franks, from Uniting Care Wesley Port Pirie, and Mr Mark Malcolm from the Port Pirie Regional Development Board form the core review panel.

The Port Pirie Regional Council, local health services, schools, Zinofex and the EPA will be fully involved through a reference group. All members of the Port Pirie community are encouraged to provide submissions and discuss issues face-to-face with the review panel. I certainly hope that everyone with an interest in the Port Pirie Lead Program will take this opportunity to participate in planning for the future of this important children's health protection initiative. I would like to ask Dr Kevin Buckett, the Director of Environmental Health, to provide additional information on the terms of reference. While he is doing that, I would just like your permission for Dr Buckett to make a correction to some technical information he gave earlier today.

Dr BUCKETT: Thank you. As the minister has just identified, the current program is a world leader in understanding how children are exposed to lead and what can be done about it. This was in fact recognised in an international conference which was held in Port Pirie last year. However, the program is finding it difficult to reduce blood lead levels further in children to optimum levels, and therefore the review, and the panel that the minister referred to has been asked to deliver to the minister by September 2004 recommendations on the future focus of the Port Pirie lead implementation program, including strategies and delivery methods for achieving the improved health outcomes.

The panel has been asked to adopt the principles which were articulated in the Generational Health Review, which include improving the quality and safety of services, greater opportunities for inclusion and community participation, strengthening and reorienting services towards prevention and primary health care and developing responses based on service integration and coordination.

The terms of reference of the review are: to recommend the future goals and focus of the Port Pirie lead implementation program; to recommend effective strategies for achieving those goals; and to recommend methods for delivering those strategies. Essentially, there will be extensive consultation with stakeholders, especially the local community, to understand the strengths and weaknesses of the current program and also to identify the partnerships, roles and initiatives needed for the future. These strategies will address the social and economic inequalities that contribute to differences in outcome and the capacity of families to protect their children from a contaminated environment.

If I may, I would now like to correct a comment which I made during the earlier discussion on honey. I reported that nitrofurans were carcinogenic and were found in other foods. This is not correct, and I apologise for giving that incorrect information. I confused nitrofurans with another class of chemicals called nitrosamines. Nitrosamines are chemicals found in a range of foods, particularly when food is burnt. These chemicals can cause cancer. Nitrofurans are antibiotics which are still used for treating people. They have not been classified as carcinogens by the International Agency for Research on Cancer, the lead international agency which classifies chemicals according to their ability to cause cancer. Therefore, they are not recognised internationally as cancer-causing agents. Nitrofurans have been found at very low levels in some imported honey, not nitrosamines.

The ACTING CHAIRMAN (Mr Caica): Thank you for clarifying that. The member for Florey raised this matter during the luncheon break.

Mr VENNING: Further to the minister's earlier explanation, when will the new Barossa hospital at Nuriootpa be built, and where does it sit in relation to other hospitals on the government's capital works priority list?

The Hon. L. STEVENS: I will ask Mr Peter Jackson, who heads our Capital Works Department, to answer your question.

Mr JACKSON: I am looking at the draft capital investment plan for 2005-06 and beyond. To answer the honourable member's question, the Barossa Health Service sits as one of our unfunded priorities at the moment. We will be developing a brief around the facilities needed to build a new hospital for consideration by the government later this year in the next round of the budget bilaterals.

Mr VENNING: Supplementary to that, obviously there is a list. Can we have a copy of that list?

The Hon. L. STEVENS: At the moment, it is a draft list. It needs to go to cabinet, so I cannot give you a copy of it. It is not in its final form; it is a cabinet submission in relation to the department's capital works forward plan.

Mr VENNING: My second question therefore is: is there any truth in the rumour that under the government's new Generational Health Review the Barossa area health facilities will be downgraded in favour of improved facilities at Gawler?

The Hon. L. STEVENS: No.

Mr VENNING: Does the Angaston hospital meet departmental and occupational health and safety standards for staff, patients and volunteers?

The Hon. L. STEVENS: I will need to take that question on notice unless Mr Jackson can answer it. I am advised that $300 000 has been put in to address matters of occupational health and safety.

Mr VENNING: Supplementary to that, the minister is aware that the site has been purchased and is in a very poor condition. Will the minister advise what arrangements are in place to maintain the site which has been earmarked and purchased for the new hospital, particularly the old building which is on it? As the minister knows, this site is in the middle of Nuriootpa.

Mr JACKSON: If the honourable member is referring to the site at Nuriootpa which has been earmarked for a possible new Barossa hospital, it is still owned by the Housing Trust, and it is under their care and maintenance at present.

Mr VENNING: It is under nobody's care and maintenance. Has the department done any work on the cost of keeping the current hospital maintained in its present condition versus the interest on a loan for a new hospital? We have talked about a build-own-operate scheme or any other scheme. We know the government is strapped for money, but the cost of maintaining the existing hospital must be comparable to the cost of interest on a new facility.

The Hon. L. STEVENS: No, we have not undertaken that analysis.

Mr VENNING: Could you?

The Hon. L. STEVENS: I think we can give that some consideration.

The Hon. DEAN BROWN: I will now read the omnibus questions. We are not looking for responses at this stage.

1. What budget savings did all departments and agencies reporting to the minister have to meet to achieve the savings targets for 2003-04 set for them in the 2002-03 and 2003-04 budgets, and what specific proposed project and program cuts were not implemented?

2. Will the minister provide a detailed breakdown of expenditure on consultants in 2003-04 for all departments and agencies reporting to her, listing the name of the consultant, the cost, the work undertaken and the method of appointment?

3. For each department or agency reporting to the minister, how many surplus employees are there, and for each surplus employee what is the title or classification of the employee and the total employment cost (often referred to as TEC) of the employee?

4. In the financial year 2002-03, for all departments and agencies reporting to the minister, what underspending on projects and programs was not approved by cabinet for carryover expenditure in 2003-04?

5. For all departments and agencies reporting to the minister, what is the estimated level of under-expenditure in 2003-04 and has cabinet approved any carryover expenditure in 2004-05?

6. (i) What was the total number of employees for the total employment cost of $100 000 or more per employee and also, as a subcategory, the total number of employees for the total employment cost of $200 000 or more per employee for all departments and agencies reporting to the minister as at 30 June 2003?

   (ii) What is the estimate for 30 June 2004?

   (iii) Between 30 June 2003 and 30 June 2004, will the minister list job title and total employment cost of each position with a total estimated cost of $100 000 or more:

      (a) which has been abolished?

      (b) which has been created?

7. (i) What is the difference between consultants and contractors, and how many people or services previously classed as consultants are now shown as contractors?

   (ii) What is the value of their contracts and what was the service they provided?

The ACTING CHAIRMAN (Mr Caica): Thank you. I believe the honourable member has one more question.

The Hon. DEAN BROWN: Thank you, Mr Acting Chairman. I raise an issue concerning the cochlear implant program. I have a letter from a very concerned mother of a 26-year-old son who was born with a hearing impairment due to a viral infection. Fortunately, his hearing loss has been a slow deterioration, so he has been lucky to be able to learn to speak. However, his hearing is rapidly deteriorating to the extent that he cannot hear his alarm clock in the morning and, when his mother speaks to him whilst standing next to him, he can only understand what she is saying by the movement of her lips. They have been looking for an assessment for him for the cochlear implant program through the University of Adelaide. However, they have been told that there is no state funding.

This issue has been taken up by a few people with similar hearing loss and for whom the cochlear implant program could be of value. It is an issue that has also been raised on their behalf by the President of Cicada SA, which is the support group for cochlear implantees. They have taken up this issue to try to get support. They say that South Australia has now over 100 adult implantees, with approximately 60 to 70 on the waiting list. I understand that a further 70 to 80 child implantees are under the care of the Women's and Children's Hospital cochlear program, many of whom would probably be at Cora Barclay. The cost, of course, is significant for these people and, in most cases, they cannot afford it themselves. It is clearly a health issue, and these people need support. Therefore, I wonder whether the minister can give some indication of how much support the state government will make available so that these people with an hearing impairment are able to take advantage of modern technology and secure a cochlear implant.

The Hon. L. STEVENS: I think I signed off a letter to the shadow minister on this very matter in the last day or so. The cochlear implant program is currently under review. We are looking at increasing funding towards that program, but I cannot say to what extent until that review has been completed.

The Hon. DEAN BROWN: Can the minister clarify her answer to my question? The minister has talked about an increase in funding, but, in fact, there is no state funding at all for adult cochlear implanting and the ongoing assessment of those people. How can the minister increase something that has nothing there to start with? This is turning into a *Yes, Minister* answer, isn't it? We are increasing something that does not exist.

The Hon. L. STEVENS: The honourable member is into trick questions.

The Hon. DEAN BROWN: No, it was not a trick question.

The Hon. L. STEVENS: It is five past four in the afternoon. I am very happy to provide information to the shadow minister, and I will ask Jenny Richter to provide more information for the shadow minister.

Ms RICHTER: The adult cochlear implant program is run through Flinders Medical Centre. The pre-operative assessment and post-operative care is provided through a private service, which is an offshoot of Flinders Medical Centre. The actual operative procedure, that is the cochlear implant, is provided as part of the normal services provided by Flinders Medical Centre and funded by the government.

The Hon. DEAN BROWN: As I understand it, there is an extensive cost involved in terms of the tuning—and I remember talking about this with people at Cora Barclay last year. I understand that that could be literally tens of thousands of dollars, particularly over the first couple of years.

Ms RICHTER: Not tens of thousands of dollars over the first couple of years, but once a cochlear implant is implanted a lifetime level of support is provided. That is an outpatient type service for children and adults in the immediate stage after implant and it takes a regular period of time to tune it. I would not have said it was tens of thousands of dollars in the first couple of years. The procedure itself is very expensive.

The Hon. DEAN BROWN: This is a supplementary question because I think it is important to clarify what the state is funding. You are saying that the operation, the actual implant, is covered by the state, and the rest of it is not. The mother who wrote to me has private health insurance and she has been told that the turning on is not covered by private health insurance, whereas the actual implant would be covered if you have appropriate private health insurance or, if not, by the state. I understand that the bigger cost is in the monitoring, or what they call the 'turning on', and the ongoing maintenance from year to year, along with adjustment. Apparently there is a very high adjustment in the first couple of years and the cost can be quite considerable.

I am pretty certain that people from Cora Barclay said that it costs about $45 000 to $50 000 to have an implant, together with the monitoring, the tuning and everything else over the first few years, and that you are looking at a two-year program.

Ms RICHTER: Cora Barclay is dealing mostly with children and the service for children is totally covered by the state through the Women's and Children's service. It is the adult program—

The Hon. L. STEVENS: We can take that on notice.

The Hon. DEAN BROWN: Some of it is federal and some of it is private, too. Clearly a significant number of people need and would benefit from this procedure—and they are claiming that 60 to 70 are on the waiting list. They are clearly very concerned about the lack of resources and support at a state level to help them participate in the program.

Ms RICHTER: I would like to make a point about the growth in the numbers of patients on the waiting list. The criteria for eligibility (or suitability) for cochlear implants is changing, so that people with higher and higher levels of hearing are able to benefit from a cochlear implant. That is why the numbers are growing: it is a change in the suitability as opposed to any other factor.

The Hon. DEAN BROWN: I appreciate that.

The Hon. L. STEVENS: I am quite happy to supplement the comments that have been made by some written comments to finish that answer for the shadow minister.

Mr CAICA: I refer to Budget Paper 4, Volume. 2, page 7.69, the South Australian Ambulance Service, which was recently transferred from the Department of Justice to the Department of Human Services to allow for more integrated planning of the delivery of primary and emergency care services. What plans does the service have to maintain the excellent work undertaken by volunteers in our regional areas?

The Hon. L. STEVENS: I put on the record the importance of the 1 600 volunteers who work with the ambulance service. The recent transfer is about a closer alignment with the health system and it will help volunteers to continue the invaluable work that they do for our ambulance service. Thirteen hundred operational and 300 non-operational volunteers contribute to ambulance service provision and delivery in country South Australia. The ambulance service is an important component of the health system and it makes sense for it to be part of an integrated health network. The economic impact of volunteer contribution to ambulance services has been estimated at between $20 to $30 million per annum—that is huge. The value goes further than that because volunteer ambulance officers provide the only ambulance response in many towns and regions of South Australia.

The ambulance service has a comprehensive strategy to support volunteers, and I completely reject the recent assertion by the shadow minister for emergency services that the transfer from justice to human services, and health specifically, put the volunteer involvement in the ambulance service at risk. The South Australian Ambulance Service will continue to fund volunteer recruitment, retention and support activities to ensure sufficient volunteer resources for ambulance service provision and delivery. I invite Mr Chris Lemmer to provide the committee with some further information on the strategies implemented in 2003-04 to support volunteers and to encourage their retention.

Mr LEMMER: The maintenance and further development of an effective volunteer service in regional South Australia is the number one priority in the strategic planning for the South Australian Ambulance Service. As the minister said, a number of specific initiatives have been put in place in 2003-04 and they will continue throughout 2004-05 and beyond. Specifically, some of those include the introduction of paid, regional team leaders who live in regional areas and who encourage and support volunteers in training and human resource initiatives.

We also have an emerging problem with volunteer services which has developed over a number of years. When I was first involved 30 years ago, volunteers jealously protected all the work in their area and wanted to do both local emergency work and all transfer work through to Adelaide. Because of the change in environment and demographics in the country now, we have an increasing

number of volunteers who want to do only their local work and provide local emergency response for their community. As a result, we have had approval for funding to implement what we refer to as regional medical transfer vehicles, and they operate mainly in the fringe metropolitan areas and the denser populated regional areas. These vehicles are specifically positioned to be able to do some of the routine transfer work and allow the volunteers to maintain a presence within their local community.

We have also established a Volunteer Support Team within SAAS's corporate umbrella, employing five staff to coordinate and manage volunteer human resource activities. Previously, a single volunteer coordinator was responsible for these activities. The VST is concentrating on five new initiatives and policy developments, including: volunteer recruitment; volunteer induction; volunteer recognition for achievements; conflict resolution (which is an extremely important issue in dealing with volunteer management); and, probably most importantly, flexible learning for volunteer education.

One of the major concerns of volunteers over recent times has been the increasing requirement for education. All volunteers who operate in regional South Australia are required to have a certificate four in community studies. That involves a considerable amount of work: it involves six weekends of full-time training plus week night training, and the strong message we are getting from volunteers is that we need to find a more flexible way of doing this. We are committed to putting into place programs to allow a much more flexible approach so that we can encourage more volunteers into the system. In the last two years we have been able to achieve the following: in 2002-03, a net gain of 96 volunteers in regional areas; and a further net gain in 2003-04 of 86 volunteers. So, we believe that we are continuing to develop and support volunteers.

Mr CAICA: I know from first-hand experience the outstanding job that the South Australian Ambulance Service does through the co-location that occurred with the Metropolitan Fire Service when I was involved in that organisation—indeed, at working jobs. They not only perform an outstanding service but also they do so under what could be seen as excessive workloads. What I want to specifically know relates to Budget Paper 4, Volume 2, page 7.69, which refers to the ambulance service. What information can you provide to the committee about the increased operational resources being provided to manage increasing ambulance workloads to address occupational health and safety issues and, as a consequence, to improve response times?

The Hon. L. STEVENS: Again, I thank the member for Colton for this question because I know that historical data indicates that SAAS's workload has been increasing. For example, in 1999-2000, SAAS transported 130 155 patients; in 2000-01, 139 096 patients; in 2001-02, 143 336 patients; in 2002-03, 145 361 patients; and to April 2004, SAAS transported 121 013 patients. In 2003, the government approved additional funding over four years to $7.4 million and $1.48 million recurrent funding to allow SAAS to recruit 65 additional full-time staff. SAAS received $2.365 million increased funding in 2003-04 which was used to fund one additional seven-day ambulance transfer service crew, two additional five-day ambulance transfer service crews, one 24-hour medical transfer service crew, one regional medical transfer service at Murray Bridge, one regional medical transfer service in the lower north-west region; and, also, to pay for education and recruitment of staff and a fatigue management program. I will ask Mr Lemmer to provide briefly any further information to fill out that answer.

Mr LEMMER: Thank you, minister. There is probably not too much more I need to add, other than to say that the quoted number of patients transported represented about 75 per cent of our total dispatches. For example, in 2003-04, we had 217 000 dispatches for about 150 000 patients. The workload is not related to just the number of patients, and there is a considerable amount of work in attending where ambulances sometimes are not required and, at other times, multiple ambulances are dispatched because of the serious nature of the case.

Ms BEDFORD: I want to ask a question about meningococcal, and I refer to Budget Paper 4, Volume 2, page 7.44 dealing with the programs for disease prevention and management. I ask the minister to provide information to the committee about the immunisation program which has been running since January 2003 for meningococcal, as distinct from pneumococcal.

The Hon. L. STEVENS: Which, of course, the federal government finally has agreed to fund. I thank the member for Florey for this question, because the state government has been involved in funding the roll out of the meningococcal C conjugate catch-up vaccination program for targeted groups over a four year period, and this is the second year of that program. The outcomes for 2003-04 are as follows: 216 882 doses of meningococcal C vaccine have been distributed since the program began in January 2003 (so 216 882 is the number from January 2003 to May 2004).

The free meningoccocal C vaccine has been offered by local councils through the school-based delivery service to 38 000 high school students and to 70 000 primary school students, which is 50 per cent of the total number of primary schoolchildren. Coverage of high school students is approximately 80 per cent for students in years 9 to 13. GPs continue to offer free meningoccocal C vaccine to one to five year olds not vaccinated last year, and 57.2 per cent of one to five year olds in South Australia have been vaccinated as at 31 May this year. Adolescents not in school have been targeted using mobile clinics and promotions through council clinics, and an estimate of 12 per cent of those have been vaccinated.

In relation to the coming year and the meningoccocal program, we will be continuing to offer the remaining 70 000 primary schoolchildren free meningoccocal C vaccine, and we will endeavour to achieve at least 80 per cent coverage in primary schoolchildren. Certainly, we will be continuing to promote the program to parents of adolescents and one to five year olds not yet vaccinated. I am very pleased with the effort that we have made but, importantly, everyone needs to remember that meningoccocal C is not the predominant strain of meningoccocal that people contract in South Australia.

Unfortunately, there is no vaccine for menginoccocal B, which is the most common variation. We must be eternally vigilant to those symptoms. It is better to be safe than sorry and to seek medical advice in relation to the onset of the flu-like symptoms and, in particular, any sign of the rash.

The Hon. DEAN BROWN: I would like to run through a number of questions quickly, and the minister may need to come back with answers. When the CEO at the Flinders Medical Centre resigned to take up another job, I understand that a number of people, including the Acting CEO, obviously took higher pay. Could the minister provide me with a list of how many people took higher pay at or about that time? I understand that, at that stage, three of the most senior

finance people also went onto higher pay, as well as the Acting CEO and the Acting Deputy CEO.

It would appear that at least five people went onto higher pay, but I would like that confirmed. I would like to know how much extra pay they received, for what period they have been on that higher pay and the positions of the people involved. I am not interested in the individuals, I am interested in the positions of the people involved. I presume that the minister does not have that information?

The Hon. L. STEVENS: No.

The Hon. DEAN BROWN: I have been contacted by someone who has written to the minister concerning complaints that have been raised about gifts and gratuities offered by nursing agencies. I understand that the minister ordered an investigation by the Crown Solicitor's Office. Will the minister indicate when she thinks that investigation is likely to be finished?

The Hon. L. STEVENS: The investigation is complete.

The Hon. DEAN BROWN: Was the person who lodged the complaints interviewed? He has written to me and complained that he had not been interviewed.

The Hon. L. STEVENS: I did not conduct this review. I am happy to look into that matter for the shadow minister.

The Hon. DEAN BROWN: What is the outcome of the investigation?

The Hon. L. STEVENS: I will ask the Chief Executive to make some preliminary comments.

Mr BIRCH: In fact, two investigations are occurring: one relates to the question of the election of the Nurses Board, and that has been completed. I stand corrected, but I understand that the elections were handled properly. The second issue relates to the tender and also the arrangements for agency nursing in general, which is more of an issue of investigation of probity. I understand that that is still ongoing.

The Hon. DEAN BROWN: The issue raised with me relates to gifts and gratuities. Is that still ongoing?

Mr BIRCH: That is still on going.

The Hon. DEAN BROWN: The person concerned has not yet been interviewed.

Mr BIRCH: I am not in a position to answer that question but, certainly, we can follow that up with the Crown Solicitor and the Investigations Unit within the Crown Solicitor's Office.

The Hon. L. STEVENS: We may need some information from the honourable member as to who the person is.

The Hon. DEAN BROWN: I am happy to provide the name, but I think that, on several occasions, he has written to the minister.

The Hon. L. STEVENS: It is difficult for me. I do not know whom the honourable member is talking about.

The Hon. DEAN BROWN: He has indicated in his correspondence that he has contacted the minister on several occasions and has not yet been interviewed. I believe that you call the software personnel management system CHRIS. I am sure you understand what I am referring to. Individual agencies and individual services have been asked to cover, I think, their share of purchasing CHRIS and installing it. Can the minister give me the total cost of purchase, the total cost of implementation and the basis on which the cost has been shared between the different services? Has it been done on an employee basis or on a proportion of your employee costs? Are you able to give me that sort of detail?

A question, asked by the member for Eyre, is that—

An honourable member: The member for Stuart.

The Hon. DEAN BROWN: Sorry, it is Stuart now, but he was called the member for Eyre. Everyone knows whom I am referring to. He raised the issue of the mobile counselling service to which I understand the minister has agreed. I understand that it will be for six months. The trouble is that, if you are going to have the person for only six months, on what basis is this person going to be appointed? I understand that, if you advertise for it, it is unlikely that you will find someone to take on that type of job for a six-month period. Certainly, people have raised concerns with the minister concerning that appointment. They need the person in there as quickly as possible but, equally, some thought needs to be given to how you are going to engage that person, as it is for a very short period of appointment of six months.

The Hon. L. STEVENS: I will ask Ms Roxanne Ramsey to answer the question. I was very pleased that the member for Stuart approached me about this issue a month or so ago. We agree with the need, and we are endeavouring to get that up and running as quickly as possible. Ms Ramsey, could you answer the detail of the question?

Ms RAMSEY: The initial funding is for six months to look at the role of that position that has been funded from within the Wakefield and Mid-North health regions. I do not have the details of the employment, but they are responsible for the employment of that person. One of the major functions of the role is to look at the need for ongoing funding and what sort of services are required. So, the funding, in the first instance, is just for six months, but will be ongoing once the need and the service model are established.

The Hon. DEAN BROWN: I understand that the government has allocated $100 000 towards the helipad at the Gawler Health Service in the 2003-04 budget. Will that money now be carried forward to the 2004-05 budget as the helipad has not been built?

The Hon. L. STEVENS: Yes.

The Hon. DEAN BROWN: Am I correct in saying that the government has allocated $100 000 of its own funds for that helipad?

Mr BIRCH: Yes.

Witness:

The Hon. J.W. Weatherill, Minister for Ageing.

Departmental Advisers:

Ms K. Lennon, Chief Executive Officer, Families and Communities.

Mr C. Overland, Director, Ageing and Community Care, Department of Human Services.

Mr F. McGuinness, Acting Deputy Director, Financial Services, Department of Human Services.

Membership:

Mrs Redmond substituted for Mr Scalzi.

The CHAIRMAN: We are dealing with the line relating to ageing. Does the minister wish to make an opening statement?

The Hon. J.W. WEATHERILL: No, sir.

The CHAIRMAN: Does the member for Finniss wish to make an opening statement?

The Hon. DEAN BROWN: I do not want to make an opening statement because I do not think that is necessary,

but I do highlight the fact that it is very difficult to pinpoint ageing within the budget. There is a little information under Metropolitan Domiciliary Care and a little under HACC, but not all HACC money sits there in one. Concessions sit under FAYS. Therefore, if I was an aged person looking through this budget asking, 'Where is the line on aged care?', I would be bloody worried, especially as aged people make up 14 per cent of the state's population and there is no specific coverage for ageing as such.

My recollection was that there used to be a separate performance program on ageing. I highlight that point and perhaps that ought to be looked at. I believe that there ought to be a separate line. There is an Office for Ageing, therefore there ought to be a budget for the Office for Ageing and a list of performance programs that sit within that budget. If the minister has that information—and I am not asking necessarily that it be conveyed now—perhaps he could put together details for me as to what is the budget for the Office of Ageing. Where is the line for the Advisory Council on Ageing (which I know exists) and any consultancies or any other programs that are carried out? It may be that I have completely lost them, but I cannot find them anywhere in the budget. I think it is buried largely in other areas. Does the minister want to comment on that point as to whether there is a specific area that I have missed?

The Hon. J.W. WEATHERILL: As I understand it, the pattern of reporting is similar to that which occurred while the honourable member had responsibility for the portfolio. We report most programs, but Home and Community Care and the Commonwealth-State-Territories Disability Agreement do not neatly line up with the portfolio responsibilities for the Office of the Ageing. Home and Community Care funds elements of the health budget and, of course ageing; and the Commonwealth-State-Territories Disability Agreement funds elements of the ageing budget as well as specific disability based programs.

This area is fundamentally governed by federal government co-operative arrangements which are matched in various proportions by the state government. For budget purposes we tend to report around those program boundaries, but they do not neatly line up with the state government's portfolio arrangements. One thing that is universally welcomed by the lobby is the re-establishment of a minister for ageing. I think they welcome the fact that there is a dedicated minister for ageing notwithstanding the fact that many of the responsibilities lie with the federal government.

The Hon. DEAN BROWN: You have program K6—Ageing and Community Care Grants—for which there is a total budget of $7.6 million for the coming year (page 7.32) and the only other area that clearly relates to ageing is the Metropolitan Domiciliary Care Service, which has a budget of $42.9 million. If you put those two together you still are nowhere near the budget for the HACC program, let alone other programs. I thought that in previous budgets there was a specific line for ageing and the Office of the Ageing and that there had been some discussion about that, because I seem to recall going through it at some stage. As we are now dealing with a specific portfolio, it would be good to have a specific reference.

The Hon. J.W. WEATHERILL: I will take that suggestion on board and give it some consideration.

The Hon. DEAN BROWN: Thank you, minister. What is the total value of the HACC program for 2003-04? I would like to have a list at some stage of the details of all organisations that received HACC grants in 2003-04 and the nature of each program.

The Hon. J.W. WEATHERILL: In 2003-04 the total recurrent funding was $102.4 million and the contribution in that by the state government was $39.3 million or 38 per cent of the total funding. The remainder was provided by the commonwealth. I will provide the honourable member with a list of the projects that were funded under those matters. I think we wrote to every MP outlining on an electorate basis how the HACC programs fell into their areas. So, whilst MPs would not have a consolidated list, they were advised. Certainly, I will provide the member with a consolidated list.

The Hon. DEAN BROWN: I saw a list which I think was sent out about two months ago. It listed every organisation in the state which received funding under a new allocation of about $7 million, but clearly that was only a portion of the overall program for 2003-04. That is why I want a comprehensive list for the entire program for 2003-04.

The Hon. J.W. WEATHERILL: Is the member asking for all existing programs, in addition to the new programs for 2003-04?

The Hon. DEAN BROWN: Yes.

The Hon. J.W. WEATHERILL: Yes, I will supply that for the member.

The Hon. DEAN BROWN: That is exactly it. I want to know which organisations, how much and, obviously, a very brief description of the nature of their program.

The Hon. J.W. WEATHERILL: Certainly.

The Hon. DEAN BROWN: I would like to know the increase in HACC funding for 2004-05 compared with 2003-04.

The Hon. J.W. WEATHERILL: I do not think we can be completely certain about that because we have not had a formal offer from the commonwealth. We have indicative numbers from officers, and it is on that basis that we have committed to matching those figures. I can provide the member with the indicative numbers now, or he can wait until we have the final position from the commonwealth.

The Hon. DEAN BROWN: I would not mind the indicative numbers if the minister has them.

The Hon. J.W. WEATHERILL: Mr Overland will answer that question.

Mr OVERLAND: We think the offer will be a growth of $4.5 million, which we will have to match with about $2.8 million, giving us a little over $7 million to cover both indexation and growth. My advice is that it is about 7.13 per cent.

The Hon. DEAN BROWN: So, that would take it to what, about $109 million?

Mr OVERLAND: It is about $300 000 short of $110 million.

The Hon. DEAN BROWN: Excellent. I would like details of the membership of the committee which allocates HACC funds in South Australia. Am I right in saying that it is a joint state and federal committee, with a chair appointed?

The Hon. J.W. WEATHERILL: Mr Overland will answer that question.

Mr OVERLAND: It is not allocated by a committee as such. All applications are assessed by the officers of my branch, in association with officers from other relevant branches: for example, the Disability Services Office, when we get submissions for funding relating to younger disabled people; the Country Services Division, when we get submissions from the country; and so on. So, the allocation of

funding is an officer level exercise. The resources are shared across the state according to a formula.

The Hon. DEAN BROWN: Can I have details of that formula?

The Hon. J.W. WEATHERILL: Certainly, we will provide those details.

The Hon. DEAN BROWN: Can I have details of the actual process? I thought there was a joint commonwealth-state approval process.

The Hon. J.W. WEATHERILL: We administer the granting to the funds. What is joint about it is that the criteria and assessment is according to a set of criteria determined by the commonwealth. That is the extent of the commonwealth's input. They have commonwealth boundaries around which they determine the nature and extent of issues.

The Hon. DEAN BROWN: So, there is no formal approval. The Office of the Ageing assesses the projects and then approves them, or otherwise?

The Hon. J.W. WEATHERILL: I think the practical issue is that the officers make recommendations to me that are then approved. I then send them to the federal Minister for Ageing. These matters are in the nature of a joint announcement, and although the federal minister does not have the right of veto, if she has a difficulty with them, there tends to be some further dialogue until some consensus is reached and then a joint announcement is made.

The Hon. DEAN BROWN: First, can I have a breakdown of the sort of process it goes through and, secondly, who sits on the state committee which looks at these projects?

The Hon. J.W. WEATHERILL: There is no state committee which deliberates on these matters.

The Hon. DEAN BROWN: I think there used to be; Vickie Chapman used to be chair of it.

The Hon. J.W. WEATHERILL: There is a seniors and positive ageing development grants state committee that does have a process. It may be that the member is thinking of that committee.

The Hon. DEAN BROWN: I am pretty certain that Vickie Chapman sat as chair of a HACC program.

The Hon. J.W. WEATHERILL: I think that was a ministerial advisory committee that advised on the plans, such as strategy, but it never had a role in approval of individual grant applications. That is the distinction. That body still exists and is doing a very good work apparently.

The Hon. DEAN BROWN: Could I have the membership of that as well? Obviously, the office looks at the projects.

The Hon. J.W. WEATHERILL: Yes. The plan or the strategy is signed off by this advisory committee, and we will give the details of that committee.

The Hon. DEAN BROWN: My concern is that this is a $100 million program, and it is as big as entire agencies which rate an entire section in the budget papers, and from what I can see there are only about three or four lines on HACC in the budget papers. It does not give that sort of breakdown, and that is why I think we need greater accountability. It is touched on in 7.32 and under Domiciliary Care. I would appreciate knowing how much of the HACC program goes to the Domiciliary Care program. As I understand it, there is a chunk of HACC funding that goes to Domiciliary Care.

The Hon. J.W. WEATHERILL: There is, but that would be apparent by asking the Minister for Health, or by doing the balance of whatever we take out of the HACC funding. We can provide that information to you.

The Hon. DEAN BROWN: Thank you. There were no increases in concessions this year for council rates, water and sewerage rates for pensioners.

The Hon. J.W. WEATHERILL: I think it is too early to reach that conclusion. We are presently considering an offer from the commonwealth concerning those matters. It may well be that there will be increases in concessions that flow from that.

The Hon. DEAN BROWN: I understood that that offer was in relation to self-funded retirees or those with a commonwealth health care card. I am talking about existing pensioner concessions for council rates, water and sewerage rates.

The Hon. J.W. WEATHERILL: That is within the Families and Communities budget, so I do not have my briefings at the moment for that.

The Hon. DEAN BROWN: Perhaps my colleague could follow that up.

The Hon. J.W. WEATHERILL: Yes.

The Hon. DEAN BROWN: Again, I guess that highlights the problem here. The concession is for those who are pensioners and not covered under an aged area. I then come to the issue of the negotiations with the federal government on concessions for self-funded retirees. How are those negotiations progressing? There is a section in the budget that deals specifically with that.

The Hon. J.W. WEATHERILL: There are two elements of concessions: one is the extension of concessions to self-funded retirees; and the other is the question of the extension of the travel concessions that exist on a seniors card, which is provided by South Australia. You would recall that there are difficulties with interstate jurisdictions providing those concessions for South Australians to travel interstate. The commonwealth, as they are wont to do, boldly announce programs that require us to make a contribution, and it is very important to clarify precisely what it is that we are to contribute and what we are buying into.

One of the things that we are particularly concerned about with these commonwealth offers is what happens if they do not pass on indexation in the future, and so maintaining the real value of those concessions falls on the state government to retain them, and all the political pressure is brought to bear on the state government. We are involved in those negotiations. The commonwealth's offer is something that we are obviously carefully looking at. We want, if possible, to extend the capacity for transport and other concessions to commonwealth seniors health card holders, and we could be very close to sorting that out with the commonwealth.

The Hon. DEAN BROWN: We accepted and signed off on the commonwealth's offer made to the previous government, and despite certain claims to the contrary there was a formal exchange of letters between the federal and state minister on the matter, and formal sign-off by cabinet. My understanding was that the federal government was going to cover it on a percentage basis and, therefore, whatever concessions were offered to pensioners the federal government would cover. I think it was about 62 per cent, or something like that, and I understand that they have lifted that to, perhaps, 75 per cent of the same concessions being offered to self-funded retirees, to put it in a broad category, but, more specifically, those who hold a commonwealth health care concessions card.

The Hon. J.W. WEATHERILL: I do not think it is extended to 75 per cent; at least I do not think it is. I think it is 60 per cent. When the offer was made to the previous

government, it involved an effect on the budget and, as we found when we came to government, there was no provision for the funding of that concession at that time. So, that informed our decision making. We are re-looking at this matter, and we have a revised offer on the table. Since that time the state government has expanded its concessions in the area of electricity concessions to self-funded retirees, as indeed it did to all pensioners. So, we are prepared to re-look at that issue, and negotiations are progressing well.

The Hon. DEAN BROWN: The statement that no funding was provided is incorrect because I sat in cabinet and cabinet signed off against it, against specific head-room in the budget. It was there, and it was formally agreed to against that headroom, and that money sat with Treasury. So, if Treasury are now denying that, that is not factually correct. Cabinet had a specific allocation of money for that and a couple of other initiatives, and they were all signed off against that allocation.

The Hon. J.W. WEATHERILL: I think 'specific headroom' is a contradiction in terms. Either there is something in the budget for it or it is on the never-never, which probably gets into the same category as the funding for the QEH upgrade. That was specific headroom.

The Hon. DEAN BROWN: It was specifically allocated as money approved by cabinet for expenditure.

The Hon. J.W. WEATHERILL: Specifically allocated in a general way against no particular line item in the budget.

The Hon. DEAN BROWN: But it was: it was allocated against a line in the budget. Cabinet had a specific amount and we spent some considerable time working through a number of different options, and the money was allocated for this.

The Hon. J.W. WEATHERILL: I have to accept your word for it because I was not at the cabinet meeting, but all I can say is that I suppose things have moved on. We have a new offer and are actively considering it.

The Hon. DEAN BROWN: A lot of self-funded retirees have missed out on the concessions as a result of the decision not to go ahead with that as of 1 July 2002.

The Hon. J.W. WEATHERILL: I will answer that by saying it would be wrong to communicate that message to those self-funded retirees without also acknowledging that the government has extended its energy concession to those very same self-funded retirees for the first time.

The Hon. DEAN BROWN: I think that was done late last year, or in the second half of last year.

The Hon. J.W. WEATHERILL: Yes.

The Hon. DEAN BROWN: The next issue I want to take up is the review of the Retirement Villages Act, which was initiated in late 2001. I think I am right in saying that there had been a review (which we had implemented and acted on) of the regulations concerning the Retirement Villages Act. I had become Minister for the Ageing, and I then initiated a review of the act. I wonder where we are with that review, and when can we expect amendments to be introduced? It is now approaching three years since that was initiated.

The Hon. J.W. WEATHERILL: Yes, I appreciate that and I think it is an important area that could be described as almost consumer protection. It is obviously an important issue for aged people (and I know the member for Heysen has a special interest in this matter). In September 2003, a foundation document was circulated for public comment that outlined the rationale for proposed amendments. A very extensive set of responses came back in relation to those matters.

The present position is that I intend to approve the release of a second progress report in the near future. The report summarises the feedback that we have received on the foundation document and will provide the public with both the views expressed and the recommendations which the government will consider in drafting any proposed amendments. So, that important piece of work will obviously form a draft bill, which we expect to have before the house probably in the first part of next year.

The Hon. DEAN BROWN: When the next draft goes out with specific responses, I would appreciate receiving a copy of it.

The Hon. J.W. WEATHERILL: Certainly.

Mrs REDMOND: I would like clarification on a number of the things that appear in the performance criteria and commentary on page 7.32 of Budget Paper 4, Volume 2. In particular, I note the comments about how from 2001 we have changed to the minimum data set (MDS) figures and, as a result, there will be greater understanding of the number of clients who are assisted and the patterns of services that are utilised. When I look at the performance indicators, although I am grateful to know the number of hours of all the various indicators, I am a bit puzzled as to where they fit with the MDS figures, because they do not tell me anything about how many clients were assisted or the breakdown of the clients.

This is a question you may have to take on notice, but are there figures under the MDS data that tell us how many clients we help rather than the number of hours? I am quite happy to have the number of hours, but I would also like to know how many clients there were and whether they were ageing. Indeed, is there a breakdown as to whether those ageing people are in domestic or institutional situations, and so on?

The Hon. J.W. WEATHERILL: I think the point about this minimum data set is that it is all designed to get a much better quality of information, so you will see some differences in the material. A lot of it has to do with the fact that, as you get better quality data, people stop putting hours just in the column 'assessment', because it is like an 'all others' column for when they do not know where to put the hours that they are spending. So, we expect that the quality of the data will improve and, when that data exists in that fashion, we can then answer questions such as the question you asked, because that is the whole point of the new data set. The commonwealth has put some quite onerous obligations on us and we have had to put on more staff to meet the much tighter reporting requirements. This is the second full year of that, and we should be in a position to answer questions in that detail. I can either take that specific question on notice or you could reformulate it.

Mrs REDMOND: I am happy to wait until next year. I just want to keep an eye on those figures, because in the next 20 years one in four of us will be over the age of 65 years, and it is a looming issue. I think it is important for us to know where we are heading.

The Hon. J.W. WEATHERILL: Yes, I will certainly assist in that.

Mrs REDMOND: In terms of the performance footnote (a), which refers to a notional 4 per cent increase being planned for 'high priority' assistance, it then refers to domestic assistance, personal care, and home maintenance and modification, but only a 1 per cent increase for lower priority HACC assistance. I take it from that that the other things listed there, such as respite care and social support, are therefore in that area that has received only a 1 per cent

funding increase. First, could the minister confirm whether my reading of that is correct; and, secondly, I need to be clear about just what is meant by 'social support'. I assume that it means things like taking someone shopping and that sort of thing, because personal care would be actual personal care, and domestic assistance would be cleaning the bathroom at home and those sorts of things. I assume that the social support would mean driving people to medical appointments or to shopping and so on.

I want to know the effect of only a 1 per cent increase, given that, presumably, we have more people going into the system and that increased costs are associated with providing services every year. It would seem to me that 1 per cent would mean that there will therefore be less provision of services of that nature to people who currently get them.

The Hon. J.W. WEATHERILL: I think that the honourable member's understanding of the figures is fundamentally correct. The rearrangement of the distribution of funding as between the different sub-elements of that program is informed by what are considered to be priorities. It is also informed by benchmarking against what happens in other states in terms of where we allocate our resources. Fundamentally it is a question of priorities as between those areas, but it is informed a little by what our present effort looks to be like in areas of greater need. So, we may not be doing as much as we should in areas of high need and the adjustment is based on that analysis.

Mrs REDMOND: I refer to the bottom line of the performance indicators, and a note at the bottom relates to the agencies that have had their national service standards appraisal externally reviewed. The target for the year just completing is 157 and the actual result is 127. I am curious as to why only 30 are listed for the target for this year.

The Hon. J.W. WEATHERILL: I think that we are almost done.

Mrs REDMOND: Are there only 157 agencies, minister?

The Hon. J.W. WEATHERILL: I think the explanation is that we will have completed an external evaluation of every HACC agency within the next short period. So, we are commencing, if you like, the next round.

Mrs REDMOND: Is it done three-yearly? Are they done on a three-yearly basis?

The Hon. J.W. WEATHERILL: Mr Overland will provide some information.

Mr OVERLAND: It is a three-year cycle. We will have completed, we think, all of the HACC-funded agencies by the end of this month.

Mrs REDMOND: Can I ask Mr Overland, through the minister: are they all on three-yearly evaluation or is it that, like a number of other hospitals and agencies of that kind, some of them only get a one-year accreditation, as it were, in the first instance until they pull their standard up to the level, or do they all instantly go onto a three-year cycle?

Mr OVERLAND: It is not actually an accreditation process at this stage of the game, in the same sense as one might expect for hospitals. It is really designed as a developmental process to get agencies interested in quality assurance-type work. It has been funded over three years because that seemed like a sensible cycle to do it over. There is actually no agreed position, but it would appear that, from what has been happening in other states and territories, people accept that a three-year cycle is probably appropriate; otherwise, the administrative workload is too great.

Mr BRINDAL: I would like to know, through you, minister, what your officer means by 'get agencies interested in quality assurance'? I thought that, as a minister of the Crown, agencies would be mandated to be interested. I am going to be interested in pursuing this line. I hope that the minister will explain to me what the officer meant because it was a very Freudian slip.

The Hon. J.W. WEATHERILL: I think that the agencies about which Mr Overland was speaking were HACC-funded agencies, and we are talking about bodies that might be as small as community clubs. There is always this trade-off between having a very vigorous process of evaluating them and burdening them with those responsibilities, as well as ensuring that they are of sufficient quality. There is always a tension there. It is not a government agency. Of course all government agencies should behave to the highest standard.

Mr BRINDAL: You expect the Anglican Church to be squeaky clean, minister. What sized agencies do you draw the line at when you come to squeaky clean?

The Hon. J.W. WEATHERILL: That is a nice debating point.

Mrs REDMOND: I have a question with which, I hope, Mr Overland may be able to help me. I will try to couch it in general terms, but, essentially, it concerns a problem which arose this year in a HACC-funded aged care/day care facility at Aldgate and which, for some years, received its funding via the Mount Barker District Hospital. That was then rectified and the funding went direct to it and, for some years, it did not have any increase in funding. However, in the middle of this year there seemed to be a problem which sent it into a complete tizz, because it was put under a lot of pressure to produce documents that it understood it had already provided.

I am just wondering whether there is any sort of simplicity in the documentation required, because, as the minister has pointed out, a number of these agencies are quite small and do not necessarily have financial administrative people to help with the management. It appeared to me that the problem arose because of that sort of issue. I am wondering whether there is a simplification of those procedures to enable those small agencies to manage the HACC-funding process within the minister's office?

The Hon. J.W. WEATHERILL: That is the very point that I have written to Julie Bishop about, the federal Minister for Ageing. Some bureaucrat in Canberra has got it into their head that they really want chapter and verse about what is happening to HACC funding, which is fine; but, at a practical level, it places ridiculously onerous demands on small agencies. We keep having the accountability requirements racheted up on us. It has meant that we have had to put on additional resources to actually comply with them. We then have to ask a whole lot of onerous questions of these agencies; and they complain to us and to you. So, I have raised that with the federal minister, and I hope that she will simplify the arrangements for small agencies. That is the very point that I put to her.

Mrs REDMOND: In that regard, minister, referring to the point you and Mr Overland made before about this three-yearly cycle. Is there any possibility of the agencies being able to get their funding on a three-yearly cycle so that they do not actually have to do it annually, provided that they are providing the same services?

The Hon. J.W. WEATHERILL: That is what we do as a matter of practice, and it has been frowned upon by the federal government. In fact, we have been hauled over the coals for providing grant funding on a longer than yearly cycle. The federal minister has insisted that we fund on a yearly basis, which has meant that some programs, which we

know we will be rolling on for three years, have to go through the ridiculous process of reapplying each year, and to say the least they are not happy with it. I have raised their displeasure with the federal minister, and I hope that she will see the good sense of that point of view.

Mrs REDMOND: I have one other question, minister, in relation to your response on the Retirement Villages Act. I am pleased to know that it is still progressing, and I had a long meeting with the advisers to the previous minister highlighting some of the issues that arise under that act. You would be aware, minister, that the act actually works hand in hand with the residential tenancies legislation. I am curious as to whether you are also looking at that legislation and at the management of that area. I can tell you, for instance, that I had an experience in practice of running a five-day trial with instructing solicitor and barrister on one side and myself on the other, which the Residential Tenancies Tribunal is clearly not equipped to handle. They do not have recording facilities for transcript, and they do not have the space or anything else. If the Retirement Villages Act is going to continue to present the sorts of problems that have arisen under it (hopefully the corrections to the legislation will fix it) but, on the assumption that they will continue to go to the Residential Tenancies Tribunal, I suggest that we need to look at the Residential Tenancies Tribunal structure hand in hand with it, because that is where they go, unless we set up a separate tribunal altogether simply for retirement villages.

The Hon. J.W. WEATHERILL: I will take that on board as part and parcel of the process of reviewing the Retirement Villages Act. I am conscious of the fact that all of this legislation—whether it be SRFs, retirement villages, boarding houses or a whole range of accommodation, for people with high needs especially—needs consideration, so I will certainly take that on board.

Additional Departmental Advisers:

Ms N. Saunders, Director, Family and Youth Services.

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

Ms M. Russell, Policy Officer, Department of Human Services.

Ms M. Whiting, Policy Officer, Department of Human Services.

Membership:

Mr Goldsworthy substituted for Mrs Penfold.

Mr Brindal substituted for the Hon. D.C. Brown.

The CHAIRMAN: Under the portfolio of Minister for Families and Communities, we now move to Community Services. Minister, do you wish to make a statement?

The Hon. J.W. WEATHERILL: No, sir.

The CHAIRMAN: Member for Heysen, do wish to make a statement?

Mrs REDMOND: Yes, I do. Minister, the government is to be congratulated on putting significant new funding into the employment of large numbers of staff for FAYS. I trust that the minister has read the workload analysis report (in fact, I know he has) and recognises that just employing new staff will not be the answer. The report itself states that the problems in that department are deep and systemic, and points out that one of the most obvious issues is that such a high percentage of the case workers (almost half) are in their first two years postgraduation. However, whilst the government is putting in the extra funding towards at least attempting to address part of the problem for the future, it seems to continue to ignore the very real need to address the issues of the past. I refer, of course, to the need for a royal commission, or an inquiry with royal commission powers, into the abuse of children who were wards of the state in institutional care in this state in past years.

Those people are still your responsibility, I believe, minister. It is not enough to say that it cannot happen anymore. Clearly, that is so. We no longer run orphanages and so on, but that does not resolve the outstanding issues for those who were abused and whose lives have been severely affected and continue to be affected by what happened to them. It is not enough for the government to say that it has removed the pre-1982 barrier on the instigation of complaints. Of course, I support the government in having done that, but it does not address the problem. It is not sufficient to say that you can take your case to the police and have it prosecuted. The minister would know, as well as I do, how hard it would be to build a case to prove beyond reasonable doubt, especially after so many years when the victims were so young and the perpetrators and potential witnesses are often long gone.

However, in reading a report like that produced by the Anglican church, it becomes obvious that, even if no one individual case could be proven beyond reasonable doubt for a prosecution, there is a certain flavour to the consistency of the stories told by victims and witnesses that creates a compelling case that what these people are talking about really did happen and that the response of those who should have acted to protect them was disgraceful and appalling. Nor is it sufficient for the government to say, 'We have set up an abuse hotline to help you.' Certainly a part of the healing process is often talking about what happened, but the listening needs to be by someone in authority, not just an anonymous person on the other end of a telephone. In fact, some people who have been affected by abuse have already contacted the leader's office and said that they are not satisfied with the abuse hotline. They have no faith that it will not simply be used to identify them and arrange for the removal of their files.

It is not an excuse to say that such a commission or inquiry would cost too much money. The Anglican Church spent their own money conducting their inquiry; the Catholic Church spent their own money conducting their own inquiry. Surely neither the government nor the community would have found it acceptable if those organisations had just said, 'It is too expensive.' It is fundamental to this whole issue that we as a community must face up to the reality that has been buried for so long, and the government owes it to those who were abused as wards of the state to conduct an independent inquiry, no matter what the cost. It needs to be in the form of a royal commission, or at least have the powers of one, to ensure that those who come before it can feel safe from threats of defamation and are able to tell their stories in confidence. Many who have gone on to build successful lives have lived with this secret that they have never even disclosed to their families.

Minister, now is the time for the government to address this issue on behalf of all of us. I urge you and your colleagues to accept that the only way forward (as it was for the Anglican Church and the Catholic Church) is to open all the closets, bring it out into the open and address the past in a

way which allow the victims to achieve some resolution and finality. For the first time, victims can see that there is some hope of justice for them, following on from those Anglican and Catholic church inquiries. They are beginning to feel safe enough to come forward and have certainly contacted not only the office of the Leader of the Opposition but also the Hon. Andrew Evans from Family First, the Democrats and the member for Unley. I urge you, minister, to take a positive stand in that area. With those opening remarks, I would like to ask the minister a few questions.

The Hon. J.W. WEATHERILL: If it is the liberty of the committee, I would like the opportunity to respond.

Mr BRINDAL: No, that is an opening statement. You do not respond to an opening statement.

The CHAIRMAN: The minister can respond.

The Hon. J.W. WEATHERILL: I was invited to respond by the nature of the contribution.

Members interjecting:

The Hon. J.W. WEATHERILL: I think it is important because it might also assist in answering some of the questions. The honourable member is correct in saying that the problems identified by the workload analysis report in FAYS are deeper than just the provision of additional resources. Although, as with many of these things, without the provision of additional resources, the deep-seated problems are also incapable of being grappled with. The point the honourable member raises about the importance of ensuring that people have adequate competencies to deal with what are really very sophisticated judgements about child protection is a point very well made. It is a point made in both the Layton report and the workload analysis report, and we agree with it.

The steps which we have taken and the way in which we recruit staff is to try and recruit in non-traditional areas. We have sought to look beyond formal qualifications in the way in which we seek to recruit people. We are not just recruiting social workers. We also have a commitment to an ongoing program of growing education, and I think that is an important element of this whole equation. I agree with the honourable member's points and we are seeking to address them. The second point she makes about adult survivors is also a point well made. We agree that it is crucial that we do not forget the pain and suffering of adult survivors of child sexual abuse when we address the future.

Our commitment to that issue is clear. In the budget, we made allocations for expanding the counselling services to be provided to the adult survivors of child abuse; and recently we have made further announcements about our help line, which expands the range of services available to adult survivors. Let me just explain why we have chosen this approach. It has been a deliberate approach, and it has been taken because there is a great risk of doing great harm in this area if it is handled in an inappropriate fashion. I am a member of the Anglican Church and, I must say, with all due respect, it has been a cause of some concern to me how strident we have had to be about the Anglican Church, but frankly, and I know this from quite detailed discussions with senior members of the church now, it has been a necessary part of the process for the archbishop to relinquish his position to begin the process of healing.

While that is a painful thing for people in the Anglican Church to admit—and it is probably painful for the member for Unley and a number of people who regarded the Anglican Church as an institution that has provided some comfort to them and ought to be respected—nevertheless, I believe it is true. I think that there is a growing awareness amongst the synod of the Anglican Church and, indeed, the broader Anglican community, that that was a necessary step for the church to take for the process of healing to begin, and to begin in a serious fashion.

I know that that has led to the natural push by those who have the interest of the Anglican Church at heart to say, 'What is the state doing? It is pointing the finger at the Anglican Church, let us see what we can do to embarrass the state.' Now, frankly, I do not think that it is a question of embarrassment or otherwise. I think the search that we are undertaking on behalf of the government and adult survivors is a search to do something about improving their welfare. That is the task upon which we have embarked. We know that there are a number of ways in which people can seek justice. Some people simply want to talk to someone, as many have.

Many have often confided in members of the clergy, good members of the clergy. They simply tell their story and they need and want nothing more. Some may seek professional assistance and tell their story and, once again, they may need or want nothing more. Others may seek civil compensation. They may seek reparation because their lives have been so damaged that they seek the payment of money to redress some of the loss that they feel. That is equally appropriate. Others may seek to ensure that those who have committed these crimes are punished. They will labour through the painful and difficult process of a criminal prosecution. In all of those matters this government has sought to put in place arrangements that will assist them in achieving those things.

The helpline is much more than just a telephone call. It is a detailed case management of each of those people who may be put in touch with appropriate church processes that are under way. They may be referred by the Anglican Church to Yarrow Place, which is a state government body outside of the church because the church wanted to keep some distance from the services it provides. In much the same way, if people seek services because they are concerned about abuse that took place in state institutions, they may seek to avail themselves of services provided by Relationships Australia, which is not a state government instrumentality.

We carefully thought about ways in which we could improve the situation. We are gravely concerned about the potential costs associated with a royal commission. Before one blithely reels off the notion of a royal commission, one needs to think about the fact that when allegations are made people will need to be able to defend themselves. People are trumpeting the Anglican and Catholic Church inquiries, but these were not open inquiries that were made public. These were closed inquiries, and much of that material will remain confidential. Only that material which was obliged to be handed to the police has been given to them.

The public inquiry that is being sought is a very different beast from that which was engaged in by the Anglican and Catholic Churches. It would require lawyers and representation on a very broad scale. Before one embarked on such a process, one would need to be clear about where it would begin and end. There is a grave risk that individual reputations could be damaged unless people are given a proper opportunity to be heard. I am wary of inquiries that have no clear terms of reference. What we have always said is that we do not close our mind to the need for inquiring into matters of responsibility for the abuse of people in state care, and we remain committed to that.

Mr Brindal interjecting:

The Hon. J.W. WEATHERILL: Probably a similar amount to all of those nine people who have been charged over the 23 individuals who have been abused over the past 20 or 30 years in a range of institutions who are presently going to find their way before the criminal courts. This is all courtesy of an amendment to the criminal law sponsored by this government, which—

Mr Brindal interjecting:

The Hon. J.W. WEATHERILL: Well, we set up the Paedophile Task Force, which has unearthed this material. We have resourced the police to find out about these matters. There is a spirit of openness now. Before members opposite seek to play politics with this issue, it is important to realise that we have taken a rock off an issue which could potentially cause a great deal of harm and an enormous amount of suffering for those who have suffered abuse in the past. We do not want to make that abuse worse by subjecting them to an ill-thought through public inquiry. We are open-minded about the need for some form of an inquiry, but we are very concerned about the nature and scope of such an inquiry. It has the potential to damage people who may be dragged in through unsubstantiated allegations. We do not want this to turn into a witch-hunt which could have very negative consequences for the community.

I share the sentiments expressed by the minister, the leader and the member for Unley in the past. A crucial part of the healing process involves the truth being told. We need to find a sensible bipartisan way in which that can be done so that innocent individuals are not damaged and so that it will not completely drain resources which could better be spent on repairing the harm that has been done. I am sorry I have taken so long to say that, but I think it is important to put that point on the public record.

The Hon. R.G. KERIN: I agree with the last couple of points made by the minister. What I do not want to see is anyone who is innocent being hurt. There has to be an opportunity for witnesses to give evidence in camera. There are people who want to tell their story but for a number of reasons they do not want their identity known.

I refer to subprogram K81, which relates to guardianship issues and child protection investigations. With the current focus on child abuse and paedophilia, the opposition has been approached by a number of former wards of the state some of whom have been informed that their departmental files have been destroyed, whilst others have been given incomplete files under FOI. My questions relating to these files are in no way an attack on the current minister. I make it clear that a lot of this action took place under multiple governments across the years. Will the minister tell the committee under whose authority and in what circumstances wards of the state files have been destroyed by FAYS or its predecessors?

The Hon. J.W. WEATHERILL: I will have to take on notice the question about policies in relation to preparation of records. The present policy is—and has been for some time—to preserve all records.

The Hon. R.G. KERIN: Another question which may also have to be taken on notice is whether or not the department retains details of what files have been destroyed. I know from what various people have been told that there was a period when quite a few files were destroyed. One of the problems with files over a period, from what several people have told me—both those who have worked within the department and ex-wards of the state—is that, over the years, there has been a practice of not numbering the pages, which makes it very hard to tell whether or not the file is complete. Is that practice still in vogue or has that been discontinued?

The Hon. J.W. WEATHERILL: I can confirm that quality of record management is certainly one of the issues that has been raised within FAYS. Indeed, some money has been set aside in the budget to deal with record management. I suspect that, like many government files, a lot of these files would be managed in chronological order in the form of a docket, so they would not be paginated in the same way a legal brief would be. I will take on notice the other aspect of the leader's question about whether we can now identify those files which have been destroyed by reference to other records.

The Hon. R.G. KERIN: It is an issue that is pretty important to some of the ex-wards of the state. Can the minister advise where the records of ex-wards of the state are stored?

The Hon. J.W. WEATHERILL: Given the volume of those records, I think they are kept in a range of locations around the metropolitan area in the state government archives.

The Hon. R.G. KERIN: Will the minister commit to making these files freely available to any ex-ward of the state who requests them, because quite a few of them have raised with me that they have enormous difficulty getting hold of their files? Can those wards of the state, because of the existing situation, have easier access to their files?

The Hon. J.W. WEATHERILL: Certainly, if anyone is having difficulty getting access to their files, we will facilitate that. The only thing which I could imagine might bear on that would be if some third party was identified in a way which disclosed their personal affairs, and that may trigger some exemption under some piece of legislation.

The Hon. R.G. KERIN: In relation to that point, when a ward of the state FOIs their file, would it be normal practice to provide them with the original or a copy? I saw a file the other day and most of what was in the file were originals. However, where paper had been placed over the pages to blank out information, the paper just peeled off. In that particular instance, it makes me wonder whether what the department has is a copy, which would then mean that the FOI recipient would have a better record than the department.

The Hon. J.W. WEATHERILL: I think there are certain obligations under the State Records Act about the maintenance of state records, so I am sure such a thing could not happen.

The Hon. R.G. KERIN: I have actually seen an instance where it has happened, but I will leave that one with the minister.

Members interjecting:

The CHAIRMAN: Order!

The Hon. R.G. KERIN: On a slightly different issue and one which is a local issue for me, when will the government fulfil the pledge made by the former minister to provide recurrent funding of $140 000 for a family violence outreach service to cover both the Barossa and Lower North regions? Twenty months ago, the former minister wrote to Carers Link in Clare advising it of the allocation of $140 000 for a domestic violence program and that the service was to be put out to tender. Twenty months later, no tender has been called. As last week's *Argus* stated in its editorial headline, 'Domestic violence victims still waiting.'

The Hon. J.W. WEATHERILL: I will take that question on notice, but only until the committee addresses the housing area because that is a program funded under the supported

accommodation program. I think that is when my briefs will answer that question.

Mrs REDMOND: Minister, perhaps if I could first of all tidy up the question asked in the previous section under ageing relating to concessions. First, can the minister confirm whether any concessions were increased this year for pensioners regarding their council rates and so on? It appears from the budget that there has not been. The second part of the question is: can the minister advise why single pensioners appear to have been excluded from concessions available to married and de facto couples?

The Hon. J.W. WEATHERILL: The first part of the question is that it is too early to conclude that there has been no increase in concessions because those negotiations are progressing well with the federal government and there may well be an extension of the concessions for self-funded retirees. So, that is the extent to which concessions have been dealt with there, and there are those ongoing discussions with the commonwealth concerning the extension of the senior's travel arrangements for interstate travel. In relation to the second point, once again the single pensioners without dependents are eligible for some concessions, not all. Single pensioners without dependents are eligible for electricity concessions. Certain single people receiving certain pensions are not eligible for concessions under the state government, and that has been a longstanding arrangement, one which predated the existence of our government.

Mrs REDMOND: If I can refer you to page 7.37 and the performance indicators. The bottom of the performance indicators relates to the percentage of child protection investigations meeting the 42-day standard. I have assumed that within six weeks all notifications should be investigated, assessed and dealt with. Is my understanding of what is meant by the 42-day standard correct, and, if that 42-day standard is that all matters should be investigated and assessed and dealt with within six weeks, why isn't the target 100 per cent instead of 90 per cent?

The Hon. J.W. WEATHERILL: The nature of the standard is that they are investigated and assessed within that 42-day period. There might be ongoing action that is taken; there might be steps that occur after that.

Mrs REDMOND: Does that mean that 100 per cent of them will be at least investigated and assessed with those 42 days?

The Hon. J.W. WEATHERILL: I think the target was 90 per cent.

Mrs REDMOND: That is what I am trying to clarify. I think it should be 100 per cent. I understood from your first answer then that, in fact, the investigation and assessment would take place within six weeks. Is the minister saying that—

The Hon. J.W. WEATHERILL: No, I am saying that the nature of the standard is that it refers to the investigation and the assessment.

Mrs REDMOND: Shouldn't it be 100 per cent?

The Hon. J.W. WEATHERILL: In a perfect world it should. What we also know is that something like 60 per cent of our child protection notifications end up not having a substantiation. There is a lively issue about the way in which we allocate resources within child protection. Theoretically, we could allocate all of our resources to the question of assessment and notification, and as the honourable member would be aware by reading the workload analysis report, that is one of the criticisms of the present system in that, of what resources there are in the system—and there are not enough resources generally in the system—they are skewed too much in favour of investigation and court based processes, and not enough in terms of intervention and assisting people to cope with whatever it is that is causing the dysfunction within a family. We have a very difficult choice to make. We can continue to try and give the bare minimum assessment investigation with no follow-up, or little follow-up, and then see the rates of re-notification that we are seeing at present—that is something like two-thirds—or we can make sure that we have sufficient resources devoted to supporting families so that we begin to see a tailing off of re-notifications.

We are aiming for an improvement in our capacity to do this, but in the short term there may well be an increase in notifications. All of this current debate about child protection will no doubt stimulate a massive increase in notifications as people's awareness is heightened about the question of child protection. So, it is a very big public policy conundrum. Some states do not even have mandatory notification. Having a notification that something might be happening does not necessarily equate to the fact that there is something happening. It does require some assessment, and the assessment has to get beyond the evaluation of whether an incident occurred, and probably a more detailed diagnosis of what is needed to make this family work. In a perfect world it would be nice to have 100 per cent of those investigations within the 42-day standard.

Mr BRINDAL: I accept that one of the problems is caseload and therefore one of the critical tools for your department, if it was better operating than it is, to actually assess which cases are worth looking at and which are not. You may need to come back with a detailed answer on this, but recent work from the United Kingdom suggests that it is highly unlikely statistically for the natural father of a child to sexually interfere with that child. And that is some fairly valuable work that has come out of the United Kingdom. Yet your department, or your predecessors when in charge of the department, have quite a number of cases where the department seems to hound natural fathers on the assumption that they may well be guilty.

If your department is going to increase its capability of dealing with things, why does your department chase red herrings. And I point out for the record, the case of Bruce Yates, who was awarded $250 000 compensation, and the case of Mr Crispin, who has lost his children, despite the fact that it was thrown out of court. There are a number of other cases where the statistics and the cases suggest that a wrong has been done to these people, yet huge resources were wasted investigating statistical improbabilities. I could go on for quarter of an hour about the statistical high probabilities that have been ignored by your department. I agree with what you are saying. What I am asking you is how the hell are you going to sort it out and get your department looking at the cases they should be looking at, rather than pursuing individual vendettas?

The Hon. J.W. WEATHERILL: One of the things I think is never helpful in relation to child protection is to have any broad policy that ignores the individual instance. It seems to me that we have probably been in a system where the pendulum has swung from one side to the next and everybody is seeking the complete solution. Do we have a starting point that only stepfathers abuse kids? Do we have a starting point where only family reunion is best? I would say that we do not have any particular starting point. We need to investigate very carefully what has happened in an individual instance. We cannot have a situation where we begin with stereotypical

views about what has or has not happened in a particular family. It will depend on the degree of sophistication in our assessment tools, and that is something on which we are doing a lot of careful work.

In fact, quite to the contrary of what the honourable member suggests, we probably investigate more women than men, because there are more notifications concerning women. That is largely because women are the primary care givers, and most of the allegations of neglect are against women. However, most of the allegations of sexual abuse are against men, so we tend to investigate more men for that. I think the honourable member has recognised that it is a difficult conundrum. However, we are committed to looking at evidence-based processes, and that is a very strong commitment that has been given by the new Chief Executive, and I know it is supported by the head of the agency; and we will continue to learn from that academic research.

Mrs REDMOND: Minister, I appreciate your comments about the difficulty that the department faces in meeting its statutory obligations when, in fact, often what is needed is the ongoing assessment. But you will recall that the workload analysis in March revealed that 5 per cent of tier one cases (that is, where a child was at imminent risk) were not investigated within 24 hours, and I think you would agree that is probably not acceptable (and maybe you would like to comment on that). Is that corrected in the current budget?

The Hon. J.W. WEATHERILL: Most certainly. In fact, it was corrected before the current budget with the allocation of resources as soon as we were aware that we were not meeting those obligations. One needs to be careful about the use of statutory requirements. The 42 days is a policy standard, and the statutory requirement is to investigate expeditiously in relation to matters where the child is at risk. We regard category one notifications as something that must be investigated within 24 hours. There may be the rarest example where that does not occur, but I certainly have not been advised, at any time since it was drawn to our attention, that there were at least some cases we were not getting to.

The CHAIRMAN: Minister, I have written to you and some of the other ministers about the fact that parents feel that they have had their rights taken away—and we know that is not true, but that is a perception. One of the issues is that the material given out by the government makes it quite plain that there is no clear-cut legal position in relation to the role of parents in respect of, for example, punishment. The brochures say something like 'parents should be reasonable'. That tells people nothing. It also says that there is no law or rule relating to when a child can leave home, and we know, in reality, that agencies say that if you are 15 years of age you are independent, yet—

Mr BRINDAL: Fourteen.

The CHAIRMAN: Many say 15. But the law says you have to support a child studying until they are 24 years of age. It is not surprising to me—and I am not trying to make an excuse for bad parenting—that it is not easy for people to know what they can and cannot do. That is why I have been suggesting that the government should make it easier for parents to know what they can and cannot do—which, by implication, means that children have rights as well. But, given the vagueness, it is not surprising that people do things that they should not do because they are not aware of what the law is, or maybe there is no law, in some cases.

The Hon. J.W. WEATHERILL: I have seen that correspondence and I have considered it, and I must say that it did interest me. The question of the role of parents and parents' rights, if you like, in relation to children is a really difficult one. The orthodoxy is that there are no particular rights and that the interests of the child are what the child protection system is concerned with, although we know, as a matter of practice, that children are safest when they are in good families. The real dilemma arises when the relationship between the parent and the child breaks down. I receive many heart-rending letters from parents saying, 'I know that my child is living in a house with an older male' who, it is suspected, has less than honourable designs on their often under-age daughter, and they want me to do something to compel them to come home.

Assuming that we had a law that was capable of compelling a minor to live with their parents, one needs to think through the practicalities of how you would supervise an order of that sort and whether you could restrain quite mature teenagers who, one way or another, have learnt quite independent living skills. I do not think there is a government policy regarding children resisting parents' demands to come home. I think it is just an overwhelming acknowledgment of the practicalities of the difficulty of requiring children to be in one place when they choose not to be. They simply run away from home.

Certainly, the Layton report has something to say about the way in which we should consider dealing with these matters, and it may be that, in respect of some children, a coercive response will work but, in respect of other children, it will simply antagonise them, and their relationship with their parents will completely break down.

I think what FAYS and the department tries to do is to re-establish a relationship by trying to establish some form of dialogue. It is very hard to establish a relationship where none exists or where it has irretrievably broken down. I suppose the other element of your question is what it means to be a parent. I think that the way in which we tend to approach the notion of parenting is to build the capacity of parents to be good parents. Some people just do not know how to be parents, frankly, and it is no surprise that they fall out with their children. They just do not have the relationship skills to be able to maintain a relationship with their children.

We try to find ways in which we can build the capacity of people to maintain those relationships. We are a little hesitant about a rule book for what children are obliged to do and not obliged to do, although there may be a proper case for some coercive steps that the state could take in conjunction with parents, but we are keen not to worsen the situation.

The CHAIRMAN: I am not suggesting necessarily coercive steps; I am just saying that I think the vagueness at the moment leads to a lot of problems. I am not saying that I have the instant answer. I am just saying that the experts in the various agencies should have a look at this issue because it crops up all the time. You only have to listen to the talk-back radio. People come into the office often with this sort of issue.

Mr BRINDAL: Minister, a 14-year old girl runs away from home. Your officers set the girl up in emergency accommodation. Your officers are told that she is cohabiting with a 29-year old man, which is against the law. Their answer is, 'What do you expect us to do—hide under the bed?' The girl subsequently becomes pregnant and has a child by the 29 year-old man. What responsibility do you then bear to society as the minister? What responsibility do your agents then bear to the parents, the child and to the girl? If you want some more examples I can go on. What you say sounds fine in practice.

I know about a girl who ran away over a disagreement about the way she was to study. She is 14 years old, and she attempted suicide. Because that 14 year old girl decided that there was a breakdown with the family, the mother was almost suicidal in her attempts to find out anything. Your agency, in supposedly protecting the child, basically destroyed the family. I am not entirely blaming you, but there are two sides to this question. Every member in this house understands that there are two sides to this question. It is all right to talk about a child's rights, but sometimes in supposedly defending the child's rights you destroy the young adult's life.

The Hon. J.W. WEATHERILL: I think that the honourable member has identified the dilemma. Our agencies are criticised for not acting quickly enough to remove children from families where they can come to harm, and then we are criticised for not facilitating a family reunion in the circumstances that the honourable member has promoted. I do not think it is helpful to say—and it is certainly not the case—that there is a policy one way or the other. All that we try to do is assess what will work in the particular case. Sometimes we are left with a set of very poor choices.

We might have a family that has some element of risk in it, and we might have an out of home arrangement which also has some degree of risk, and we have to choose between two poor options. And then, if we were to make a third option and put them into some form of government or institutional care, that is not without its own risks because they come in contact with other children who might have particular difficulties. This is an extraordinarily difficult area. A whole lot of professionals try to make very sophisticated judgments and, until now, with very few resources to assist them to do it.

I am not saying that the member for Unley is doing this, but there is a culture of blaming the person who last came into contact with the family. The reality is that rarely is a FAYS worker involved in causing harm to children. It is the rarest case to suggest that a social worker has been associated with a particular harm. It is usually a family member. We are attempting to make a conscientious judgment about what should best be done with those children. What has happened over a period of time—it is something I have observed in the agency and, certainly, I have observed it in other jurisdictions—is that we have an agency that is fearful of the sort of criticism that can occur in forums such as this.

We want these people to be making conscientious judgments about what is in the best interests of the child. We do not want them to be making risk-averse judgments about what is best to save their backside should someone come and start grilling them in public forums. I think that, as public officials, we need to be very careful about the sort of chain of events that we set up when we go after these child protection issues. Sure, if there has been failings we need to be held accountable, and ministers need to be embarrassed because we are talking about the welfare of children. There is also a point beyond which we go where what we do is to completely demoralise professionals and their professional judgment is affected.

[Sitting suspended from 6.21 to 7.05 p.m.]

Mr GOLDSWORTHY: Following on from the previous question from the member for Unley, I had a similar situation occur, which is still occurring in my electorate and which was brought to my attention by the mother of a young girl who, at the age of 15, ran away from home. You could say that she was enticed away from home by a 28 year-old man. They started to live together. FAYS workers and the police visited the young girl with the male person there. They told the police that the relationship was not one of a sexual nature. The FAYS officers supposedly investigated the situation and reported back to the mother that it seemed that her daughter was not being abused: she looked like she was healthy and well-fed; she was not in danger; so they were not taking any more action.

The mother has obviously come to see me, which is how I know about it. Subsequent to that, I wrote to the then minister—not you, sir; it was your predecessor—and the response I received was that it is a difficult situation. The young lady was reported to be in a transitional period and that the department could offer counselling to the mother. I think that is a totally inadequate response. Subsequently, the police have interviewed this male person, and he has admitted that their relationship is of a sexual nature. However, they believe that—and I have not necessarily pursued this—it would be hard for them to charge the male person with any alleged offence. I add that the mother, on receiving the information from the then minister, regards it as a total insult to her that the government has offered her counselling.

The Hon. J.W. WEATHERILL: I am yet to detect a question in the member's contribution.

Mr BRINDAL: Well, the question is this: your act is very clear in that it gives paramount protection to the child. Case law exists where parents have said that their rights were overridden, as you know. I think the High Court of Australia ruled—in the Hilmer case, I think—that the act gives an absolute direct responsibility to your department to err in favour of protection of the child. I emphasise that—in all cases, to err in favour of the protection of the child.

The question implicit in my colleague's and my contribution is that, when FAYS so many times has taken children away (sometimes wrongly) on the grounds that they must err in favour of the child, why is it that, when the child may be in danger from predatory behaviour from older men, FAYS seems not to err in favour of the child? FAYS did not have to hide under the bed; it did not have to have a burden of proof; it did not have to believe the lies that were apparently told to it, but it chose to use a higher burden of proof to excuse its responsibilities from that girl than it does in a lot of cases with parents. That is quite an easy question. If you want to make the protection of the child paramount, why do you not make it paramount? Why, in cases like that, do you not err in favour of the protection of the child rather than assuming that nothing is happening until the person is pregnant, and then do nothing when she is pregnant?

The Hon. J.W. WEATHERILL: The starting point here is that this parliament in its wisdom has decided that it will not vest coercive powers in FAYS officers. It will not allow them to simply, on their own judgment, act to take one person from one family and put them in another family. It requires a court process to enable that to occur. So, there is a process of accountability, which is not unnatural. It would be unusual to think that some functionary of the state could make their own independent judgment without having an evidentiary basis for doing so.

An honourable member interjecting:

The Hon. J.W. WEATHERILL: That is the Youth Court. They have to persuade a judge that a person has to be subject to an order and that order can then compel them to do or not do certain things—

Mr Brindal interjecting:

The Hon. J.W. WEATHERILL: I am trying to answer your question. To satisfy a court—and once you are in a court, you are in the world not of surmise, you are in the world of evidence—you have to actually provide a factual basis. It would not come as any surprise to the honourable member that a young girl in that situation may not be offering any information which will allow someone to suggest that there has been a sexual relationship. It is unlikely that a person of their own volition will offer that they are in a sexual relationship with an under-age person. There is a real practical problem about the sort of material which can be put before a court to persuade them to make an order of the type that you would expect.

Are we to have a different regime; that is, that people can act on the basis of surmise? One of the central dilemmas with the child protection system is that it is an evidence-based system, and we can suspect (as we often do) that there may be a risk, but we have to back up that judgment in court so that the court will grant us the authority necessary to take the steps to remove the child from one place and put in another place. The dilemma about which we are speaking is essentially a dilemma about a lack of evidence, and until this parliament agrees to empower FAYS officers to simply act without evidence and on their own gut feeling about what may be in the best interests of the child, there will not be an easy solution to the problem that is posed.

Mr BRINDAL: On the grounds of the proposition which the minister has put forward, how does he justify calls about surmise in relation to the extradition of the Reverend Mountford, when the person who supposedly was sexually molested will not and has consistently refused to give evidence? Everyone has tried him and found him guilty when there is in fact no accuser. If that standard is good enough for your department, why is it not good enough for your Premier?

The Hon. J.W. WEATHERILL: I think it is pretty dangerous to be speculating about matters that are before the criminal courts.

The CHAIRMAN: Members should be careful not to get into individual cases here.

Mr Brindal interjecting:

The Hon. J.W. WEATHERILL: He looked to be in the vicinity of a court yesterday, if that was the man in question.

Mr Brindal interjecting:

The CHAIRMAN: Members need to be careful about getting onto individual cases in estimates.

Mrs REDMOND: Without wanting to get onto an individual case by name, I want to ask a number of questions relating to the death of a baby at Victor Harbor recently. Was FAYS notified under the Every Chance for Every Child scheme? It is understood that there was a visit from a CAMHS officer, and I am yet to find out whether FAYS was notified. However, more generally, what protocols are in place to ensure appropriate communication exists between CAMHS and FAYS? My understanding of the Every Chance for Every Child program is that there will be a visit to the home in the case of all newborns. I support that concept in as much as clearly conscientious mothers are the ones who visit child health centres to have their babies checked for appropriate weight, and probably the ones most in need are the ones who do not attend those centres.

I am quite comfortable with the idea of the visit to the home, but my understanding is that FAYS is supposed to be notified of any baby who is identified as being at risk. What protocols are there for that communication to take place and what consequences flow from it, if there is such a communication? CAMHS nurses are mandated notifiers, so they are bound by the ordinary obligations. They are in an especially strong position to make that sort of an assessment, because they go into people's homes. Given the take-up rate, which has been very high, obviously they are going into many homes. I can tell the honourable member from my own personal experience that they have a detailed questionnaire which seems to identify risk factors for child abuse. That information is fed into a central process so that those who need it can be provided with more sustained home visiting. That is an example of the early intervention system working very effectively.

I will provide the honourable member with a detailed answer about the specific protocols that are in place between FAYS and the child and health nurse arrangement, but I suspect that they would be consistent with the usual processes that a child and youth health nurse would follow if they witnessed any form of conduct which would trigger a notification under the Child Protection Act.

Mrs REDMOND: Supplementary to that, the minister mentioned the take-up rate. My understanding was that it was a mandated procedure now and that all babies born in this state are subject to a visit under the scheme. Is that so?

The Hon. J.W. WEATHERILL: As a matter of practice, that is the way it has turned out, but obviously you cannot force your way into someone's home. It is offered to everyone.

Mr BRINDAL: My question relates to the matters that the minister raised earlier. He admitted that some people may well look for compensation and that whatever form this inquiry takes there may be a case to be answered that requires compensation of some victims who were wards of the state and that, therefore, the state would have liability for those people. Where can I find the budget line that details the amount of compensation that has been set aside for these people?

The Hon. J.W. WEATHERILL: Lest it be said that I have been verballed by the member for Unley, there has been no agreement to establish an inquiry. One of the things that will interest us is the findings of the Senate inquiry into abuse in institutional care, which the honourable member himself addressed. We will also carefully monitor the results of our helpline. No specific line has been set aside for compensation for victims. I am aware that substantial sums of compensation have been paid in the past to victims of child sexual abuse who were in the care of the state and no doubt others may wish to come forward. If they have a case, no doubt they will also receive a proper measure of compensation.

Mr BRINDAL: What is the forum for them to come forward and present their case? A number of people have had to go to the most extraordinary lengths in the public media and on programs such as *Today Tonight* before they would even be listened to. We have seen the unedifying spectacle of the Anglican Church. If previous governments of this state have been negligent for 30 years and have a case to answer, where and how can these people address their concerns in a way that they know is appropriate, sympathetic and makes them believe that the government of South Australia is not ignoring their cries?

The Hon. J.W. WEATHERILL: They go to the helpline. They will be allocated to a person who will listen carefully. Not all people will seek compensation. They may not think that that is an important part of the exercise, but some people will think that it is important. If they do, protocols will be established with the helpline to enable them to be referred to

the appropriate process. We will ensure that if they need legal representation they will be put in touch with the appropriate body, and the process of exploring their issues will take place. That is the natural course that any claim for compensation should take.

Mr BRINDAL: Minister, the lessons of the Anglican Church inquiry are that these people took that sort of avenue. They went to the Bishop, and repeatedly the inquiry found that they found the Bishop unsympathetic, wanting to get them out of the door as quickly as possible, wanting to collect the evidence and no more. I have already had instances of people ringing my office saying that they are not going to the helpline because Caesar is judging Caesar. This is a government instrumentality creating a helpline. Some of them think—I hope wrongly—that this is to cover up government inadequacies.

That is one of the great lessons of the Anglican inquiry. It came to light only when the Anglican Church got Justice Olsson, did it independently, caused it to be put on the table and referred the matters to the police. When people could see that it was independent and fair, when they had trust in the inquiry, they came forward. But for so long as they thought the church was intent on covering up its own mess, they did not come forward.

I put to the minister that I am already getting—and so are my colleagues—people ringing me and saying, 'This is a whitewash. This is a government trying to cover itself.' Even the allegation about what the helpline is doing—and I know that it is an allegation and that it is not fair; however, people believe it, and perception is everything—is—

The Hon. J.W. WEATHERILL: The member should discourage them and tell them that the government has established an independent helpline run by Relationships Australia and that the government has made a commitment that it will sympathetically listen to their calls. The government will also case manage them through a process that will involve either supporting them to bring a criminal prosecution, to seek the payment of money, if that is what they seek; seek therapeutic services for them; or just be a kindly person to listen to their complaints. I respectfully submit that that is what the member should be telling them, if he is playing a proper role in seeking to advance the welfare of those people.

If the member suggests that what is being put up by the government is seeking to absolve the government of some responsibility and play politics with this issue, no doubt the member will dash that person's confidence in the process that has been set up. There is a very important responsibility on those who have set themselves up as the advocate of the people who have been abused in care to encourage them to take advantage of this genuine offer that has been made to assist them.

Mr BRINDAL: No, that is not fair. I have sat where the minister has sat. I have genuine confidence in the minister's integrity, and I have genuine confidence in all my colleagues in this house. However, I know, as the minister must know, that the minister cannot speak for his entire department.

The Hon. J.W. WEATHERILL: It is not being run by my department: it is being run by Relationships Australia, which is an independent body.

Mrs REDMOND: Before leaving this topic, I want to be clear about what the minister said in relation to the legal assistance provision and the possibility of getting monetary compensation. Is it the case that the minister is indicating that his government is prepared to provide legal assistance to these people who have come forward? Is it also the case that the minister is saying that they have to be able to produce evidence that would get them a criminal prosecution, or is the government prepared to look at compensating them in circumstances where they may have quite a compelling tale to tell but not one which is capable of being proven beyond reasonable doubt?

The Hon. J.W. WEATHERILL: We are prepared to assist them to obtain legal assistance. We are prepared to entertain, as we have in the past—and when I say we, I mean collectively the state—claims of compensation as paid money to former wards of the state in circumstances where it has obviously assessed that there has been some culpability by the state in the standard of care that the government has provided to a particular ward of the state.

In many cases, as we have seen recently, some of the wards of the state were abused by members of other institutions, such as churches. It may be that the primary liability should, in fact, be that church or institution. In that sense, the role of the helpline would be to case manage and to assist that person to ensure that they receive appropriate justice before that particular church. We are not seeking to step into the shoes of a primary wrongdoer. We may have some culpability for essentially allowing this to occur, but it may be that some primary culpability lies with some third person. It could be that the church institution may not be providing what they ought to be providing quickly enough, in which case we will case manage that project and provide proper assistance for that person. In a sense, we stand there to try to support people through a process, and I do not think we have insisted on a criminal standard of proof in the past, nor would that be proper.

Mrs REDMOND: It may be an opportune moment for me to read the omnibus questions into the record. If the minister is happy, these omnibus questions are for all the portfolios. I do not want to have to read these questions through three times for the various portfolios—they are all within the minister's jurisdiction.

1. Did all departments and agencies reporting to the minister meet all required budget savings targets for 2003-04 set for them in the 2002-03 and 2003-04 budgets? If not, what specific proposed project and program cuts were not implemented?

2. Will the minister provide a detailed breakdown of expenditure on consultants in 2003-04 for all departments and agencies reporting to the minister, listing the name of the consultant, cost, work undertaken and method of appointment?

The CHAIRMAN: Only for consultancies above $5 000. That is consistent across all estimates.

Mrs REDMOND: We did not want to have reports on consultancies—if anyone can find one—of less than that amount.

3. For each department or agency reporting to the minister, how many surplus employees are there and for each surplus employee what is the title or classification of the employee and the total employment cost (or TEC) of the employee?

4. In the financial year 2002-03, for all departments and agencies reporting to the minister, what underspending on projects and programs was not approved by cabinet for carry-over expenditure in 2003-04?

5. For all departments and agencies reporting to the minister, what is the estimated level of under-expenditure for 2003-04, and has cabinet approved any carry-over expenditure into 2004-05?

6. (i) What was the total number of employees with a total employment cost of $100 000 or more per employee, and also—as a subcategory—the total number of employees with a total employment cost of $200 000 or more per employee for all departments and agencies reporting to the minister as at 30 June 2003?
   (ii) What is the estimate for 30 June 2004?
   (iii) Between 30 June 2003 and 30 June 2004 will the minister list job, title and total employment cost of each position with a total estimated cost of $100 000 or more (a) which has been abolished, and (b) which has been created?
7. (i) What is the difference between consultants and contractors, and how many people or services that were previously classed as consultants are now shown as contractors?
   (ii) What is the value of their contracts and what are the services that they provide?

The Hon. J.W. WEATHERILL: I think will have to get a consultant in to handle that additional workload.

Mr GOLDSWORTHY: Just going on from the situation I described previously, as I understand it, parents are legally responsible in a lot of different ways for their minor children. However, you advised earlier of a scenario where you thought the pendulum had swung too far one way and, arguably, in the situation described by myself and also described previously by the member for Unley, the pendulum has also swung too far in that instance. It seems to me that the focus is on the rights of the child and on what needs to be done to protect the child, but what rights do the parents have in a situation like this? And, in cases such as this, where the young daughter has allegedly run away with an older male, is there any compulsion on the FAYS officers who investigate these matters to try to reconcile the differences that may have caused the minor to leave the home, or to try to reconcile the differences between the mother and the daughter?

The Hon. J.W. WEATHERILL: They are all very good questions. The key formulation is not the rights of the child but rather the welfare of the child being paramount, and that may or may not be about what the child thinks is in its best interest. There is meant to be an assessment based on what objectively is in the best interests of the child, and that may differ from how both the parent and the child see the situation. Of course, the wishes of the child are very important in that exercise, and also there is a principle in the act about family reunion. So, all of that sits there. The problem is that it does not take you very far, because it only suggests that there are a whole lot of competing priorities, and you have got to make a very finely balanced judgement. I think the difficulty that arises here is that people naturally think that they have rights in relation to their children, and it is a natural feeling that people have. It is just that it does not happen to find its expression in the law of the land, and it is only on a moment's reflection that it must be the case that that cannot be the paramount consideration.

It is the policy of our department to try to reconcile differences that exist between parents and their families, and you should find that in each of the cases—I do not know about the specific cases you talk about—that there would have been attempts to engage in some process of trying to reconcile the family with the children. So, if that has not happened, then it is something that should have happened.

Mr GOLDSWORTHY: Can I refer this issue to you?

The Hon. J.W. WEATHERILL: Most certainly, and the member for Unley can—I think we have tried to get details from the member for Unley. I am sure that, if he wants us to take it a step further, he will supply us with more details.

Mr BRINDAL: Could the minister explain to me, because I do not understand, how a 14-year old boy can be abducted, or taken away, by a 29-year old man, who can be accused of being a paedophile and charged with all sorts of offences, but a different 29-year old man runs away with a 14-year old girl and no offence seems to be committed? I just do not understand it. There seems to be very much a double standard. If it is a boy with an older man, there are charges and it is all over *The Advertiser* and the whole community is outraged, and if it is a 14-year old girl who gets pregnant by a man the same age, there is apparently no offence. Isn't this a double standard? I thought we lived in a world where there was equality and that it was not against the law to be gay. I thought it was about power relationships and, if it is, could you please explain what the difference is, because I cannot see it?

The Hon. J.W. WEATHERILL: There is only one assessment that needs to be made in all cases, and that is what is in the best interests of the child. I have said before that there are many vagaries about the evidential basis that exists that allows us to act. The way you put it, the cases look unsafe. I do not know whether they are all the facts. If there is an unsafe environment for a child then FAYS should act to put that child into a safe situation.

The CHAIRMAN: I raised with the Attorney-General and with the minister responsible for the status of women the issue of domestic violence. I do not ask for an answer on the spot, but are you prepared to liaise with those ministers to see whether the strategies we adopt in dealing with domestic violence are the best that we can come up with in this day and age? I know it is a difficult area, but we still seem to have significant numbers of not only women in shelters but also women in motels who are there because they cannot get into a shelter. We also have some violence by women against men—that is the smaller component—and by teenage girls against their mothers and so on, and I think it is time that this whole issue was revisited with the various agencies looking to see whether we can do better.

The Hon. J.W. WEATHERILL: Most definitely. There is an extensive program of increasing our efforts around domestic violence both in terms of the quality of the services that we provide to people and also the accommodation options that are available. We are gratified by the federal government's current advertising program, which is raising public awareness about the issue. A whole range of important services need to be provided, and we will make some important announcements about that soon. One of the important initiatives in the new department will be to develop a strategy for domestic and family violence, and that will involve taking a whole of government approach and engaging the very agencies which you have mentioned. It is a very topical question, and you can expect to see further announcements about this matter.

The CHAIRMAN: We will now move to consider the lines relating to housing.

Additional Departmental Advisers:

Mr M. Downey, Director, South Australian Housing Trust.

Mr C. Larkin, General Manager, Aboriginal Housing Association.

The CHAIRMAN: Do you wish to make an opening statement, minister?

The Hon. J.W. WEATHERILL: No.

Mrs REDMOND: I will not make a long opening statement, but I will make a comment or two. Obviously, homelessness is not an issue which gets the attention it probably deserves. It is not a sexy issue, obviously, and it does not affect most of the people living in the state. But we do have, I understand, 600 people who are classified as homeless, and another 6 900 whose accommodation is inadequate or inappropriate. As I am sure you would agree, it is clearly a blight on our standing as a community if we do not address the issue. In the face of those figures, while the minister recently announced some initiatives on the issue which are welcome, I would have to suggest that they are not adequate, especially in light of the Labor Party's policy of reducing homelessness by 50 per cent. I will be interested to ask questions about just how much we know about the homeless we have: where they come from, the nature of the homelessness, how it came about, the age groups, what the problems are and so on. To that end, my first question is, hopefully, straightforward. In the highlights for last year and targets for this year on page 7.126, could you explain what is meant by the term 'complex needs'?

The Hon. J.W. WEATHERILL: 'Complex needs' is a broad term to describe a range of people who present to the social housing agencies with some form of disability, for example, a mental disability, a physical disability or maybe a disability through a range of experiences which they may have had. It may be people who have recently come from prison or, perhaps, people who have formerly been inhabitants of Aboriginal lands. It really is a very broad way of describing the sorts of people who present to social housing agencies and the additional complexities involved in managing a tenancy of that sort.

Mrs REDMOND: I am curious about a suggestion made to me the other night at a church service for the homeless. One of the people attending that service suggested to me that, in fact, one had to have complex needs in order to classify as being eligible to go on even category 2 of the Housing Trust list. Is it the case that actually being homeless in South Australia does not of itself entitle a person even to category 2 status on the Housing Trust waiting list?

The Hon. J.W. WEATHERILL: You use the term 'homeless', but there are three types of homelessness—primary, secondary and tertiary. Primary homelessness is people who are in what is said to be improvised accommodation—sometimes described as 'sleeping rough'; and those people whom we might traditionally describe as homeless in the common parlance automatically qualify as category one. So, the question is really about category two people and, to get on to that list, one needs to demonstrate a number of factors—usually some form of inappropriate accommodation and also some form of disability, and that disability could be any of the particular complex needs to which I referred earlier.

Mrs REDMOND: So you are saying it is 'and'—you must be in both inadequate accommodation and have some additional need to get onto that list?

The Hon. J.W. WEATHERILL: To get on to the category two list.

Mr BRINDAL: Minister, you said everyone who is sleeping rough is automatically category one.

The Hon. J.W. WEATHERILL: Sorry, it is almost never the case that somebody who is sleeping rough does not have at least some form of complex need. I do not think we can ever contemplate an example of somebody who is sleeping rough and has no particular needs—unless they are sleeping rough as a matter of choice, and then you might query whether they should be category one.

Mr BRINDAL: But if men, in particular, who are sleeping rough go to the William Booth or St Mary Magdalene centres, or some of those other places (as most do), my understanding is that they do not automatically get priority for emergency Housing Trust accommodation, and those people sometimes have to wait years and simply are not on the list. They come on the list well after a lot of other categories before they are provided with stable, medium to long-term accommodation. They are either expected to sleep rough or go to William Booth, St Mary Magdalene, St Vincent de Paul's or one of the other temporary accommodations and make do while you look after everyone else first.

The Hon. J.W. WEATHERILL: I think there is a bit of a misunderstanding between the emergency responses and the longer-term South Australian Housing Trust responses. The accommodation that is provided by the Housing Trust is clearly not appropriate for somebody in an emergency situation. Those people need to be put in touch with an emergency response service, and they will tend to be supported through a different scheme—either the Support Accommodation Program or some emergency rent relief system in some immediate accommodation to get them 'off the ground', if you like. But it then becomes a secondary issue about where they fit on a waiting list to get into the more permanent accommodation that is characterised by the South Australian Housing Trust public housing arrangements.

Mr BRINDAL: I am merely exploring this. If a man is sleeping rough and is then assisted into short-term emergency accommodation, how long after he goes into the short-term emergency accommodation can he expect to be given Housing Trust housing? Will he ever get a Housing Trust house or will he spend the rest of his life in William Booth and the rest of the centres? Certainly, my electors tell me that that man will be months or years (even indefinitely) in emergency accommodation whereas, if it is a woman, she will get different treatment and come out of the women's shelter much more quickly and be found emergency accommodation.

Members interjecting:

The CHAIRMAN: Order! We will declare gender peace now and let the minister answer.

The Hon. J.W. WEATHERILL: There is no different set of rules that apply to men and women in this regard, but I think the real question you ask is about waiting lists. I think that is really the point. Once you are in some other form of accommodation you are on a waiting list. If you are on a category one waiting list I think the current average is something of the order of four months, which is a very long wait for a category one waiting list. Category two is an even longer period, and for category three applicants it really is an extraordinarily long waiting list.

Mr Brindal interjecting:

The Hon. J.W. WEATHERILL: Fundamentally, before licking your chops about that, you need to realise that what has happened over a period of time is that there has been a fairly substantial reduction in the amount of funds that have been made available from the commonwealth through the commonwealth-state housing agreement. We also recently received a further blow; because we do not receive GST compensation we now have a further cut to the funds that are

made available. Over quite a lengthy period of time (and it was not confined to the most recent Liberal government) money has been taken out of the capital works programs for building new houses and put into rent relief and, indeed, into things such as the first home owners grant. What has occurred is that demand has been stimulated through those mechanisms but supply has not been increased. We have also seen quite massive speculation in property prices, which only serves to exacerbate the matter.

There is a real need for some national leadership on this issue. I think it is an issue with which the previous government was grappling, and we are certainly also grappling with it. There is a very large element of the housing debate that is the responsibility of the commonwealth, and we need to see what we can do within the current environment. It has not been assisted by the fact that, over the past 10 years or so, there has been a reduction of about 10 000 social housing units within the public housing system. That becomes the essence of the difficulty that we face. However, housing alone is not entirely the answer. Many of the people who find themselves homeless once had houses. So, it becomes a question of how they are sustained in their accommodation, and that raises issues about the sorts of services we can provide to people to keep them in their homes. That is where there is an important interface between the health system, the social welfare system and the housing system.

Members will see the initiatives that we have put in place—the $12 million over four years that was announced in the last budget and the $8 million over four years in this budget. Many of those things have been directed at trying to sustain people in their tenancies to ensure that they can maintain a successful tenancy. Some people have trouble living in houses, as strange as that may seem, and they need some assistance to do so, otherwise they can find themselves on the streets.

The CHAIRMAN: Do we know how many homeless people there are in South Australia?

The Hon. J.W. WEATHERILL: The most recent figures, I think (and, once again, it is a question of characterisation), are that something of the order of 800 people in the state fall into the primary category. However, that figure needs to be taken a little carefully because some of those numbers include improvised housing that people in, say, Kangaroo Island use; people who live a semi-transient lifestyle by choice. There would be some elements of the Aboriginal community within the lands who live a semi-transient mobile lifestyle, which may not necessarily be capable of being characterised as homeless. But within that there is still a snapshot on any one night of that being the number.

Within the city itself it seems to be something in the order of about 120 during the winter period, and in the broader metropolitan area a further 200; that seems to be the parameter. The 7 500 to 8 000 figure is the primary and tertiary homeless, which might be things such as caravans, car parks, inappropriate boarding house accommodation, sleeping on couches, moving in between houses, overcrowded houses and those sorts of things; people who are perhaps sitting in transitional accommodation for too long.

Mr GOLDSWORTHY: I understand that some people do find it difficult living in a home and need support to do that. You also said that providing accommodation is not the only answer to the problem and I can appreciate that, too. How many new homes or units does the government propose to build this year? I recall that your predecessor, the Hon. Steph Key, announced as a new policy coming into government that a facility would be built, not necessarily in the inner Adelaide area but close to inner Adelaide to accommodate homeless people. What progress has been made on building that infrastructure facility?

The Hon. J.W. WEATHERILL: A range of programs are directed at expansion. Your question relates to the number of actual places that exist. We cannot separate out the nature of the accommodation from this effort. For instance, we have committed $4.5 million for a new 60-bed facility for prematurely frail and frail aged homeless people. It is very similar to the 40-bed facility that was recently opened in Brompton. That is a very important initiative. They will often be men, the very people whom the member for Unley is concerned about. When I say frail and frail aged, these are often people who might not be in their 60s, they might be in their 50s, but for a range of reasons such as drug and alcohol abuse or health problems they may have prematurely aged, or they may have been living in an exposed environment that has prematurely aged them. To that will be added some funding from Anglicare, and that will be an important initiative.

It is true to say, though, that there will continue to be a fall in stock, as there has been over the years. The reality is that the Housing Trust has had to sell stock to maintain its operations, although we are projecting the smallest fall in stock for what appears to be a decade in the next two years. In terms of the new build program itself, $64.4 million will be committed to the construction of 450 new houses through the new build and Better Neighbourhoods Program. In the inner ring suburbs we have looked at one-for-one replacements where we can use the selling of one block to finance the building of another. That process is allowing us to renew estates that are running down. A lot of the Housing Trust stock is old and does not necessarily suit the needs of the people. It may not be an appropriate configuration. We are also looking at $20.5 million committed to the renovation of 480 houses. It is about the configuration of the houses as well as the building of new houses.

In the community housing area, $2.2 million will be provided for the development of 15 units at the Mawson Lakes site, and in the AHA budget $5 million will be committed to three special housing projects in Ceduna, Coober Pedy and the APY lands. We are expanding the stock but, unfortunately, some stock is being consumed in urban regeneration projects. A project commenced by the previous government in Westwood is chewing up quite a lot of Housing Trust stock in the north-west suburbs, so we are seeing some stock disappearing as we are rebuilding and regenerating other stock. The rate at which that has occurred has slowed under this government.

Mr GOLDSWORTHY: What you are saying is that, if a Housing Trust home is sold, you use the proceeds of that, adding some more money to it, to buy another property to replace that one.

The Hon. J.W. WEATHERILL: Some of the blocks are quite large so we can subdivide and put two homes where there used to be one. It involves levelling the block, rebuilding and selling off one to finance the regeneration of the area.

Mr BRINDAL: The Premier has just spoken about water and how precious it is and he has mandated that shortly every new house built will have not only to have a rainwater tank but also be double plumbed. As the biggest landlord in South Australia, what are your plans for ensuring that? I hope you will tell the committee that every new house will have the same requirement at law as every private dwelling. Secondly,

for renovated houses what is the plan to be the model citizen and put in rainwater tanks and double plumbing? Finally, when you get past the renovated houses to old stock not necessarily scheduled for renovation, what is the government's time line for mandating for itself a standard that it is now setting for the community with rainwater tanks?

The Hon. J.W. WEATHERILL: We are seeking to exceed the standards we set for the rest of the community not only by putting in rainwater tanks for new houses but also when we are conducting renovations. We are seeking to ensure that proper water saving devices such as low flow shower heads are incorporated into new and renovated dwellings. It is important that we be an exemplar of promoting water sensitive design, and we take it seriously.

Mr BRINDAL: I note that the Channel 7 current affairs program is alleging some form of corruption in the Housing Trust. Can you tell this house whether there is corruption in the Housing Trust?

Ms Breuer interjecting:

Mr BRINDAL: No, it has been aired on a public program: either there is or there is not. I am giving the minister the chance to defend his department or to comment on what Channel 7 is alleging.

The Hon. J.W. WEATHERILL: The program made a number of allegations. I met with Tony Olivier from the Housing Tenants Association, who put a lot of material before us that we have looked at carefully. He has grave suspicions about some of the material demonstrating corruption, and we have taken it seriously and investigated it. We cannot reach the same conclusion he reached about it, although we have taken it very seriously. We will not close off our mind to the suggestions he made. Certainly I cannot give a blanket bill of good health for the Housing Trust.

I noted the other day that somebody in the Housing Trust was before the courts facing criminal charges for what could be described as fitting within the category of the conduct you suggested, certainly fraudulent behaviour in relation to Housing Trust assets. It does occur. We certainly understand the need to be vigilant. It is clear that we need to review our systems to prevent these sort of things from happening again, and I am advised that it is well under way.

Mrs REDMOND: You mentioned the regeneration project known as Westwood being undertaken by the corporation, and I understand from a response you gave to a question of mine in the house that the contract with Westwood contains some obligations in relation to the social aspects and not just the building aspects. I know anecdotally and from talk-back radio that a wave of dislocation appears to follow these regeneration projects. What precisely is being done pursuant to the contract and the obligation of Westwood to address the sort of social problems that appear to be arising as the regeneration projects go through an area?

The Hon. J.W. WEATHERILL: There is no doubt about that, but with the benefit of hindsight the previous government may have paid a little more attention to the social elements of the regeneration of the area rather than merely its physical elements. While the Westwood project was initiated to transform an area in serious decline, we need to understand the starting point. It is South Australia's most disadvantaged area, with an index of relative socioeconomic disadvantage of 755, compared with Elizabeth of 801 and South Australia as a whole of 1 000. So, it is an extraordinarily disadvantaged set of suburbs. The Westwood urban renewal project is being undertaken as a joint venture and a commercial arrangement between the trust and Urban Pacific. The contractual obligation requires the parties to achieve a number of social goals over the life of the project, such as creating a living environment which results in an overall improvement in the current residential amenity and an environmental quality which is supportive of a variety of lifestyles and aspirations and is a positive force for local community and economic development.

Those are very broad objectives and, over time, there has been an understanding that there is a need to supply some additional resources to ensure that the dislocations that occur as a consequence of such a large urban renewal project are grappled with. One of the difficulties is that there is a very long time line for the completion of the Westwood project. I have taken a particular interest in this, because part of The Parks area is in my electorate and adjoins the electorate of the member for Enfield. The story of The Parks is the story of the trust in the broad, that is, it contains a whole range of Housing Trust stock which, once upon a time, used to house quite a broad cross-section of the community but which now houses people invariably with very high and complex needs. The difficulty is that it creates a culture within a suburb that can conquer its spirit.

There is no doubt that, with its level of unemployment and social disadvantage, The Parks has become a very dysfunctional set of suburbs. Obviously, crime is a very serious issue, as are disruptive tenancies. Of course, many people have held these tenancies for some 40 or so years, and they are very distressed at the way in which the neighbourhood has changed. So, a smaller number of people are being crammed into a reduced housing stock. They have many complex needs, but they are not getting the support they need, and the concentration in one area of people with these very high needs is getting on top of the suburb.

A whole range of initiatives has been put in place under the Westwood project. An important step forward will be to accelerate the project. If you are living in a suburb that is earmarked for development in 10 years' time, it does not give you much hope for any serious change in the circumstances of that suburb in the near future. So, I have asked both the trust and the consortium partner to consider ways in which we can speed up the balance of this project. Some tense negotiations are under way between the developer and the trust. The developer believes that it is costing them a lot of money to undertake the additional requirements to make the project viable and, obviously, the trust has its legal obligations.

As the local member, I have encouraged the establishment of a neighbourhood house and a community group to be involved. I have tried to encourage the Charles Sturt council, which is on my side of the road, to play a much greater role in putting resources into the suburbs. The other side of the road is the Port Adelaide Enfield council, so we are seeking to engage both those bodies. Often, these suburbs become a bit difficult for councils, and they tend to ignore them. The Housing Trust employs a neighbourhood development officer to work with local residents, tenants and community service agencies in the area of education, community safety, integration and cultural development.

We look forward to the building of the Queen Elizabeth Hospital, which is not very far away, and I have written to the Minister for Health suggesting that that nearby development may present some useful opportunities for jobs in the local community. As it happens, a new construction industry training body may locate in that suburb as well. There might be some good opportunities for us to turn around this area. I

must say it is a suburb that is really under enormous stress. We need to manage the disruptive tenants issues by protecting people who have lived in these suburbs for 40 years, but, at the same time, we need to work on the physical regeneration of these suburbs.

I think a suburb that gets a reputation for being in decline attracts the very worst elements in society, and there is no doubt that the very worst elements in society have preyed on these sets of suburbs. We are in the process of turning around that area, but it is a long hard process.

Mrs REDMOND: Minister, in relation to the disruptive tenancies, I seem to recall reading a statement by you. Have you a policy specifically directed at how you will deal with it? I know that New South Wales has introduced a 'three strikes and you're out' rule. Are we looking at that type of legislation? Do you have a particular policy that can be published to the community so that they understand there will be consequences for disruption?

The Hon. J.W. WEATHERILL: We have promulgated a new policy and it came into operation on 1 June. We have acted on a number of the recommendations in the report of the Statutory Authorities Review Committee on difficult and disruptive tenancies from the Housing Trust. We accepted almost all the recommendations. I think some are still with the Attorney-General for actioning, because they relate to the Residential Tenancies Act and the capacity to evict people who do behave in a disruptive fashion. Certainly, the model about which you speak is the one recommended by the Legislative Council and accepted by the government.

There is a balance here. We want tolerance, but our tolerance does not extend to allowing abusive conduct to continue to make people's lives a misery. We want to ensure that people with mental health difficulties are not scapegoated or evicted when really what they need is support. I think there is an important dovetailing of support services and managing difficult and disruptive tenancies. Many people would argue that a large, significant proportion of the issue of difficult and disruptive tenancies involves inappropriate support for people with mental disabilities.

The CHAIRMAN: We now will move to a consideration of disability services.

Additional Departmental Adviser:

Mr D. Caudrey, Director, Disability Services.

Mr BRINDAL: What are the provisions in this budget—I know there are some; and I think it is a good news story for the government—for those people who are fairly profoundly intellectually disabled? They come out of the system, basically, and there was a program that looked after them. It was inadequate and did not provide enough places. I think I remember the minister in the budget highlighting the fact that they are now providing more places for those categories of people. Will he explain that to the committee? Does he believe this year's funding is adequate to meet the need, or is there a further way to go to meet the need?

The Hon. J.W. WEATHERILL: This question relates to the Moving On program. The Moving On program was established in 1997 to provide intensive ongoing support to young adult school leavers. Of course, when those children are at school they have a place to be during the day. I think something in the order of 482 young adult school leavers with moderate to severe intellectual disability are provided with meaningful day options after leaving school.

Currently, 447 adults benefit from the Moving On program. It is essentially a service for young school leavers with moderate to severe multiple disabilities who cannot gain employment because of their disabilities. It gives them the opportunity to experience a wide range of meaningful activities, but one of the difficulties is that there is a new group of people who come on to the waiting list for that program every year. Last year we put in an additional $750 000 and this year we have increased it to an additional $1.2 million. That will ensure that everybody receives some degree of support, and we have also indexed it for the first time so that that support will not be eroded over time through price increases, but there will still be some people who may have three days' support and may wish to have five days' support.

Certainly, this allows us to provide some measure of support to everyone, and that is why the substantial injection, I think an 18 per cent increase, in the funding has been provided. Once again, it is another of these areas where waiting lists continue to be a substantial issue. There is a way to go to completely wipe out what people would say is their ambition, that is, to have a complete provision of day care for a range of four or five days a week.

Mr BRINDAL: As a supplementary question, you mentioned 447 participants in the Moving On program have entered the program within the last three years. You might need to take this on notice, but how many of those who entered the program in the last three years were in receipt of five day funding and, as a result of your budget increases, how many next year will be in receipt of funding and what is the measure of the funding: five days, four days, three days?

The Hon. J.W. WEATHERILL: I will have to take that on notice because it will depend on how we assess their needs. There will be a measure of people who will receive five days' funding because of their extreme needs, but we will provide you with the precise details of that.

The CHAIRMAN: The member for Heysen wanted to make an opening statement. We had better let her, otherwise it will be a closing statement!

Mrs REDMOND: I want to canvass very briefly an issue that does not appear in the budget in the sense that it is an issue that I think is going to come upon us. I am not trying to ascribe blame or anything like that, but it seems to me from my contacts within my electorate and right round the state now as shadow minister, that we have a looming crisis, almost, of a generational nature created by the fact that, over the last 40 or 50 years, so many families have elected lovingly and well to raise their profoundly disabled children in their homes. That has been fantastic and, no doubt, saved the state a lot of money and a lot of the programs like Moving On have been put in place to support that situation, whereas more than 50 years ago many of those children were institutionalised for their whole lives.

What is happening now is that those parents are becoming elderly, frail and dying, and we have therefore middle aged profoundly disabled people who have lived in a family setting their whole lives, and it would be my submission that they should be given a high degree of priority. I recognise that it has to take the form of looking into the future and trying to plan now for a future crisis. As I said, it seems to me there are so many of these in my electorate that they must be of significant numbers, and I do not know whether there are any studies on foot to indicate just how many people there are in

this situation and what plans are being produced now to address this issue.

It seems to me that it is inappropriate for our society to say that these people who have lived in the family setting for 40 or 50 years, when they no longer have parents who can support them in doing that, should be confronted with the idea of institutionalisation, especially when, according to all the papers in the budget, we are actually moving towards emptying the institutions in favour of supported community accommodation. Where do these people come into the priority list and how are we looking to address this, because it will loom larger and larger over the next few years?

The Hon. J.W. WEATHERILL: I will take the last part of the honourable member's question first. They will get assessed as a very high priority because of the very circumstances raised by the honourable member, and that determines their access to funding. With respect to the other part of the honourable member's question in which she raised the broader demographic issue that is about to confront us, I could do nothing but agree. In fact, it is actually upon us. In less than nine years we have had almost a doubling of the number of people seeking this level of support from us. It has arrived. However, it is probably true to say that it is likely to become a much more significant issue in the future.

We are taking steps. The rate at which we are being asked to provide services is growing faster than even the cost index for the health budget, and most people tend to suggest that that is a major issue for us in terms of the way in which that is accelerating. These are relatively small numbers compared, say, with the health system, but the rates of increase are very steep. I think that the honourable member is right to identify this as an important long-term issue. It is certainly an issue that is coming out of our consultations around the carer's policy, which is presently being worked on.

Mrs REDMOND: Do we have any Ph.D. students, for instance, or someone undertaking studies in this area? At the moment I do not think that we know—and maybe the minister's advisers can tell me differently—how many people are in that circumstance and what the future is likely to hold in terms of numbers and the level of disability.

The Hon. J.W. WEATHERILL: Mr Caudrey has a higher degree, I think. I think that we do know a little about the demographics. In fact, I think that we can project what the future is going to hold for us. We know the rate at which it has been growing in the past, and we are happy to share those figures with the honourable member. Certainly, they are on our books at the moment. We know the demographic about which we are talking and we know the rate. You see, some people also identify themselves prior to their getting to that stage. People anticipate.

They become concerned about what is going to happen to their children, so that at age 50 or 60 they think, 'What am I going to be like at age 70?', and so put their name down with IDSC 10 years beforehand realising that there will be a waiting list. We do have quite a bit of information about that, and the situation is as serious as the honourable member mentions.

Mr BRINDAL: I would like to ask a supplementary question almost opposite to that posed by the shadow minister. My experience is that a number of people at Brighton have an adult child, for instance, who would clearly classify as a person to be taken care of at Minda Home. Those people, unlike some to which the shadow minister was referring, are almost terrified of deinstitutionalisation. They have waited until they might be in their 50s or 60s thinking that the option for them at the end of their life was that their child would become a patient at Minda, and that they would be in institutionalised care which they know, which they understand and which is down the street.

They are as terrified of deinstitutionalisation as some other parents are of institutionalisation. Quite frankly, I am not quite sure that when we were in government we had it right. We were always talking about deinstitutionalisation. I think that there is a place for both, and I am wondering how this government intends to address the need that there are different expectations by different people in the community; and that, maybe, the best solution is about choice and how you reach the compromise or what you are trying to do to reach the compromise because, as I said, I am not sure that we had it right.

The Hon. J.W. WEATHERILL: It is a good point. People's perceptions about what deinstitutionalisation means may not match up with the reality. Certainly, some years ago I detected concern about the appropriateness of deinstitutionalisation and its being seen as a cheaper option and a way of simply saving money and leading people to a lower standard of care. Certainly, that is not the experience. The deinstitutionalisation that has occurred up to this point has been much more expensive.

I think it is generally accepted now that it is a much higher quality of care that people experience. That is not to criticise the institutions, but it is certainly a different quality of experience that one can receive in an institution. I think there has been a bit of a shift in thinking about that, but we have to be very careful to manage people's anxieties around this. It may be that many people had their hopes in putting somebody in an institution and, because they cannot see that institution anymore, they may feel now as though their children are at the mercy of some unclear waiting list. So, I think we have some work to do to persuade people that it is a better option. It is certainly not a cheap option for the government, though.

Mr HANNA: I have a question for the minister about the day options program. The minister would be aware that funding for people with severe disabilities of the ages of 18 and over has not kept pace with the cost of providing options and has not kept pace with the demand for daytime activities for these people. The minister has advised a number of my constituents that an extra $1.2 million has been directed towards this type of service provision by the government; however, my constituents are telling me that it is not good enough for their young people or their adult children to be given less than five days in terms of options services. Is it in fact the case that services will be cut for many people in this situation? Can the government put in sufficient money to maintain a five day a week option for those people with severe disabilities who have finished their schooling?

The Hon. J.W. WEATHERILL: I thank the honourable member for his question. It is a very good question that we dealt with earlier in the session, but I am happy to answer it again, because it is an important issue about which there is quite a lot of public controversy. I can guarantee the honourable member that there will be no service cuts and, in fact, we will index those sums for the first time so that the real value of those packages will be retained. It is true to say that some people will not receive the full five days notwithstanding the fact that we have put an extra $1.2 million into the program, and that is an 18 per cent increase.

Mr HANNA: That means that service is cut, though.

The Hon. J.W. WEATHERILL: No, it is not; because there is a whole stock of people that are in the system at present who may be receiving whatever it is they receive—their five day a week options—those people will have the real value of their options coordination process maintained through the indexation. Up until now the indexation funds have actually been spread over to make more places available for people, so it ended up that the funding was spread more thinly over a larger number of people.

We have sought to maintain the real value of everyone's funding and to provide additional funding for those new people coming into the system, so it is indexation plus $1.2 million for additional packages. That will mean that everybody who comes into the system this year will receive a package, and it will be a question of whether they receive three, four or five-day packages depending on their circumstances. Most people will want five days, and we will not be able to offer five days for everyone because of the nature of the waiting list. We are also conscious of the fact that it is a legitimate ambition to have five days respite. For working parents, many of them have to confront going part-time, and some of them even throw in their jobs to grapple with this issue.

So, we are very aware of that and we are thinking about longer-term ways in which we can manage this galloping growth in the demand for these programs. There is a range of demographic factors that are bearing on this. I think the number of people who are coming into the program each year is somewhere between 75 and 90. We are also perhaps seeing some household formations change so that there are fewer carers who are capable of actually looking after a child who has finished their schooling.

There are a range of demographic measures which are escalating the rate at which this program is growing. I must say that, when the previous government put this program in place, I do think there was a particular plan to grapple with the fact that each year there will be a new group of people coming into the system and you will still have the stock of people who are already in it. All that happens is that they are getting older.

This program commenced in about 1997, I think. So, we still have the first adults or young people who left school just getting seven years older, and there will be new people coming onto the system. That will continue to happen until the end of the life of the first person who came off this program. So, this program will continue to grow. We have had to give some serious thought as to how we are going to manage this quite dramatic growth in this funding program. It is undoubtedly a program that needs to be funded, and we will continue to find ways in which we can increase our commitment.

Mr HANNA: I have a supplementary question. When the minister says that it is a program that needs to be funded, is it not the case that if people warrant the day options program it is warranted for five days a week, generally speaking?

The Hon. J.W. WEATHERILL: It is like any waiting list. You might suggest that people should have their teeth fixed up, but there is a very long waiting list for the federal government dental health program. There is a waiting list for elective surgery. It becomes another one of these social services waiting lists. We have put in an extraordinary amount of extra money ahead of inflation, but we need to provide even an additional amount if we are to extend this scheme further. We think we have provided a modest degree of assistance to everyone, but of course we could provide more service to everyone, and we need to continue to work on that issue.

Mr HANNA: As a further supplementary question, does the minister anticipate that there might be some carers, whether they be single or married, married parents or whatever, who decide that if only three days instead of five days options care is given they are better off virtually presenting their child to the state to say, 'You look after this person full-time, because we actually cannot cope any more.' If that sort of decision does take place, isn't it going to be more expensive for the government in the long term than providing adequate options care for those parents who have severely disabled children living at home?

The Hon. J.W. WEATHERILL: That is certainly a possibility, but that then creates another waiting list issue around accommodation for people with intellectual disabilities, and that becomes an even more expensive proposition. So, there is no doubt that it does raise these dilemmas, and we are looking at strategies in which we can find savings in other areas of our effort. We think that we can better utilise resources than try to expand this program. There no doubt that this is a serious piece of work that we need to grapple with.

Mrs REDMOND: Minister, to get it on the record, I just want quickly to ask a question about disability services. It has been brought to my attention that people with disabilities are having to wait significant amounts of time to get even basic equipment necessary to allow them to function. For instance, I have a situation where the parents of a five and half year old boy who is a client of Novita Children's Services have advised me that their son has grown out of his wheelchair and, despite being on the high priority list for a suitable new wheelchair, he has already been waiting more than 10 months, and he has moved down the list from seventh to fifteenth. Minister, what steps are you taking to address this shortfall in funding, so that families can get the appropriate equipment?

The Hon. J.W. WEATHERILL: I will take that question on notice, because I want to provide you with a detailed answer about how we are going to go about that. Certainly, however, we have been doing some work on some initiatives that will I think assist us in dealing with that issue.

The CHAIRMAN: I know that members would like to be here longer, but I declare closed the examination of the proposed payments.

ADJOURNMENT

At 8.32 p.m. the committee adjourned until Wednesday 23 June at 11 a.m.