HOUSE OF ASSEMBLY

Friday 17 June 2005

ESTIMATES COMMITTEE A

Chairman:
Mr J.J. Snelling

Members:
The Hon. D.C. Brown
Mr P. Caica
Mr T. Koutsantonis
The Hon. W.A. Matthew
Mr E.J. Meier
The Hon. P.L. White

The Committee met at 9.30 a.m.

Department of Health $1 475 210 000
Administered Items for the Department of Health $46 907 000

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

Departmental Advisers:
Mr J. Birch, Chief Executive, Department of Health.
Ms I. Haythorpe, Director, Office of the Chief Executive.
Prof. C. Baggoley, Executive Director, Public Health and Clinical Coordination.
Dr D. Filby, Executive Director, Health System Improvement and Reform.
Dr K. Buckett, Director, Public Health.
Dr T. Stubbs, Executive Director, Health System Management.
Mr C. Lemmer, Chief Executive, SA Ambulance Service.
Mr A. Chia, Director, Finance and Corporate Services, SA Ambulance Service.
Mr B. Dixon, Executive Director, Aboriginal Services.
Mr G. Tattersall, Director, Financial Services.
Mr C. Bernardi, Deputy Director, Financial Services.
Mr D. Swan, Chief Executive, Southern Adelaide Health Service.
Ms J. Richter, Executive Director, Strategic Planning and Policy, Southern Adelaide Health Service.
Mr D. Exton, Acting Director, Asset Services.
Mr J. Brayley, Director, Mental Health.
Ms L. Durrington, Deputy Director, Mental Health.
Assoc. Prof. K. Challinger, Acting Chief Executive, Central Northern Adelaide Health Service.
Ms M. Russell, Acting Manager, Parliamentary and Executive Services.
Ms R. Staugas, Acting Chief Executive, Children, Youth and Women's Health.
Ms R. Ramsey, Executive Director, Country Division.

The CHAIRMAN: The estimates committees are a relatively informal procedure and, as such, there is no need to stand to ask or answer questions. The committee will determine an approximate time for consideration of proposed payments to facilitate the changeover of departmental advisers. The minister and the lead speaker for the opposition have agreed on a timetable for today's proceedings, and I believe we have a copy of that. Changes to committee membership will be notified as they occur. Members should ensure that the chair is provided with a completed request to be discharged form. If the minister undertakes to supply information at a later date, it must be submitted to the committee secretary by no later than Friday 29 July. I propose to allow both the minister and the lead speaker for the opposition to make opening statements of about 10 minutes each.

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

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

I declare the proposed payments open for examination and refer members to appendix C, page 3, in the Budget Statement and Portfolio Statements Volume 2, part 7, pages 1 to 77. I invite the Minister for Health to make an opening statement if she wishes to do so.

The Hon. L. STEVENS: Today is the last health estimates before the next state election, so I believe it is timely, in the process of examining this year's allocations, to briefly review progress in health that the government has made to date over its term. Even before coming to government, we realised that it could not just be business as usual in health. Health needed fundamental repair and a fundamental transformation. Now is not the time to talk about the parlous state in which we found the health system which was left to us by the previous government. I simply want to say that I took my role as minister very seriously then, and I take it seriously now.

The government, once elected, moved quickly to establish a generational health review, which, in our first year, consulted very widely with the South Australian community and with health providers. The generational health review in mid 2003 presented the government with a 20-year blueprint for health, and the government responded immediately. In June 2003, by releasing the health reform agenda called First Steps Forward, we aimed to make a difference in health, and we are doing so. Put simply, the government's reform agenda was based on five key pillars: improving the quality and safety of services; greater opportunities for inclusion and community participation; strengthening and reorienting services towards prevention and primary health care; developing service integration and coordination; and whole of government approaches to advance and improve health status. It was all about putting people first; making services

more locally available and accessible; working with people to prevent illness and promote their own health; listening to and including clinicians and service providers in decision making; ensuring the health system works together as a system; but above all else providing the basis for delivering 21st century health for the people of this state.

There has been significant reform of governance arrangements in the metropolitan area. On 1 July last year, two regions north and south of the city were established in addition to the creation of the new statewide health service for children, youth and women. From that date, 1 July 2004, the new organisations of the Central Northern Adelaide Health Service, the Southern Adelaide Health Service and Children, Youth and Women's Health Service together became responsible for approximately $1.3 billion of capital assets, over $1.5 billion in recurrent annual expenditure, and providing services to the vast majority of South Australians by the hard work of over 13 000 dedicated staff. These organisations are major employers of South Australians, and they are major economic generators.

We are talking here not just about the core of South Australia's health system but also about the bulk of it. That is why the changes we brought about less than a year ago are so profound. These changes will now provide our health services with the opportunity to come together and work far more cooperatively than ever before. We have broken down organisational barriers and got needless bureaucracy out of the way. That is why I am pleased to have the three chief executives of the three new organisations, or their representatives, here today to provide further detail on these major reforms.

In addition to these new organisations, which are significantly improving the way we run and deliver services, I am also pleased to see these three chief executives now sitting on the portfolio executive group of the department. This strengthens the workings of the entire health portfolio and greatly emphasises the fact that we are all working as a system. The more we work as a system the more we are able to provide the best of care. So, rather than needless and wasteful competition between health units, the new way we develop and deliver health services here in South Australia is through cooperation and teamwork, and that is the way it should have been, that is the way it now is, and that is the way it should always be.

In the metropolitan area, and progressively throughout the state, we will see a greater emphasis on better planning, and on better health care delivery. What we are on about is the planning and delivery of care on the basis of people's health needs rather than on the historic activity of any one particular health institution.

In the country, this focus on better planning saw the launch of a new framework called Strategic Directions for Country Health in October 2004. This new framework forms the basis for each country region and their health services to refine, reform and refresh their responses to people's health. We are very serious about the health of people in country areas of the state. That is why, in addition to a better planning and development process, we see in this year's budget an increase of some $46 million in funding for rural health, over and above the 2004-05 budget—that is almost a 15 per cent increase. Part of this country health budget is a significant reform package for improving our capacity to recruit and retain and work with rural doctors.

The $27.2 million doctor reform package for rural areas was developed in very close collaboration with country GPs and their representative organisations, and I would like to pay tribute to the diligence and dedication of everyone involved in that process, including the Rural Doctors Association, the Rural Doctors Workforce Agency, the South Australian Divisions of General Practice and the Australian Medical Association. This has been an excellent illustration of the importance of partnerships and working together to which I referred earlier.

In addition to changes in the health service system, the department itself is undergoing very significant changes as it builds itself towards becoming a better organisation—better designed to build better health. I am sure that Mr Birch would be able to explain the process of reformation that he is leading within his organisation. But the critical starting point of this process was the split of the Department of Human Services into the Department of Health and the Department of Families and Communities. This came into effect on 1 July last year. There were two primary drivers of this, not the least of which was to strengthen financial management and accountability in these portfolios. As revealed by the Treasurer at the time, in December 2003, nothing short of a shambles was inherited by this government, and it took almost two years for departmental officers to get to the bottom of the lack of accountability, inappropriate shifts of funds and, frankly, questionable accounting practices. But the main purpose was to give this government a laser-like focus—

The Hon. W.A. MATTHEW: On a point of order, Mr Chairman, I appreciate that an opening statement by a minister gives a fair bit of latitude, but I ask for your ruling: is it appropriate that an opening statement includes myriad political platitudes which, in many cases, have no resemblance to fact?

The CHAIRMAN: There is no point of order. The Minister is free to make a statement, but she is getting close to 10 minutes.

The Hon. L. STEVENS: The main purpose was to give this government a laser-like focus on two vital areas of reform, that is, health and child protection. In addition to the reform agenda that I have outlined, my department is also playing a significant role in delivering on the South Australian Strategic Plan, and is a major contributor to the State Infrastructure Plan, on which, again, we can provide more information for the committee. There are many initiatives which we have taken over this term and which we have consolidated in this budget, and I trust we will get a chance to highlight some of them today. However, in truth, there are probably too many to do justice to each one today, and I will look forward to the opportunity to highlight them in other forums.

We have a good story to tell about health here in South Australia. I am not saying that everything is right in health, that everything is fixed, or that there is no more to do—far from it. We have much to repair, and much to do to address the years of neglect that we found. And, in any event, health is a constant work. If you stop, if you do not plan ahead, if you do not keep working at it, you will fall behind and, eventually, fail the people you are there to serve.

This budget continues our commitment to sustain the health system as we go about the business of not only repairing but also truly reforming and reshaping the way we serve the health needs of the people of this state. There are many initiatives that I could highlight today. For example, at the very bottom line, expenditure in health for 2005-06 is at a record $2.71 billion. We are spending close to a billion

extra dollars in health since Labor came to government. In this budget we are committing over $200 million in extra funding over the next four years. And it is not just about spending more money: it is about spending it wisely and in the right areas, to bring about reform—to bring about better health and better health care.

In addition to recurrent funding, we have committed $0.5 billion of new money in the last few years to rebuild our state's public hospitals. We are undertaking major rebuilding works at the Queen Elizabeth, the Royal Adelaide and the Women's and Children's Hospitals and the Lyell McEwin Health Service.

We have also launched a major redevelopment of mental health as part of the South Australian mental health reform agenda. The replacement of the state's old and run-down mental health facilities is long overdue, and we are committed to a major program of specialist, purpose-built facilities worth $110 million to achieve that. We also have a $45 million funding boost for mental health services targeted where it is needed most—in the community. The extra funding includes a special $25 million injection, with the majority to be spent over the next two years by non-government agencies and general practitioners to provide extra community support services for people with mental illnesses.

We have also committed $58.1 million over five years to boost hospital activity, and $33.9 million over four years will be used to fund peaks in hospital demands over the winter months. The Royal Flying Doctor Service has been given additional funding to increase primary health care services in the northern region of the state and to continue providing timely, safe and effective retrieval services for country residents.

The Repatriation General Hospital has received $18.7 million over five years to ensure that it continues in its vital role of caring for South Australia's veteran community, and I am on the record (and glad to be so) as saying I will make sure that the Repat is there, and will always be there, to take care of the vets. This funding guarantee is a clear demonstration of the government's commitment to veterans' health.

There is also $22 million over four years to provide for transition care for older South Australians to match the commonwealth's offer for 176 transition care places. Transition care means providing a way for older South Australians to move out of hospital stays into more appropriate care more quickly. This will address what has been called 'bed blockage' by some in the public hospital system due to older patients not being able to be placed quickly into appropriate aged care.

The Hon. W.A. MATTHEW: I rise on a point of order, Mr Chairman.

The CHAIRMAN: I know. Has the minister got much more of her opening statement to go?

The Hon. Dean Brown: You can go for 10 minutes and she has now had 16 minutes.

The CHAIRMAN: Would the opposition just keep quiet for a moment.

The Hon. L. STEVENS: I am not sure what the time has been, sir.

The CHAIRMAN: I think you have been going for more than 10 minutes now.

The Hon. L. STEVENS: I am happy to finish off now. There are many more things to talk about and I will be happy to do so during the day.

The Hon. DEAN BROWN: I will make a very brief opening statement, Mr Chairman. We have had what is, I think, some of the most incredible political rhetoric I have ever heard from any minister in an opening statement. One would have thought we were about a week away from an election campaign. Here is the minister trying to claim what marvellous things she has produced for the health system when we have record waiting lists for elective surgery—the highest this state has ever seen. According to the latest annual report of the department, we have had a reduction in hospital beds here in South Australia compared to when the Rann government was elected, and we also have the lowest per capita funding on mental health of any state in Australia, according to the Mental Health Coalition.

So, let us look at what is actually occurring within our hospitals and with care for patients. The minister spent some time talking about new boards and the generational health review, about new organisations and a new structure. It is all about new bureaucracy. We have 24 advisers here—even though the department has been split in more than half, we have the largest number of advisers that I can ever recall here supporting the minister—and the very point I have been making is that the money is going into paying for bureaucracy rather than treating patients. Sure, there has been additional money, but the patients are not getting it. That is why we have record waiting lists for surgery and why we have these incredible delays such as a 75 year old having to wait for 19 hours on a hospital trolley in an emergency department. That is why we have a collapse of the mental health system here in South Australia.

I rest my opening remarks on that because, in fact, the minister's own statement highlighted the extent to which the money is going to bureaucracy rather than into treating patients. Do you realise, Mr Chairman, that the proportional increase in administrators in the health system has been three times greater than the increase in nursing numbers within the hospitals, according to the Auditor-General's figures? So, the money is going into bureaucracy, not into nurses and doctors who will be treating the extra patients.

I would like to ask the first of my questions, and it relates to the issue of mental health. Minister, do you accept that it is inappropriate treatment for a woman with a serious mental illness to be detained in a cubicle in the emergency department of the Queen Elizabeth Hospital for five days without a shower or change of clothes and with only a hand basin, with no personal privacy at all? In discussing this case with the family over the past couple of days, they pointed out that the condition of the young woman deteriorated significantly during her stay in hospital because of the circumstances under which she was held. This reflects a critical shortage of mental health beds and a critical breakdown and crisis in the mental health system. So I ask my question. Does the minister think that is appropriate treatment for a young woman with a mental illness?

The Hon. L. STEVENS: First, let me say that I will certainly look into this matter. I am very surprised that the Deputy Leader did not phone me or my office a couple of days ago when he heard about this so that I could immediately look into the issue. Unfortunately, he has not done that, but I am very happy—

The Hon. Dean Brown: That is because the family took her out of the hospital—

The CHAIRMAN: Order! The minister has the call.

The Hon. L. STEVENS: I would prefer to know about these things immediately so that I can deal with them rather

than come in here and do it like this; and, as members in this place would know, I have said that numerous times over the years. However, that being said, I would be very happy to look at that issue. I would like the details. Certainly, I will look into it. On the face of it, it is concerning. I must say that I have learned in the past that, sometimes, what the deputy leader asserts at first glance is not necessarily borne out.

However, I am very concerned to hear this allegation. I would like the details, and I will have it investigated immediately. I turn now to mental health. I must say that I am amazed that the deputy leader is able, in a bare-faced way, to criticise this government in terms of its efforts in mental health. The government has made no secret of the fact that it has a long way to go in addressing mental health services in this state. We have never made any secret of that fact. The previous minister's own report (undertaken by Peter Brennan in, I think, the year 2000) made it quite clear that South Australia, over the decade of the 1990s, went from the leading state to the last state in the nation in terms of its efforts in mental health.

Who was the person who presided over the mental health system for the vast majority of those years? It was the deputy leader, either as a former premier initially and then, of course, as the health minister. When we came to government we knew that we had a very big task with respect to mental health. On taking office, this government immediately increased recurrent funds in mental health. In fact, when the next year starts and when the new recently announced money comes into the system for expenditure, we will have already increased recurrent funding by $20 million per annum. We will have already put in place a capital works program worth $80 million.

Since this state budget, we have now boosted services to the tune of a $45 million funding package, and our forward capital works project for mental health facilities is now $110 million. I have said many times that we have a lot of work to do. Unfortunately, I wish I did have the ability to be able instantly to repair the damage of 10 years of decline that occurred previously; but, unfortunately, the reality is that we cannot wave a magic wand. However, we have put in more money—particularly in this budget—than has been put into mental health services in this state before.

We will get on to spending that money in building the acute facilities, building up services in the community through non-government organisations and through the general practitioners who are very keen to work with us in this area. We will get on to that task as soon as we can. As an example, I think, of the amnesia of the deputy leader, I want to bring some information to the attention of this committee. I would like to talk about mental health capital spend. I got my department to do some work on the years between 1993-94 and 2001-02, because the deputy leader is very fond of criticising, but he does not want to look at his own record.

The advice of my department is that, over this nine-year period, the overall expenditure was $26 million in capital works in mental health—nine years it took to spend $26 million in capital works. Now the opposition wonders why we have a big job to do. We are onto that job. The Margaret Tobin Centre is proceeding now; the repat capital works is proceeding now; the next stage of the Lyell McEwin Health Service facilities, including a 65-bed mental health unit and the planning for that is being done now, as is the planning for other mental health capital works. We are onto that.

In terms of the recurrent funding, the $25 million boost into community services, plus the $5 million recurrent money into a range of services is all proceeding.

The Hon. DEAN BROWN: I do remind the minister—

Members interjecting:

The CHAIRMAN: Order! The banter between the member for Bright and members on my right is interrupting the deputy leader. The deputy leader.

The Hon. DEAN BROWN: I do highlight to the minister and remind the committee that it was the minister, just a couple of months ago, who said that the health system in South Australia was 'stuffed'. About a month later it was the health minister who said that she wanted to transfer public hospitals across to the federal government. If ever there was a case of wanting to run up the white flag and not tackle the problems within the health system, those two statements alone gave a very clear indication to all South Australians where this government stands.

I return to the issue of mental health, and I will give the minister another example. Incidentally, the minister raised the matter of the family involved. I point out that the family has now taken that young woman out of the public system and put her in the care of a private psychiatrist. The family is now very satisfied with the treatment that she is getting in a private mental health hospital (the Adelaide Clinic), as well as the treatment she got from the private psychiatrist. Also, I highlight that, on numerous occasions, I have referred cases to the minister and I have had no response whatsoever to those cases. One of those recent cases involved a young lad with a mental health problem who stabbed a policeman in the arm with a stake.

An honourable member interjecting:

The Hon. DEAN BROWN: I am highlighting the fact that I have had no response from the minister in relation to that case, either. I want to refer to another problem. I have been dealing with family—

An honourable member interjecting:

The Hon. DEAN BROWN: It is under the mental health budget. I will refer to the sister-in-law as Stella, because she is the one who has been dealing with me for several weeks about this issue. Since the beginning of May, Stella has had to call both an ambulance and the police on five separate occasions because her sister-in-law has a serious mental problem. Stella has been trying to get suitable treatment for her sister-in-law in a public acute hospital and from community health support. On the first occasion, on the advice of a doctor, her sister-in-law was taken to the Royal Adelaide Hospital. She was held there for about 24 to 36 hours, and she was then discharged. She was told that she could not stay in the hospital because no mental health beds were available. A short time later, another serious incident occurred, and her doctor referred her to Glenside with an order, but she was turned away again because of a shortage of beds.

On a third occasion (this all occurred in May), an ambulance and the police were again called, and this time she was taken to Flinders Medical Centre, with a certification from a private psychiatrist. I have spoken to that psychiatrist on several occasions. She was held for about two days and then discharged. Two days later, she made a very serious attempt to commit suicide. Stella has described how she had to haul her sister-in-law back over the balcony of a two-storey home. As a result of that incident, she was again taken by the police and an ambulance to the Flinders Medical Centre, and this time she was held for a longer period. Stella pointed out that

her sister-in-law went for over a week without a shower and a change of clothes whilst she was in the hospital. She was finally discharged last Friday, having been again told that there was a shortage of beds. However, she was promised that Community Mental Health and ASIS would call and give her ongoing support at their home.

Yesterday afternoon, Stella again telephoned me to say that her sister-in-law had again attempted to commit suicide, and she had to again call an ambulance and the police. Her sister-in-law was rushed to the Royal Adelaide Hospital, where she was held overnight. Stella made the point that this is having a catastrophic effect on her sister-in-law and on her family—her husband, children and mother. Clearly, there is a shortage of mental health beds, and I have raised that matter previously. It was the case in relation to Matthew. It was also the case in relation to another person at Noarlunga, about which I have written to the minister, but I have not had a reply.

I could name numerous major hospitals in Adelaide where patients cannot get access to mental health beds. In this case, an enormous amount of money is being spent on ambulance services and police, but no effective treatment has been provided. On numerous occasions, Stella has been told that community health support will be given to her and to her sister-in-law, but it has never arrived. Even when Stella has telephoned ASIS, they have said that they cannot come, and that has occurred on several occasions. I think that is an appalling situation. Here is a middle-aged woman who continues to want to take her own life. As Stella has pointed out, she has threatened to go out on the road and commit suicide by causing a major accident. Clearly, if that occurred, that would endanger the lives of other people, and Stella is concerned about that.

This is another tragic and ongoing case where the family cannot get help. They have been to the minister's office, but they have been unable to get help. So, they have come to me and asked, 'For goodness sake, what can be done?' I ask the minister whether that is acceptable treatment of mental health patients.

The Hon. L. STEVENS: There are a number of things to which I would like to refer, because the deputy leader made some other comments before he asked his question. First of all, in relation to the point about federal-state interfaces in health, I take it that the deputy leader does not believe there is a problem with the number of GPs we have in South Australia and, in fact, in other states as well. I take it that the deputy leader does not believe there is a problem, when about 100 people are occupying public hospital beds when they should be in aged care facilities. However, because those aged care facilities are not available through commonwealth government arrangements, these people are parked in our public hospitals and therefore take up spaces—

An honourable member interjecting:

The Hon. L. STEVENS: About 100 people at any one time occupy state public hospital beds when they should be somewhere else, that is, being cared for in an aged care facility. That is what I was talking about in terms of the issues between federal and state governments. I am not sure that I would say the deputy leader has a real understanding of health, but he would have to be the only person who does not want to accept that there is a problem and that we should talk about it and indeed do something about it. Clearly, when he was minister he had no interest in doing something about it, but I certainly have.

I am very pleased that a week or so ago these issues were at last put on the COAG agenda for discussion. I will be talking to Tony Abbott shortly, and I hope he will accept our invitation to work together to make a difference. I know that for most of his time as minister the deputy leader made an art form of blaming everyone else. Let us stop placing blame, and let us try to fix the situation.

The Hon. W.A. Matthew: You hypocrite!

The CHAIRMAN: Order! The member for Bright well knows that the use of the word 'hypocrite' is grossly unparliamentary.

The Hon. L. STEVENS: Thank you, sir. Perhaps he should take a Bex and lie down.

The CHAIRMAN: I direct him to immediately withdraw and apologise.

The Hon. W.A. MATTHEW: I humbly apologise and withdraw, sir.

The Hon. L. STEVENS: I am sure there is a Bex if he needs one to calm down.

Mr Meier interjecting:

The Hon. L. STEVENS: I don't need them.

Mr Meier: You are in charge of the health system. You should know what is available and what is not available.

The Hon. L. STEVENS: Not really—I am not a doctor.

The CHAIRMAN: Order!

The Hon. L. STEVENS: In relation to the mental health patient mentioned earlier, the deputy leader said that the person had been moved to a private hospital for care. It is always important to learn from issues, and I should not have thought that would be an obstruction to his picking up the phone and telling me about it. As to the other issue he raised, in terms of mental health services in South Australia (and I will ask Learne Durrington to add some detail to my comments), when we came to government we were faced with a real problem in that acute care was South Australia's only response to people with a mental illness. Of course, the deputy leader was faced with this issue, too, but failed to act.

The huge gap in South Australia has been the lack of community-based services. People with a mental illness are no different from those with other illnesses, in that there needs to be a whole range of service responses. For example, if you have a bad cough, cold or the flu, you should not have to be admitted to a hospital. You should be able to go to your general practitioner, receive services early, be supported and never have to use the acute hospital system. Unfortunately, we have not had the whole area of services in mental health to fill in the gap between a person who is okay and one who should go to hospital. This problem occurs not just in South Australia, but we have been a supreme example because, in the past, we have been tardy in dealing with it. People have been left to their own devices, when they should have received care early on.

That is what the national mental health reform process and strategy were all about, and it is what the states all signed up to in the early 1990s. It is where we fell so far behind in South Australia throughout the nineties, and we are now faced with redressing the issue. It is what some of the $20 million recurrent we had already put in prior to this budget was about—increasing those services. Putting in those services early is certainly what the $45 million boost is largely about—for GPs and non-government organisations to provide support services so that, hopefully, people do not get to the point of having to go to hospital or, if they have been in hospital for some time, when they come out they are given the proper rehabilitation and ongoing support they need

to keep them well, so that we have a system that moves people through and generally keeps them well, rather than relying on the crisis model, which has been the situation in South Australia for so long.

Unfortunately, we cannot just wave a magic wand to fix it up and make it all happen within a year or two. It will take some time to redress, but the government is onto it. No government in South Australia's history has put the amount of money we are now putting into mental health services. I will ask Learne Durrington to talk about the new money, which addresses community-based services and better crisis intervention services and allows for more 'hospital in the home' mental health beds to be brought online. So, we are attacking the issue in all three areas. Jim or Learne will give the committee some more information.

Mr BIRCH: I will introduce Learne Durrington, who is the Deputy Director of the Mental Health Unit and was recently appointed the Executive Director of Central Northern Adelaide Health Services in the mental health services area. Dr John Brayley, the Director of the Mental Health Unit, would have been here today, but his wife had a baby last night.

Ms DURRINGTON: In relation to the $5 million for crisis services to which the minister referred, those funds will be made available for three strategies, and one is to increase our ACIS emergency crisis response and access to the 'hospital in the home program' across metropolitan Adelaide. This program is designed for those people who need an acute service but do not necessarily have to receive it in hospital and who may, clinically, achieve better outcomes by doing so at home. It also provides for post-acute follow-up. It provides an assertive follow-up service for those who have been in hospital and are discharged.

Two or three streams of the funds are being made available to the community sector, the first of which aims to build shared care with the general practitioners in our system. It improves consultant liaison services and particularly targets perinatal and infants (mothers and babies), and aims to build better service responses for that group. It increases funding to Beyond Blue to work with GPs to expand their capacity to work with patients who may have anxiety and depression, and it also expands our community awareness and literacy programs. It provides for shared care and joint case management with 3 GPs and, in particular, provides allied mental health workers into GPs. What that means is social workers, occupational therapists and psychologists in GP services to assist them with the non-clinical components of care.

Related to that is the expansion to southern Adelaide of the GP access program that currently operates in the west, which is a program that assists consumers to access their GP and follow up their medication programs. That is complemented by a series of community-based services, which includes community care packages for individuals to assist them to remain at home safely; respite services for both carers and individuals (as you know, carers often need respite in caring for a family member); rehabilitation programs to enable consumers of mental health services to work with their peers to re-establish their lifestyle; and programs for both supporting carers and training carers as well as consumers in managing their illness. That is a very short summary of how the $25 million will be expended, but it largely funds a range of non-government agencies, including the divisions of GPs.

The Hon. DEAN BROWN: This question is in relation to Wudinna Hospital. As a brief outline to the committee, we know that nationally a lot of publicity has been given to serious mistakes being made in public hospitals. Last year, the case of Wudinna was raised and very serious allegations were made. The local board appointed a clinical review, which sat about seven or eight months ago and had evidence presented. The minister has stated in answer to this house that she has not seen, read or had that clinical review.

If that is the case, I believe I should read to the minister some excerpts of the evidence given by Dr Peter du Toit, the local GP and doctor at Wudinna Hospital at the time these serious allegations were made. I bring them to the attention of the minister because I believe they are very serious issues that need to be dealt with. I stress I have pages and pages of issues, but I will give only a brief summary of some of those issues. This was evidence given by Dr du Toit to the clinical review, which the minister has said she has not read and does not wish to read.

The Hon. L. Stevens interjecting:

The Hon. DEAN BROWN: She did. I asked her the question and she said no, she was not going to read it, she did not have it, it was up to the local board. These excerpts are as follows:

> Medication errors. An elderly patient sought assistance at the surgery when advised by the community nurse that she was taking a duplication of medications. The patient had been discharged from Wudinna Hospital three days earlier. Medications were supplied and instructions were given by nursing staff on their use. I discovered that three of the medications were incorrect. When I tried to sort out the problem, the Director of Nursing (DON) and the CNC refused to allow me access to the notes and demanded that I sign a freedom of information form to read the patient's notes within the hospital. The DON eventually carried the patient's notes from the hospital to the surgery on the same grounds and stood beside me whilst I resolved the problem with the patient.
>
> Medication errors. On one Saturday afternoon I found seven drug errors from one shift. Drugs were not given, wrong doses were given, and drugs were signed and not given and signed retrospectively.

Another is from August last year:

> Hypothermia. Patient was a respite patient in the Wudinna Hospital. She was found semi-conscious in her room some days after admission. Her temperature was 29°. I was called for urgent resuscitation of the patient and flew her out to Adelaide that night. I complained in writing to the Director of Nursing. She replied that the patient had received the highest standard of nursing care. No nursing care had been recorded in her medical record. The same patient had a similar episode of hypothermia in the Wudinna Hospital a few days before I resigned. I was astounded that they had learned nothing.

The third case refers to a cardiac incident, and reads as follows:

> A patient was admitted to the Wudinna Hospital on 26 October 2004 with an acute subendocardial MI (heart attack). I was again professionally alarmed by the lack of basic knowledge of the DON and CNC in caring for this patient. For example, raised blood pressure not reported, chest pain not treated, no nitrolingual (emergency medication) available for patient, no routine cardiac observations, RN did not recognise PVC (abnormal cardiac rhythm), DON did not know the difference between GTN and Strep (emergency cardiac drugs), Enrolled Nurses specialled the patient with a GTN infusion. A registered nurse would be expected to provide this care in any facility.
>
> The DON and CNC went home. No cardiac protocols were available despite my request to the CNC more than a year ago. I remain uninformed as to the formal process that has been undertaken to rectify these problems.

He cites another case in December of 2003, I think it would be, and states:

> During the month of December, many essential medications were unavailable in the hospital. These included normal saline, antibiotics, sleeping tablets and many others. The staff complained that the CNC was not maintaining supplies. In-patient medications were inconsistently provided. My staff continually supplied the hospital with drugs

[that is from his private clinic] and I had to open the surgery pharmacy after hours to obtain medications for use in the hospital for in-patients. Drugs were expired in casualty. Sutures in casualty were two to three years out of date. A patient was left for three days for an X-ray which I considered may have been a fractured hip. The CNC considered the X-ray non-urgent.

Yet another excerpt is as follows:

Autologous blood—the CNC took the label, which I had completed and attached myself, of a bag of autologous blood and returned the blood to the laboratory. The IMVS director wanted an explanation for my incompetence when he phoned to inform me the next day that the blood had been destroyed. I had signed the accompanying paperwork on completion of the procedure. The CNC blames the IMVS staff for advising her to send the blood with no label. A year later I awaited the management evidence that the incident was appropriately addressed. I would at least have expected an apology to the staff member accused at the IMVS, myself and, most importantly, the patient.

I stress that these are just some of the incidents that have occurred at the Wudinna Hospital. The member for Flinders and I have asked questions about these issues, particularly about the release of the report of the clinical review, which was done seven or eight months ago. There are also serious allegations that senior hospital staff have used the doctor's personal credit card number to order drugs for the hospital on two occasions—that issue has not yet been resolved—and there is the alleged fraudulent signing of a resignation form on behalf of one of the nurses who did not even know that she was about to resign. In other words, someone fraudulently used that nurse's signature.

Despite these serious allegations of clinical mistakes and incompetence, the minister has not read the report of the clinical review and has left it up to the board about whom many of the complaints have been made. This is similar to the dismissal of the complaints made about the Bundaberg Base Hospital in Queensland. I will not go into that further, but we all know what has been revealed about that hospital.

I point out that the doctor was very distressed and he asked for this clinical review. He says in a letter to me that the clinical review team was made up of two people who came into the area: a director of nursing from another hospital and a country GP. He said that when the review team last saw him they had to leave to catch a plane. He said that he asked the CEO in writing two days prior to the review for five hours but that he only got 1½ hours and that they had barely reached the clinical issues that the matter was all about.

If you are going to order a clinical review, I would have thought that the first thing to do would be to hear all the complaints and make sure that they were appropriately laid out so that they could be dealt with. Dr Peter du Toit is very upset. These legitimate issues must be tackled. We cannot repeat the turning of a blind eye to what is going on in our hospitals as occurred at Bristol and the Bundaberg Base Hospital. These matters must be dealt with, and they must be dealt with at the highest level by the minister.

We know what happened in the Queensland parliament, how the minister decried the member who raised these serious issues. The same sort of attitude has prevailed in our parliament. I have heard abuse being thrown at the member for Flinders over her attempt to make sure that these issues were properly investigated. I raise them now because they are very serious issues indeed. It would appear that even the doctor who is laying the complaints in some detail is not being given the chance to voice his concerns about the clinical problems that are occurring within the hospital.

I think the minister can see from the issues I have raised that these are serious issues that could be life-threatening for patients in hospitals. My question is: when will the minister read the report of the clinical review and when will it be made public; what action has been taken (seven or eight months after the clinical review) to correct the mistakes made at the hospital; and will she give us some assurance—as the local people of Wudinna have requested—that appropriate action will be taken?

The Hon. L. STEVENS: That is a very long but very important question.

Members interjecting:

The CHAIRMAN: Order!

The Hon. W.A. Matthew interjecting:

The CHAIRMAN: Order! The minister has the call.

The Hon. L. STEVENS: I thought you would be keen to hear the answer.

The Hon. W.A. Matthew interjecting:

The CHAIRMAN: Order!

The Hon. L. STEVENS: I am surprised at the member for Bright. I thought he would be interested in hearing an answer rather than playing around like a schoolboy.

Members interjecting:

The CHAIRMAN: Order! Members of the opposition are eating up their own time.

Members interjecting:

The CHAIRMAN: Order! I am happy to sit here all day while this banter goes on between both sides. The minister.

The Hon. L. STEVENS: Thank you, sir. Quality and safety in health care is probably one of the most significant issues that we face, and this government takes these issues very seriously. I think the government has already demonstrated in other instances that it is not turning a blind eye to these issues as perhaps some others have done. A case in point is the Mount Gambier Hospital. I established a review at the Mount Gambier Hospital in terms of quality and safety involving issues that have been occurring over a number of years, and those issues have been addressed.

In relation to the matter of Wudinna, in answering the question I will talk briefly about the Wudinna process and the stage it has reached and some wrong assertions that were made by the deputy leader. I will ask Ms Roxanne Ramsey to provide further detail on the specifics of Wudinna, and then I will invite Professor Chris Baggoley, the chief medical officer in the Department of Health, to respond in general on quality and safety issues, some of which the deputy leader mentioned as specifics in relation to Wudinna but which also have ramifications in terms of general quality and safety systems across any health care system, ours being no different from anywhere else. We have a lot of good things to say here, and a lot of effort is being made to keep ahead of the game.

In relation to Wudinna Hospital, I want to correct straightaway an outrageous comment made by the deputy leader that 'the minister did not wish to read the report from Wudinna'. That is absolutely wrong. Of course the minister will read the report when it is finished. In relation to the Wudinna Hospital, the allegations were made by a range of people. The board of the Midwest Health Service, of which Wudinna Hospital is a part, requested a clinical review of the hospital in regard to the allegations which were raised and which centred around difficulties between the nursing staff and the then general medical practitioner. The review was established. It was an independent review, and two people were engaged by the board to undertake the review. Dr David Rosenthal is not just a GP from the country, as the deputy leader said, but is part of the rural clinical school of Flinders

University. I recall seeing in the media statements of confidence in Dr David Rosenthal that were made by the deputy leader. So, I am a little surprised that—

The Hon. Dean Brown interjecting:

The Hon. L. STEVENS: From memory (and I will check), around the time that the—

The Hon. Dean Brown interjecting:

The Hon. L. STEVENS: Exactly. That is what I am saying. The deputy leader has just said that he has the highest regard for Dr David Rosenthal—

The Hon. Dean Brown interjecting:

The Hon. L. STEVENS: It is difficult when the deputy leader keeps interrupting me.

The CHAIRMAN: We will hear the answer to the question in silence.

The Hon. L. STEVENS: Dr David Rosenthal is one of the reviewers, and the deputy leader is just reiterating (which is what I was referring to in the media) that he has the highest regard for him. Dr Rosenthal is well regarded, and he is one of the reviewers. The Director of Nursing, Genevieve Hebert, is the other person undertaking the review. The work has been done but is not completed; it is in progress. I will hand over to Roxanne Ramsey to provide the detail of the stage that has been reached.

Ms RAMSEY: The review has been extensive and has raised many issues. Everyone has a different perspective on the issues that have been raised, so it has been necessary to work through all of them. Certainly, the material provided by Dr Du Toit has been considered by the review team. However, the board is very keen to do move on and make sure that the issues that have been raised are appropriately addressed. As recommendations are being made, the board is acting on them and making sure that, where there are any procedures that need to be rectified or new procedures put in place, they are immediately put in place.

The board has taken very seriously the allegations and all the material that has been put before it. The department has been working closely with the board to make sure that it is receiving the best advice and that it is working through the issues. However, the report is not yet completed, and until it is completed the board does not wish to provide it in any sense apart from addressing the issues as they arise. A lot of feathery topics have come into this and we need to make sure that the statements that are being made are correct. A number of the statements that have been made have been quite unfounded when they have been investigated. The small group that has been delegated by the board to look at the recommendations is meeting again on 22 June. Its members are hopeful that they will be able to finalise the report then, but they are not able to make that a definite date until they look at what they have before them.

The Hon. DEAN BROWN: I have a supplementary question—

The Hon. L. STEVENS: Before the deputy leader asks his supplementary question, I want to reiterate that, when the final report is received by the board, that report will be made available to me and to the department, and then we will be doing some more work as well in terms of those recommendations. I want to reiterate that we take this matter very seriously indeed, and it is really important that we work through those processes in a methodical and comprehensive way. I will ask Jim Birch to make a couple of comments.

Mr BIRCH: Following on from what the minister has said, when we receive a report on any issue of quality and safety or, indeed, a Coroner's report in the event of an unfortunate death, the department examines the report very thoroughly and looks not only at whether the remedies that have been suggested have occurred within the health care agency but also whether there are any other lessons that ought to be extrapolated across our entire health care system.

I would like to introduce Professor Chris Baggoley, who has just been appointed to the position of Executive Director of Clinical Coordination. In introducing him, I think that it is important for members to know that Chris has had a long involvement in quality and safety in Australia. He is currently a member of the Australian Quality and Safety Council, he is Chair of the National Institute of Clinical Studies, he is formerly the Director of Emergency Medicine at the Royal Adelaide Hospital and, also, previous to that, at Flinders Medical Centre and at Ashford Hospital as part of the ACHA group. As one of the main portfolios in his new role, Chris will overlook quality and safety.

Prof. BAGGOLEY: Sir, it is serendipitous that the question on safety and quality arises at this time because South Australia has just made its report to the Australian Council for Safety and Quality in Health Care. The review process of that council is nearing competition, so there is a strong focus on this nationally. I also emphasise that questions of mistakes in public hospitals should not be confined just to the public area. In fact, the emphasis is on the issue of safety and quality in both the public and private arena. I would like to talk about the patient safety framework and what that has achieved to date, and also how we are looking at training programs for 2005 and 2006. The department has developed and implemented a patient safety framework, and the framework has been published and is available on the web site. It deals with issues around sentinel events and reporting. It deals with adverse events and how to deal with them, with intentional unsafe acts, with incident monitoring and reporting, with root cause analysis training, with quality performance indicators, and with consumer participation, as well as patient evaluation. So, the framework is really quite comprehensive.

Part of the incident reporting framework is the advanced incident monitoring system, and that system has been rolled out to all country areas, which is important in the context of this question. All regions have had training and education in this form of incident reporting system and, in fact, all country areas, in contrast to the city areas, can do this now electronically.

The programs that have been developed by clinical systems, by the department in conjunction with clinicians all around the state, include a range of programs to reduce patient harm, and that has been a primary objective. Included amongst the major projects is the issue of improving medication safety and quality—something that was raised by the deputy opposition leader. There is a national focus on medication safety because it is a problem all around the country, and recognised internationally as a major issue to address if patient harm can be reduced. So, areas that we are focusing on include: the development of consensus guidelines introduced about the prevention of venous thrombosis and the use of anticoagulants; the use of drugs cleared by kidneys; and, in conjunction with the OACIS system that has been introduced by this government, developing a pharmacy order management which will, in time, provide a decision support function.

Also, in initiatives to reduce patient harm, there is a strong program around the reduction of the risk of injury of hip fractures from falls. Falls and medication areas form two of

the major issues for safety, again right across the country. So there is a vitamin D falls and hip fractures working group, as well as harm minimisation project funding that has gone to Osteoporosis Australia (SA Branch). Another key program that is being undertaken at the moment is around the prevention of pressure ulcers. Pressure ulcers can cost $586 per month to care for, so programs about reducing the incidences of pressure ulcers are clearly important. There is a whole range of activities also being undertaken, including a major clinical practice improvement program, and 108 senior clinicians completed such training in 2004-05. This program involves a five-day residential course, development of a project, regular reviews of a project, and it takes place over six to eight months, adding to the improvement of clinical care in South Australia. We are also improving the efficiency, appropriateness, and the safety and administration of blood and blood products—the so-called Bloodsafe program—and I could expand on that at another time.

The plans for 2005 and 2006 are to have 340 people undertake training in root cause analysis or patient safety training, and there will be a country course in Port Augusta, which 60 people will undertake, and there will be 340 all up.

The Hon. DEAN BROWN: On a point of order, Mr Chairman: this answer has now been going for more than 15 minutes. I appreciate this information, and it is useful, but I ask if it can be tabled, because it is very important. My question was about what is happening with the clinical review at Wudinna, not a general statement about hospital safety. It is a very important issue, indeed, and I am pleased to have access to the information, but I do not think that it is appropriate to go off away from the original question that was raised.

The CHAIRMAN: There is no facility during estimates to table documents.

The Hon. DEAN BROWN: The minister can make it available by other means.

The CHAIRMAN: Order! The minister can make it available but there is no facility to table. I point out to the member for Finniss that his question went for a good 15 or 20 minutes, so he can hardly complain when the minister is providing a substantial answer. Minister, was there anything to add?

The Hon. L. STEVENS: Yes, I just want to make a point, sir. The deputy leader has said that this is about Wudinna, and we have given some information about that review at Wudinna, but the deputy leader, in asking his question, made reference to the Bristol incident, he made reference to the Queensland issue, and these issues are enormous quality and safety issues across health systems that have had very big ramifications in terms of quality and safety, and quality and safety in terms of a systems approach.

If the Deputy Leader wants to bring in these very significant matters, we will answer those questions with the seriousness they deserve. In fact, these issues—what has happened in Queensland, in Bristol, and the King Edward Memorial issue in Western Australia—have major ramifications, and South Australia responded, and continues to respond, by doing everything we can to ensure that our systems are set up in the best possible way in terms improving quality and safety in hospitals and health care. I will now ask Professor Baggoley to continue his remarks.

Prof. BAGGOLEY: Training for 2005-06 will include a new program around health care failure mode effect analysis, which is a sophisticated program that we hope 50 people will undertake. We will continue our continuous practice improvement program and patient safety training, and quality and clinical risk managers will be utilised for about 100 people. Importantly—and particularly in relation to the question—there will be a medication forum which 80 to 100 people are expected to attend. There will be four quality and safety workshops in 2005 and 2006, and each of these attracts 80 people. I also point out that in the rural package it is proposed to recruit five country doctors (including one involved in safety and quality) to a chief consultants group, and I think that, too, will help with the emphasis on safety and quality in country areas.

Finally, in my role as chief medical officer for the Department of Health, I will certainly be auditing our own safety and quality efforts. There are many fine things that can be done, but it is always important to undertake audits in any process, and I will be looking for ways to make it even better.

The Hon. L. STEVENS: I would like to make one final point before handing back to the deputy leader, who has tried to suggest that I have not been interested in reading this report and that I should have known about the details of it now. I think what is really important is that the consultants be given the opportunity, without any interference from a minister, to do their job and to do it as conscientiously, as thoroughly and as comprehensively as they can. When that job is done we will certainly receive that report, and both the board and the department will consider it and take whatever action is appropriate.

The Hon. DEAN BROWN: I have a supplementary question. I would like to point out that it is more than 18 months since Dr du Toit first raised these issues, and even the clinical review was only achieved when I took Dr du Toit to both the Ombudsman and the Commissioner of Equal Opportunity on one occasion. We spent about two hours in their office, and it was the Ombudsman who immediately put a stay on the hospital board. These matters had been raised with the hospital board nine months earlier but no action had been taken. In fact, several of the allegations I have outlined actually involved the hospital board, so I ask: what action is going to be taken?

I understand that it is a clinical review process—and let me say that I know personally both the doctor and the director of nursing involved, and I have the highest regard for them—but I point out that Dr du Toit himself said that his time had been cut critically short and that he was the last one to give evidence, yet he was the one who raised these matters and the seriousness of the issues. He could not get action from the board over about a nine-month period; we went to the Ombudsman, who finally ordered action to be taken.

I have concerns, though. The board is driving the process, but I would like to know what is being done to investigate the issue of the alleged fraudulent signing of a resignation form and what is being done to deal with the misuse of the doctor's private credit cards to order supplies for the hospital. The doctor has not been satisfied on those matters at all, even though he was directly involved on both those occasions, and, to my knowledge, those matters are not being resolved by the clinical review. The board is absolutely inappropriate to handle those matters, so I ask: what action has been taken to deal with those other serious matters as well?

It is fine to have all the systems in place—and I am delighted, Chris, to hear what you are doing because it is very important indeed—but Australian hospitals must learn from mistakes that have been made in the past. There cannot be a clearer message, and I am delighted that it appears to be so thorough. However, here is a case where allegations were

raised 18 months ago and the doctor could not get action. It was only when I went off to the Ombudsman with the doctor that we got some action—and that is exactly the same sort of problem that has arisen at the Bundaberg Base Hospital; and it is exactly the same situation that arose at the Bristol Hospital as well. You must have a system so that when these issues occur they are reported directly to the highest authority and action is taken outside the circumstances so that you are not protecting people, boards or individuals in terms of mistakes that may have been made—and I think that is clearly the evidence that has come out of Wudinna.

The Hon. L. STEVENS: I would like to make some quick points. First, I think the deputy leader indicated that he had the highest confidence in the people who are conducting the review, and I am pleased to hear that he has that confidence. I say, 'Let them do their work.' Secondly, the State Ombudsman has indicated that he is satisfied with the process that is being undertaken. I think it is really important that those people are allowed to get on with their work. When that is finished—and we hope that will be in the not too distant future; I understand that they are endeavouring to do this as quickly as possible—we will have that report. If the deputy leader suggests that Dr du Toit does not think he had enough say, I am sure that we can allow the reviewers to see the *Hansard* of today's proceedings and they may remedy that with Dr du Toit.

The Hon. Dean Brown: He has written to them and he has not had an answer.

The Hon. L. STEVENS: You know—

The Hon. Dean Brown: He has written to them and has not had an answer.

The CHAIRMAN: Order!

The Hon. L. STEVENS: Deputy leader, we have set up a review process that has been sanctioned by the Ombudsman. You said that you have confidence in the two reviewers to do the job. We are providing them with support to proceed with such a review in terms of natural justice and dealing with those matters. We will endeavour to get them the *Hansard* so that they can read your comments today. I think we need to leave it to those reviewers to do the job.

The Hon. Dean Brown: And the criminal behaviour?

The Hon. L. STEVENS: That is part of the investigation.

The Hon. P.L. WHITE: My question refers to Budget Paper 4, Volume 2, page 59 (chapter 7) and intensive care services at the Women's and Children's Hospital. I do have a budget question, and it is a very important one. Will the minister inform the committee about the recent redevelopment of the Paediatric Intensive Care Unit at the Women's and Children's Hospital?

The Hon. L. STEVENS: I am absolutely delighted to talk about this, because I visited the unit this morning, and it is amazing. A $3.55 million redevelopment has seen a complete revamp of the Paediatric Intensive Care Unit (PICU) space at the Women's and Children's Hospital. The Paediatric Intensive Care Unit is now collocated with the High Dependency Unit to form a new state-of-the-art 13 bed Department of Paediatric Critical Care. The PICU is the only facility of its kind in the state, with about 1 100 patients currently admitted to the unit each year, including about 100 patients retrieved from remote areas—it is really state wide. It retrieves from the Northern Territory as well.

The Rann Labor government provided two-thirds of the funds for the redevelopment (that is, $2.35 million), while two charities (Variety—the Children's Charity, and the Friends of the Women's and Children's Hospital) donated $1.2 million. The redevelopment includes purpose built bigger bed spaces, with an average 20 square metres compared to the previous 12 square metres. It is just so much better. It also provides new counselling and respite areas for families, improved direct patient observation and upgraded isolation areas with now three isolation rooms compared with only two previously.

Each patient area is now equipped with an overhead services pendant, which keeps equipment such as cables, oxygen and suction devices safely out of the way and increases room for staff and family. These space-saving devices are valued at $350 000. The government made a commitment to rebuild the health system, and this includes bricks and mortar, but we know that this redevelopment is so much more than that. New state-of-the-art equipment, exceptional design and increased space will enhance positive outcomes for patients and their families, and create a much improved working environment. We are very pleased with the outcome.

I remember very clearly when we announced about a year ago that we would do this. I made the comment that the then space was old, tired and pretty cluttered. Today, there is a fantastic transformation. Together with wonderful organisations such as Variety and the Friends of the Women's and Children's Hospital, we have been able to bring together a very important partnership to build better health services.

Upgrading the paediatric intensive care unit has been an important priority of the Women's and Children's Hospital so that it can continue to provide the very best of care for some of the state's sickest children. Along with the redevelopment of the Emergency Department (also being jointly funded by the state government), this will see even further improvements to this already world-class hospital. The $8.2 million redevelopment of the Women's and Children's Hospital's Emergency Department is being funded jointly with Savings and Loans Credit Union, and it is currently well under way.

The Hon. P.L. WHITE: Budget Paper 4, Volume 2, Chapter 7, page 14 refers to elective surgery targets. Minister, can you provide the committee with details of the government's progress in reducing waits for elective surgery?

The Hon. L. STEVENS: I am pleased to inform the committee that the amount of elective surgery being performed in our public hospitals continues to increase. Figures released today by the health department show that the waiting list for surgery has also fallen, and long waits have come down substantially. These figures show that 27 193 elective surgery patients were operated on in the seven major metropolitan hospitals in the first nine months of this financial year. This is up by 719 patients compared with the same period two years ago and up 223 patients compared with the same period last year.

I can also inform the committee that the number of patients waiting more than 12 months for surgery has fallen by almost 20 per cent compared with six months ago. This means that, in the six months to the end of the March 2005, 50 per cent of all elective surgery patients were operated on within 36 days and 90 per cent of all elective surgery patients were operated on within 195 days. Also pleasing is that hospital initiated surgery cancellations were down by 13 per cent compared with two years ago.

Additional surgery not included in the increased amount of surgery done has also been undertaken at Noarlunga and three country hospitals, namely, Victor Harbor, Mount Barker and Port Augusta. Health department figures also show that

the waiting list for elective surgery has now fallen to below 11 000 for the first time in 16 months. I am pleased with progress, but I am well aware that there is plenty more work to do. This government has adopted a deliberate strategy to target those patients who have been waiting longest. It is pleasing to see that that number has been reducing quite rapidly, while we are still dealing with the patients who have the highest priority first. The important thing is that we have well and truly reversed the pattern of sustained cuts to elective surgery that occurred under the previous government. Through a total injection of $21 million in extra funding, on top of the base load of about $140 million a year since we came to office, we have really started to turn things around.

The amount of elective surgery was cut in all four years of the previous government's second term, with more than 3 500 fewer operations being performed in the last year compared with the first year of that term. I am mindful that, because of our ageing population, there is a rapidly increasing demand for surgery. The challenge for us is to keep up with this increasing demand, and that is why we are putting so many extra resources into performing even more surgery. As I have said, this is in contrast with the previous Liberal government, which cut elective surgery each year over its last four years in office.

Our figures show that the median wait for urgent elective surgery in the last quarter was 13 days, which is the same as the previous quarter. In the March quarter, 76 per cent of urgent cases were admitted within 30 days, and seven in every 10 semi-urgent cases were admitted within 90 days, with the median wait for those semi-urgent cases being 55 days. This means that the median waits for semi-urgent and non-urgent surgery became a little longer than the previous quarter while we target those in the long wait category. Nevertheless, 50 per cent of all patients were admitted within 36 days and 90 per cent of all patients were admitted within 195 days. While these results are encouraging, these are all figures we want to work on. We will continue our efforts to do that, while continuing to target those who have had long waits.

As well as committing millions of extra dollars to keep the improved momentum on elective surgery going, the government is taking other measures to ease the pressure on hospital admissions. Included in this is the $20.5 million injection for expanded home care options, which began last year and carries through, and the $22 million to expand transition care places, which is part of this budget. I must stress, though, that other measures to ease pressure on public hospitals are still needed from the federal government. The federal government must play its part by increasing the number of aged care beds. As I mentioned in an earlier answer, around 100 beds in our metropolitan hospitals are occupied each day by elderly patients waiting for a place in a nursing home. The federal government could also help by reversing the $75 million health funding cut delivered to South Australia in the latest health care agreement. This was a funding cut that both the leader and the deputy leader of the opposition supported. Without this cut, we could have delivered thousands more procedures.

The federal government could also fix bulk billing rates and general practitioner numbers, particularly in the northern and southern suburbs of Adelaide, and increase the number of nurses, doctors and certain types of specialist being trained. As I have said on many occasions, the Rann Labor government remains committed to improving our public health system, and I urge those opposite to encourage their federal counterparts to do likewise.

The Hon. P.L. WHITE: On the same page, there is reference to mental health services. Will the minister inform the committee about the progress of mental health reform in this state and outline some of the major reform initiatives undertaken by the government?

The Hon. L. STEVENS: We have already had some discussion on mental health services, but I will focus on some of the issues I do not believe were mentioned. The good news is that we are slowly but surely improving service responses with the $110 million capital infrastructure program. We are also building physical facilities. However, I would like to talk about some of the other mental health initiatives that have been funded over the last year.

The sum of $300 000 was provided to fund the GP access program that aims to improve links between general practitioners and other mental health support services to ensure seamless care and support for consumers. A total of $1 million was provided to enable the expansion of the assessment and crisis intervention service and to provide extended hours crisis cover for people requiring mental health assistance. Of course, this has been extended again as part of this year's funding. In this program, mobile teams of mental health professionals work alongside emergency services, such as the South Australian Ambulance Service and the police, to ensure that help is there when it is needed. The sum of $2 million was allocated for the establishment of a preferred provider panel and expanded community care packages to help people return home after a hospital stay. These packages of care include social skills and self-help training, daily home visits and mentoring, family and carer support, help with medication management and help from mental health professionals to monitor treatment and clinical follow-up.

A contribution of $380 000 was made to the Beyond Blue program, through both a state contribution to the national initiative and by supporting local initiatives, such as the antenatal and postnatal depression screening project. As was mentioned before, in this budget Beyond Blue has received $1 million to continue in a range of areas. The sum of $250 000 was spent to implement a global approach to mental health consumer information, assessment and outcomes, including development of a community-based information system to collect information to assist service planning, continuity of care, improved consumer outcomes and reporting mechanisms. Funding of $300 000 was provided to four sites to increase capacity in local hospitals to manage mental health consumers, and $600 000 went to country mental health planning and clinical infrastructure enhancement, with additional positions in all regions. A sum of $25 million was part of this year's budget, and it has already been discussed earlier.

During the past year, we have also completed a comprehensive review of the Mental Health Act and other related legislation. We have commenced planning for the development of three community rehabilitation centres across the metropolitan area, including comprehensive service modelling to ensure that the facilities are fit for the purpose and offer best practice care and support for consumers. We have begun the construction at the Flinders Medical Centre and the Repatriation Hospital, and we have almost finished about $700 000 worth of minor works at Woodleigh House at Modbury Hospital. We have also awarded design brief contracts for stage B of the Lyell McEwin Health Service, the Adelaide West Community Rehabilitation Centre, forensic

and secure rehabilitation facilities and the Noarlunga Health Service. Our mental health reform agenda, of course, will continue next year and in the years to come. I will not detail all the parts of the $25 million package, because they have been dealt with before.

The Hon. DEAN BROWN: My question concerns a survey currently being carried out by the Department of Health. In fact, someone who had been asked to complete the survey telephoned me last night. Is the minister aware of this survey?

The Hon. L. STEVENS: I need more detail, as we do lots of surveys.

The Hon. DEAN BROWN: I will highlight for the minister the nature of the survey, which is being carried out under the name of Anne Taylor from Population Research and Outcome Services. About a fortnight ago, the person was sent a letter stating that their household had been selected for the survey. Last night, they received a telephone call and questions were asked. The questions required very personal information indeed and concerned what treatments they may have received in the public hospital system. There were also asked a series of questions about the attitude of the doctor and how long they had to wait for treatment, and I assume that this related to whether they had to attend an emergency department or have elective surgery. They were asked their opinion, and they were also asked how the service could be improved.

Clearly, this is highly political information indeed. The person surveyed declined to answer most of the questions, because they believed that it was clearly being used for political purposes, and that came across when discussing it with the person on the telephone. Will the minister table in parliament, or make available publicly to the opposition and others who want the information, the collated results of the survey? If not, why not?

The Hon. L. STEVENS: I refer the question to the chief executive.

Mr BIRCH: We will take the detail of that question on notice and bring back a detailed response. However, Anne Taylor, although I do not know the exact title, essentially heads up our population, health and epidemiology area. I can assure the Deputy Leader that there have been no instructions from the minister to me or from me to Anne Taylor to undertake any surveys associated with any political questioning. I am assuming that this is part of an epidemiological survey, but we will get that response and may well be able to answer the question later in the afternoon or in the next session.

The Hon. DEAN BROWN: As a supplementary question, how many people are being surveyed? What is the total cost of the survey? Which company is doing the actual surveying and collating of results? I presume that, if the answer given by Mr Birch is the case, there would be absolutely no reason why this information should not be made available publicly and anyone who wishes to see the survey results should be able to.

The Hon. L. STEVENS: We will get the information and come back as soon as we can.

The Hon. DEAN BROWN: My next question concerns the Mount Gambier Hospital. When parliament met at Mount Gambier, I pointed out to the minister that there were five doctors at the Mount Gambier Hospital taking legal action either against the hospital or against the state government. In relation to the action taken by Dr Kevin Johnston, which I raised in this parliament last year, is it correct that the state government settled the legal claims by Dr Johnston against the Mount Gambier Hospital before the court trial commenced, and what is the total cost of that settlement to the taxpayers of South Australia?

The Hon. L. STEVENS: I will ask Ms Ramsey to respond.

Ms RAMSEY: The matter has been settled. The terms of the settlement contain a confidentiality clause. I would need to check the confidentiality clause before providing any details, to find out what I am able to put on the table.

The Hon. DEAN BROWN: Can I ask that you check with Dr Johnston whether he is willing for the disclosure of the amount if there has been a settlement, so that it is not the government hiding this? It is the government that keeps wanting to put in these confidentiality clauses: I have seen enough of the government to know that. If Dr Johnston is happy for this figure to be released, will the government release the figure of the settlement and not hide behind its own confidentiality clause? The taxpayers deserve to know the outcome of this case. I have raised the matter in this parliament and never had an answer, and there has been no response back to the parliament. They are serious matters and we deserve to know how taxpayers' money is being used.

The Hon. L. STEVENS: Ms Ramsey will respond.

Ms RAMSEY: I would need to seek legal advice on that matter.

The Hon. DEAN BROWN: Again whilst parliament was sitting in Mount Gambier, the minister on 4 May had met with the board of the Mount Gambier Hospital and made a ministerial statement to the parliament that she had raised with the board certain matters that had been raised in the parliament the previous day. She stated, and I quote the *Hansard* of that day 'Any claims of bullying and harassment will be thoroughly investigated', that is, by the hospital board. The chair of the hospital board on 10 May, six days later, had published in the local paper a letter to the editor that said, 'There are no complaints of harassment and bullying lodged with the board'.

Did the minister fail to raise the issues with the board despite her statement to the parliament, or was the manner in which she raised the matter with the board so vague that the chairman some five days later had apparently forgotten that the minister had raised those matters with the board? What was the outcome of the 'thorough investigation' of the bullying and harassment at the hospital?

The ACTING CHAIRMAN (Mr Koutsantonis): Will the honourable member state the budget line or page?

The Hon. DEAN BROWN: The budget line is money allocated to the South-East hospital region.

The ACTING CHAIRMAN: I am still waiting for the line on bullying and ministerial statements, but I will see if the minister has anything to add.

The Hon. DEAN BROWN: If the chair does not think bullying in the hospital is an important issue—

The ACTING CHAIRMAN: Order!

The Hon. DEAN BROWN: —then I will take issue with him.

The ACTING CHAIRMAN: Order! Don't talk over me.

The Hon. L. STEVENS: The first point is that I always tell the truth, in parliament and elsewhere, and the statement that I made in parliament in terms of raising the matter with the board was a truthful statement. When I returned from the Mount Gambier sitting I followed up the matter with the chair of the Mount Gambier Hospital board in a letter reiterating the contents of our meeting in relation to some issues that had

been raised, one of which was claims of bullying and harassment. I reiterated in my letter that I had received the board's assurance in our meeting at Mount Gambier that any claims of bullying and harassment will be thoroughly investigated. I reiterated that in my letter to him. I have not received a response to that letter, but I will be following through on that, and I am confident that that will happen.

Mr CAICA: I refer to Budget Paper 4 Volume 2 (page 7.62). Will the minister inform the committee what steps the government is taking to ensure that country hospitals and mental health services can provide quality health care services for country residents in South Australia?

The Hon. L. STEVENS: I note that the member for Goyder is present, so I am pleased to answer this question about country health services. In the recent budget, country regions received a 13.4 per cent increase on the previous budget, and I mentioned this increase in my opening statement. Regional health services understand that this is the best budget they have ever received. This money will help to pay for more nurses, better mental health support and other vital health services that people living in country communities need. The government also recently announced a package worth $27.2 million over four years to help improve the working and living conditions of rural medical practitioners.

I am not sure whether the member for Goyder has received any feedback from doctors in his area, but the government has received, generally, a very positive response from doctors in country areas about the rural doctors package which we developed in partnership with those doctors themselves. This $27.2 million package has a number of features, the key ones being: increased on-call and other allowances for resident rural doctors, with those amounts being indexed annually by the consumer price index from 1 July this year; a special telephone disruption allowance; and in addition to the on-call allowance an on-call doctor will receive a fee for each phone call received from a hospital between 11 p.m. and 7 a.m.

There are improved locum services for overworked doctors; increased development and training support for country GPs and specialists; and increased scholarships for country students as well as country based hospital internships. The government knows that country doctors need more support and recognition for the valuable contribution they make to rural communities in this state. That is why we embarked on this process with doctors to come up with a whole range of measures that they themselves believe will make a difference to doctors not only working in the country but staying in the country. So I am very pleased about what is happening in relation to country services.

I am also pleased about the formation of the two new metropolitan regions and the new Children's, Youth and Women's Health Service. We intend to have much greater cooperation and more links between the city and the country. This has been just the start of what will become more significant over the years in terms of the provision of elective surgery for country patients. Patients who are now sitting on city waiting lists will be able to have their surgery done closer to home. Three country hospitals (Victor Harbor, Port Augusta and Mount Barker) have begun to participate in elective surgery so that it can be transferred closer to where patients live. We intend to further strengthen those links between big city regions and country regions in endeavouring to provide more services for people in country areas closer to where they live.

Mr MEIER: I thank the minister for her comments about the rural doctors package. I have been asked by a division of general practice to coordinate a meeting to try to come up with incentives for doctors to come to Yorke Peninsula. I am about to start working on that, so I ask the minister whether I can have details of this package, because it could be very useful.

The Hon. L. STEVENS: You certainly can. I am arranging for all members of parliament to get the full package, but it is also on the web. I thank the member for Goyder for the work he is doing. If we can help in that work to attract doctors to the Yorke Peninsula, we would be very happy to be part of that process. We are making a significant effort to work particularly with general practitioners across the state, and we would be delighted to help.

Mr CAICA: I refer to Budget Paper 4 Volume 2 (page 7.13)—nursing employment. Will the minister please advise the committee on the current status of South Australia's nursing work force?

Mr KOUTSANTONIS: Good question.

Mr CAICA: It's a good news story.

The Hon. L. STEVENS: It is a good news story, and I thank the member for Colton for this question.

Mr Caica interjecting:

The Hon. L. STEVENS: It isn't lucky; it's planned. It is without question that the nursing work force plays an invaluable role in providing health care to the South Australian community. They really are the backbone of the system, and it is essential that we have a sustainable work force available to meet our state's health care needs. That is why in 2004-05 we again allocated nearly $3 million to a broad range of recruitment and retention strategies for nurses. The strategies include free clinical refresher and re-entry programs for registered and enrolled nurses; postgraduate education scholarships for metropolitan and country nurses and midwives; education scholarships for metropolitan and country enrolled nurses to undertake the Diploma of Nursing; a post enrolment conversion program; enrolled nursing cadetships and vocational education training in schools programs for country areas; a clinical leadership program for senior nurses; and the provision of a midwifery upskilling manual for midwives.

There are also initiatives to support Aboriginal nurses and midwives, including enrolled nursing cadetships at Leigh Creek, Ceduna and Tumby Bay and an enrolled nursing diploma program through the Pika Wiya Port Augusta Learning Centre's Nursing Pathway Program (that, of course, is for Aboriginal students); the nursing excellence awards; the nurse practitioner project, to build the capacity of the role within the work force; updates to the nursing web site nursingsa.com; a whole of public sector nursing and midwifery survey to identify factors associated with retention; a review of the nursing and midwifery transition to practice programs; local health unit nursing and midwifery retention projects, including a roving orientation nurse to support new staff transition to the workplace; enhancing a supportive environment for nurses within a community practice setting; and establishment of a country midwifery network and regional midwifery staffing pool.

It is a pleasure to inform the committee that the South Australian government's commitment to a sustainable nursing work force is, indeed, paying off. The overall vacancy rate for public sector nurses has reduced from 612.26 full-time equivalents in July 2002 to 192.79 FTEs in April 2005, a reduction of 418.47 FTEs in terms of vacancies. It has surpassed my expectations in terms of what we have been able to do. The reduction in nurse vacancies at the Queen

Elizabeth Hospital is particularly significant: it has gone from 149.71 FTEs in July 2002 to 9.6 in April 2005. That is your hospital, member for Colton and member for West Torrens. They are coming to us in droves. This reduction has been achieved in part through the recruitment of 69 overseas nurses. Since 2002, a total of 160 overseas nurses have been recruited to positions in South Australian public hospitals. Since October 2004, 22 have gained permanent residency in Australia.

I would also like to point out that employment was made available to every nurse who graduated in 2004-05. Of course, the Premier is particularly pleased about that. He went out loud and strong and said to every nurse that if they graduated they would be offered a job. The reduction in nurse and midwife vacancy levels is a reflection of the work undertaken by health units not only to recruit but also to retain nurses within the public sector work force.

In 2005-06 we will continue with the same amount of recurrent funding for nursing recruitment and retention initiatives. The funding will support a range of strategies to retain and recruit nurses and midwives, including recurrent funding for existing programs such as the nursing and midwifery refresher and re-entry programs; the scholarships for registered and enrolled nurses and midwives; nursing cadetships and VET and school programs for the country; the nursing clinical leadership program; the nurse practitioner project; various marketing strategies, including career expos; and local health unit retention projects, which they undertake at a local level according to their own needs. There is also funding for new initiatives, and they include the central casual pool for nurses; strategies arising from the public sector nursing staff survey; the research partnership with the University of Queensland to examine graduate transition and nursing work force outcomes; and an indigenous nurse project officer to work within the Department of Health's Office of Nursing.

I think that another very important factor in our success has been the new conditions for nurses in the public sector in South Australia that were achieved under the most recent enterprise bargaining agreement. There is still an issue of nurse shortage as part of the general shortages in the health work force across the country, but we have made considerable progress and we will be keeping up that effort.

Mr CAICA: I refer to page 7.47 of the same Portfolio Statements to which I referred in my previous question. My question now relates to hospital avoidance programs. Can the minister explain the purpose and nature of the Hospital Avoidance Program?

The Hon. L. STEVENS: I would be pleased to do so, because the hospital avoidance program is one of the key components of the health reform agenda. It was funded last year with, I think, about $20.3 million or $20.4 million across the forward estimates to increase these programs. The program aims to reduce metropolitan hospital presentations, admissions and readmissions for people of all ages, thus reducing the demand on the public hospital system.

In 2004-05 we invested $4.3 million for the Hospital Avoidance program. This money went towards delivering a range of client-centred services that provide appropriate alternatives to hospital care. These services are predominantly primary health care cased but work in partnership with the acute sector of hospitals. Some of these services include:

- introduction of the Home Supported Discharge service in the metropolitan area. This provides home-based care for clients who can be discharged from hospital early or for those who are at risk of readmission;
- introduction of chronic disease management services in each metropolitan region. This provides care and self-management support to clients with complex chronic conditions in order to reduce unplanned hospital admissions;
- expansion of the successful Metro Home Link service. This service is auspiced by the Advanced Community Care Association, which provides home-based rapid response to clients who present to hospital emergency departments and/or general practice. Without this support service many of these people would otherwise be admitted to hospital; and
- establishment of the Advanced Care in Residential Living program, which provides rapid response support to clients in residential care facilities. Again, without this service, many of these people would otherwise be admitted to hospital. Part of this program also provides discharge support to residential care clients who are in hospital to enable them to return home safely and on time.

The Department of Health has used detailed economic modelling to examine the effectiveness of these programs. This modelling has identified that in 2004-05 over 2 000 hospital admissions have been avoided, and approximately 1 600 bed days have been freed up for use by other patients. An independent evaluation of the Metropolitan Home Link group of services has also been conducted. The results are positive and show many benefits of this model of care for the public. In 2005-06 $4.8 million has been committed to expanding chronic disease management services in each health region. We will also commence a longitudinal evaluation of the effectiveness and efficiency of the entire Hospital Avoidance program.

I would like to reiterate that this has been a very successful program. When you think that we have been able to free up, in 2004-05, approximately 1 600 bed days and have avoided 2 000 hospital admissions, you can see how important this is, and we will be continuing that effort in the coming years.

The Hon. DEAN BROWN: I wish to ask several questions about the ambulance service. Firstly, the ambulance service has established a communications room out at Greenhill Road, and that involved the transfer from the MFS ambulance service joint facility on Wakefield Street out to this new facility on Greenhill Road. I understand emergency services funds were used to help construct this. Is the minister able to give an indication, if that is correct, whether funds from the Emergency Services Fund were used and, if so, what was the cost of this relocation or the move of the communications room?

The Hon. L. STEVENS: I will ask the Chief Executive to deal with the question or hand it on.

Mr BIRCH: I will hand the question on to Chris Lemmer, who is the Chief Executive of SA Ambulance Service, who may have to seek further information and come back today.

Mr LEMMER: The actual cost of the transfer was complicated because there was also work involving the South Australian Metropolitan Fire Service. There were components of emergency services funding within that, but I do not have the figures on me of what component of that, if any, related to the ambulance service. So, if I can take that on notice and provide that information to the minister for later tabling.

The Hon. DEAN BROWN: Just to be quite clear, I would appreciate knowing the total cost of the relocation, and I

would appreciate knowing what portion of that came out of the Emergency Services Fund, and perhaps how that was directed through—if you could give an indication of that please. My second question is: have there been complaints about delays in answering the triple 0 calls in the communications room and, if so, what is the nature of those delays; how many complaints are there about the delays; how long have some of those delays been; and what are the worst cases of delays in answering the triple 0 number?

The Hon. L. STEVENS: Again, I would like to invite Mr Chris Lemmer to address those questions.

Mr LEMMER: Thank you, minister. Again, on the specifics, if I could come back with the details. Yes, there have been delays in answering of triple 0 calls, and they come in two specific areas. One is the actual answering of the triple 0 by the Telstra triple 0 operation, which actually is interstate and is answered either in Melbourne or in Sydney. So a number of the complaints that come in do not actually relate to the delay that occurs in ambulance. But, yes, there have also been complaints about delays in answering triple 0 in ambulance, and we have recently commissioned a report from Gibson Quai to look at our call taking capacity, and that report is only recently on the table. It has identified some shortfalls in our actual capacity in call taking. Some of that relates to the implementation of new call taking protocols that came in with the call taking system that worked with the new government radio system. So there are issues relating to that. That report has yet to be tabled through to the minister, but call taking in there is an issue of concern for us. I do not know the numbers of complaints. I can come back with information on that, and what were the most significant ones. We would have all of that on record, and I can pass that through to the minister subsequent to this.

The Hon. DEAN BROWN: Supplementary to that, can you clarify whether there have been any complaints of the call even dropping out before it was finally answered within the communications room? I have been told that on one or two occasions the call has actually dropped out before it has been answered.

Mr LEMMER: I am not specifically aware of that but it is possible, and I will check the complaints that have come in for whether it has dropped out or whether people have hung up and called again. The system should not allow drop out at all because the calls are immediately re-presented when they are not answered, and they keep getting re-presented and escalating in priority according to the time they have been waiting to be answered. However, it is not inconceivable at a time of extremely high workload—particularly if there is a major accident or event that causes a lot of people to call through, and with the proliferation of mobile phones now one event can produce a very large number of calls coming through. I imagine that in those circumstances some people may hang up and try again; however, I will look at the specifics of the complaints we have had to see if there have been any specifically relating to calls dropping out and I will include that in the brief I provide the minister.

The Hon. DEAN BROWN: My third question relates to the number of employees who, in the last year, have been paid $100 000 or more—and I am working on figures out of your annual report so it is, therefore, relevant to this year's budget, because we are allocating money for the payment of employees. Last year's annual report shows that there were 30 employees who received a payment of $100 000 or more. The previous year there were 17, and so there is almost a doubling of the number of employees who received remuneration of more than $100 000.

I am using figures which specifically exclude payments made to employees in lieu of taking long service leave—there are other figures which include that and which would, obviously, impact on it. I realise those figures would include someone who may have resigned and received considerable back pay other than long service leave—it may be untaken annual leave—but, equally, the figures for the previous year also included those people. So, could you explain why the number of employees being paid $100 000 or more has gone from 17 to 30 in the space of one year?

Mr LEMMER: I can explain conceptually why that number has increased, and why it will continue to increase over time. Like the rest of the health work force we do not have the optimum number of staff on board and, for a number of reasons, have great difficulty in recruiting. Also, because of the nature of our work and having to provide mentor training with those people one-on-one on the road, there is a limited number that we can bring in at any time. So, for a number of years we have been short of the optimum number of staff and we therefore have a high overtime component that comes through. As enterprise bargainings and wages increase, the percentage of people who actually tip over the $100 000 mark increases as a result of overtime and shift penalties.

You also need to take our regional work force, in particular, into account because they provide significant on-call work, which is added onto the base rates. Many of our country ambulance officers are receiving shift penalties of about 62 per cent on top of their base rate to cover weekends and public holidays that they forego and also the on-call service that they provide. When you then add overtime payments on top of that a significant number of normal ambulance operatives will, in any one year, tip over the $100 000 mark for that reason.

The Hon. DEAN BROWN: To help clarify that answer, I do not want to know the names of the 30 individuals but I would very much appreciate having a breakdown of their roles. Were they ambulance workers in the country who received overtime, were they people who had left the service, or were they administrators within the service?

Mr HANNA: I am sure the minister will not be surprised if my first question is about the future provision of buildings for the Inner Southern Community Health Service. I am aware that there has been some planning work done for relocation of the Inner Southern Community Health Service. Can the minister give details of that planning work and when we might see a relocation, preferably to the Domain precinct in Marion?

The Hon. L. STEVENS: I thank the member for Mitchell for his question and, no, I am not surprised by it because I know of his interest in this particular matter—I am also interested in it. I am going to hand over to Jim Birch, the chief executive, to answer and then to direct it where he sees fit.

Mr BIRCH: As you are probably aware, at the moment the Southern Adelaide Area Health Service is undertaking a major capital works review for the entire southern area. That is due to be finished in late June/early July, and the question of the Inner Southern Community Health Service, its relationship to other community health services and the possibility of a Marion precinct is included in that capital works review. At this stage we are not in a position to say what priority would be given to that project until such time

as we have received that. If you are interested in getting a briefing from Mr David Swan, who is here today, on the whole capital works program and what the priorities are likely to be then I am sure we can make that available; however, it is the subject of that process and we are very hopeful that we can actually do something positive in the community health services and primary health care services in that precinct.

Mr HANNA: As a supplementary question, is it under consideration then to bring together in the one site adult mental health services, youth mental health services and the Marion Youth Service, as well as the current inner southern programs?

Mr BIRCH: Again, I can refer to Mr Swan, but we are looking at the aggregation of some services. I am not particularly familiar with whether all those services will be included. Mr Swan may want to answer that. However, we are also conscious that we should not be putting all community health services in one site because of transport and access issues. I attended the Inner Southern Community Health Service during a community cabinet meeting, and it was put to me that there needed to be multiple sites in the region but with a single large base. Mr Swan feels that is an adequate answer.

Mr HANNA: Rather than waiting for a briefing, could that be taken as a question on notice? Can I be provided with written information? Would the minister be happy with that?

The Hon. L. STEVENS: Yes; we are happy to do that. I add that the development of primary health care centres, of course, is one of the recommendations from the Generational Health Review in terms of beefing up primary health care. We are looking at a range of models around the metropolitan area. I will provide that information to the honourable member as part of the estimates process.

Mr HANNA: Thank you. Secondly, in relation to the adult and youth mental health services in the Marion district, can you give details of the increase in their business and also an increase in budget for those particular sites? I am referring to the sites on Marion Road for adult mental health services and in the Westfield office tower for youth mental health services.

The Hon. L. STEVENS: We will need to take that on notice and provide that information to the honourable member.

Mr HANNA: Thank you. That is all I have.

Mr KOUTSANTONIS: I have done some research in the break. I am very interested in—

The Hon. Dean Brown interjecting:

Mr KOUTSANTONIS: Copious notes. I am offended that the deputy leader would think that I would read out a Dorothy Dix question. I refer to Budget Paper 4, Volume 2, page 7.36. I know that we are on the same side, but I want to apologise to the honourable member in advance regarding the increased investment in biomedical equipment. Will the minister provide details on what additional equipment has been provided as a result of this increased investment?

An honourable member interjecting:

Mr KOUTSANTONIS: I want to find out from the minister first, and I will tell you whether she is right.

The Hon. L. STEVENS: I thank the member for West Torrens for the question, and I am pleased that he has done that homework. I am happy to provide some information because biomedical equipment forms an essential component of our health system. Biomedical equipment forms a significant part of our asset base, with an estimated replacement value of over $330 million. That is why it is important that we have a good replacement program to ensure that equipment remains operational and compliant with safety and quality standards. This is the third year of the program, which has seen significantly increased funding for biomedical equipment.

In 2002-03, $4.4 million was provided for medical equipment purchases, and in 2004-05 a total of $32.3 million was invested—a very significant increase. Included in the 2004-05 expenditure was $2.4 million for a replacement linear accelerator at the Royal Adelaide Hospital; $3.3 million for a Positron Emission Tomographic (PET) scanner at the Royal Adelaide Hospital; $1.8 million for a replacement MRI at the Lyell McEwin Health Service; and $24.8 million in annual program funding, including $7.1 million specifically set aside for elective surgery equipment.

Program funding also provided for significant expenditure on theatre and imaging equipment at the Lyell McEwin Health Service, as well as imaging equipment at the Flinders Medical Centre and at the Repatriation General Hospital, and $3.9 million of expenditure across all country health regions. In 2005-06, funding will address urgent replacement and new equipment requirements, including assets such as infusion pumps, defibrillators, ECG monitors, foetal monitors, anaesthetic machines, sterilisers, physiologic monitoring systems and radiographic units.

In 2005-06, we will also spend a further $3.6 million to replace three linear accelerators at the Royal Adelaide Hospital and $3 million on the Queen Elizabeth Hospital development of an off-site medical imaging facility. The last one I mentioned is being done in partnership with private sector medical practitioners and will improve access to imaging services for public and private clients. I would like to point out for the benefit of the committee that, in its last year, the Liberal government spent only $3.5 million on biomedical equipment compared with the $32.3 million expended by the Rann Labor government in 2004-05.

This government has clearly demonstrated its commitment to ensuring that our health services are supported with an up-to-date biomedical equipment program. We are delivering on that commitment. Certainly, we put our money where our mouth is. I hope that matched with the honourable member's research.

Mr KOUTSANTONIS: Precisely.

The Hon. DEAN BROWN: My next question concerns the Barossa hospitals. Of course, there are two hospitals in the Barossa Valley: one at Angaston and one at Tanunda. I think that most people would regard the Angaston Hospital as the oldest and most inappropriate facility. The Tanunda Hospital is a small and fairly old hospital, although not quite as old as the Angaston Hospital. A commitment was given by the previous government to start work on a new hospital in 2005.

Mr Koutsantonis interjecting:

The Hon. DEAN BROWN: No; funding was committed by the cabinet for that hospital, and the land was purchased. Of course, it was land held by the Housing Trust, within the Department of Human Services. I notice in the budget papers that there is not a single new capital program this year relating to a country hospital. The government is completing the aged care facilities at Millicent and Kangaroo Island, both of which have been delayed considerably, as well as at Kapunda, and the government is finishing work at Murray Bridge. However, if you look at 'New projects', you will see

that there is not one single new hospital project, major renovation or redevelopment in the budget this year.

Is it the government's intention to go ahead and build a new hospital in the Barossa Valley? The Barossa Valley is the centre of the Australian wine industry and one of the fastest growing regions in the state, and the two existing hospitals are totally inadequate. There is great concern locally that the Rann government is about to sell off the land that has been earmarked for this hospital. The people of the Barossa Valley deserve to know whether there will be a commitment to build a new hospital. If so, when will it be built and will it be built on the land that has already been earmarked for that hospital?

The Hon. L. STEVENS: First, let me clarify the issue for the committee. The deputy leader seems to have a memory problem. In fact, no funding was ever committed by the former Liberal government for the building of a new hospital in the Barossa Valley. I have said this on a number of occasions, but that does not stop the deputy leader from repeating something he hoped might have happened but did not happen.

The Hon. DEAN BROWN: Cabinet gave a specific commitment to provide the funds. It was a cabinet decision.

The Hon. L. STEVENS: The point is that no funding was ever committed.

The Hon. DEAN BROWN: It was a cabinet decision to provide the funds.

The CHAIRMAN: Order!

Members interjecting:

The CHAIRMAN: Order! The minister is giving her response, and I think she should be shown some courtesy by both sides.

The Hon. L. STEVENS: It is a little like the Margaret Tobin Centre, which was announced by the former minister in 1998 and which was to be completed in 2000. However, when we came to office in 2002, nothing had happened. So, it is more of the same. No commitment of funding was ever made to that hospital—a commitment was made, but no actual funds were set aside for that hospital.

In relation to the Barossa Hospital, the department is currently undertaking a country strategic asset planning exercise for country health services to create a plan to inform future capital investment planning. A comprehensive condition and compliance audit of all country acute hospitals is being undertaken, with a report to be made in August this year. This will feed into country strategic asset planning. In addition, an asbestos review and update of registers for country hospitals will be completed by July this year for inclusion in that exercise. This and other matters relating to country capital needs will be part of that exercise.

The Hon. DEAN BROWN: So, there is no commitment at all to the people of the Barossa Valley?

Mr Koutsantonis interjecting:

The CHAIRMAN: Order!

The Hon. DEAN BROWN: I ask the minister to answer the question about the commitment to this land.

The Hon. L. STEVENS: There has been no change to the situation in relation to the land at Reusch Park. I cannot say any more than I have already said. I am not going to say things that are not true, or give people the impression that funding has been committed when it has not at this point in time. That is something the previous minister did all the time, but I do not. The facts are as I have stated.

The Hon. DEAN BROWN: I will pass that on to the people of the Barossa Valley, because they will be disappointed. I will also advise the member for Schubert, who asked me to raise the question here today.

My second question concerns country hospitals. Country hospitals encourage local residents with a Gold Card (that is, the Department of Veterans' Affairs federally funded Gold Card) to use it. They encourage local people to have treatment locally within the hospital. It is extra revenue outside the normal source, and therefore a very important source of revenue for those hospitals. However, country hospitals get only 90 per cent of the equiseps allocation or payment made by the Department of Veterans' Affairs for that procedure. They have equiseps that are determined and, instead of being paid the 100 per cent, they receive only 90 per cent. I ask the minister why this is the case, and where the other 10 per cent goes. Does it go to the Department of Health, or does it go to the region?

Certainly, quite a few country hospitals have raised this issue with me and complained about the fact that they are getting only 90 per cent of the DVA fee. This puts extra additional pressure on all our country hospitals. It removes much, if not all, of the attraction of asking people with a Gold Card to have their treatments done in their local hospital. I might add that I do not think that occurs at the Repatriation General Hospital; that hospital gets the full fee. I think that metropolitan area hospitals used to get the full fee, but I do not know what the situation is now.

The Hon. L. STEVENS: I ask Mr Birch to address this question.

Mr BIRCH: I would like to come back and provide an answer quite separately on the specifics indicated by the deputy leader regarding whether this does or does not happen in country health units.

The Hon. DEAN BROWN: I can tell you that it does, because they are all complaining about it.

Mr BIRCH: The Department of Health allocates to country health all the funds it gets throughout the year, whether it be revenue or appropriation in grossed up terms, to country regions and health units. What I cannot be certain of—and this is why I am being cautious with the answer—is whether regions skim the repatriation payments off the top. We will get that answer. I have not had any country health CE raise that with me, so I do not know the specifics. However, we will definitely find out and provide the answer.

The Hon. DEAN BROWN: I have offered to set up an office next to the minister's office to pass on all these complaints. I can tell you that a lot of country hospitals have raised the issue with me and are very upset indeed, as they see this as extra work. Why should they not be paid the full amount, which they understand is certainly paid to the Repatriation General Hospital? Why should country hospitals be short-changed for doing this extra work on behalf of veterans?

The Hon. L. STEVENS: For obvious reasons, I do not require the deputy leader's services. However, we will look into the matter. I will hand back to Mr Birch.

Members interjecting:

The CHAIRMAN: Order!

Mr BIRCH: I will find out the detail but, at a conceptual level, we allocate funds, whether it be to a metropolitan or country health unit, on the basis of a specific number of equiseps or separations per annum. As you would know, some country hospitals are minimum volume hospitals, and they receive a fixed amount. Many country hospitals achieve below that activity or equisep level, yet we do not take the funds away for not achieving the equiseps. All I can say is

that I will need to find out. Generally, the principle I have adopted is that incentives should be retained within the system. We will find out what has happened.

The Hon. DEAN BROWN: When you say 'retained within the system', do you mean within the hospital?

Mr BIRCH: It has certainly been the policy of the department that revenue incentives be retained, either at the regional level or at the health unit level, and not retained within the department. I will find out the detail and, moreover, if we feel that there is a disincentive, we will look at it in a positive way.

The Hon. DEAN BROWN: Thank you. I know that the country hospitals would appreciate that. I assure you that many of them, right across the state, have raised the issue with me. It was on estimates day in 2003 that the minister released the recommendations of the Generational Health Review, and the priority list was one of the pieces of paper she issued. The list stated that a 24-hour telephone call centre was to be established to allow people to telephone in and get advice when they needed medical treatment, particularly after hours. It was seen as a very good initiative and as a way of taking the pressure off public hospitals. I supported it at the time and, on the day, I came out and backed it, saying that it was something I had been looking at. In fact, I visited one of these centres in England, and we had started some work towards establishing such a centre. Two years after the formal announcement that the state would establish a call centre, and fund it fully, nothing has been done. We have heard plenty of excuses, buck-passing and trying to put the blame on the federal government when, in fact, there was no mention in the announcement of federal government funding. Where is the telephone call centre? When will it be established, and who will fund it?

The Hon. L. STEVENS: I am happy to answer this question. Certainly, it was one of the recommendations of the Generational Health Review, and work began on how it would look in South Australia. One of the issues raised right at the beginning was that, before the health call centre could be established, it was important to put in place networks of services, particularly primary health care services. One concern was that, if we went straight ahead with the call centre, we would have the centre but not the enmeshing of services at the community level, particularly primary health care services, to deal with the demand coming from the centre. In fact, our first priority for funding went into the establishment of local health teams, through primary health care networks, and $3.2 million is being spent on a whole range of programs, particularly on general practitioners dealing with chronic disease management. Some of the other recommendations of the Generational Health Review related to hospital avoidance, and I have just talked about those programs, which have also been set in place.

However, early in our work on the call centre, the federal government indicated very significant interest in the concept and, in fact, pulled together all states and jurisdictions to work on a national call centre model. We entered into that process, and we were pleased to do so, because there were strong indications from the commonwealth that it would be a fifty-fifty funding arrangement. We were very pleased about that, as we were then able to put money into other programs coming out of the Generational Health Review. So, we went in with the commonwealth, and the other jurisdictions, in good faith to work on the national call centre model. Their work was very well advanced. It was only a few months before the federal election, about this time last year, that the federal government was still saying that it would be announcing money for the call centre program across the country.

It was not until after the election that the federal government had a change of heart and the money that was to have come through on call centres seemed to have gone elsewhere as part of the federal election campaign, or for some other reason. So, the federal government withdrew its support in terms of actual funding. There was discussion about this matter at the Australian health ministers meeting in January this year and the federal minister stated quite clearly that the money was no longer there, although he did leave the door slightly open in saying there was another budget coming up.

The federal budget did not bring forth any dollars for the health call centre situation, but it is pleasing to note that, at the recent COAG meeting, national health call centres were back on the federal agenda. South Australia was very disappointed about the pull-back of the federal government in relation to the clear commitments that were given to us and to other states. We are at the point of determining how we will move forward in relation to a health call centre. I am still keen to talk with the federal minister about the possibilities. Obviously, health dollars are always scarce and we have plenty of places we would like to spend them. We want the biggest bang for our buck and we would be pleased to work with the commonwealth.

The commonwealth has provided support to other jurisdictions in terms of health call centres, and we believe it is fair that it does that with us. I will be talking with Tony Abbott in coming weeks on a range of health reform matters, and this will be one of them. I will ask Mr Birch if he wants to add to what I have said.

Mr BIRCH: The only issue that I would add is to highlight the work that we believe needed to be done in advance of a call centre being established. The minister mentioned the primary health care networks. We actually have 93 general practices currently receiving secure broadband connections so they can be part of electronic care planning. The minister mentioned the chronic disease management processes. These are around three or four significant disease groups—renal, chronic obstructive pulmonary disease, diabetes etc.—which are great burdens on our hospital system. During the 2005-06 year that program, which is part of the commonwealth government's Health Connect program, will continue.

It is essential that there be a network between health services, hospitals, pharmacies, private practitioners and NGOs. NHS Direct in the UK, to which the Deputy Leader refers, is an excellent health call centre service, but the UK actually has a very significant primary health care referral base upon which it can refer away from its accident and emergency departments. There is a full business case completed on the health call centre, and the commonwealth government has received that case. We will still be working in the next six months with the COAG agenda, between senior officials, to see whether this can be advanced not only in South Australia but as a network across Australia.

Mr KOUTSANTONIS: How has the minister's department responded to the review of child protection, entitled Keeping Them Safe? I refer to Budget Paper 4, Volume 3, page 9.3, from memory.

The Hon. L. STEVENS: In recognition of the need for extra support and counselling coming out of the Layton review into child protection, Keeping Them Safe, we have funded an extra $847 000 to provide additional therapeutic

and counselling services for children aged two to 12 years who have been abused. This equates to an extra eight FTEs, who have been permanently appointed to provide additional counselling services in country and metropolitan areas. A further $551 000 has been provided for the development of therapeutic and counselling services for young people aged 12 to 18 years who have disclosed sexual abuse or sexual assault, either recently or in the past. This equates to an extra seven FTEs, permanent workers, to provide services for young people.

A model for the provision of these services is currently being developed. Further to this, $158 000 has been set aside for therapeutic and counselling services for young people who are abusers, either of siblings or of others. This funding builds on the existing work of the Mary Street services to help young people aged 12 to 18 years stop sexual abuse and sexual harassment of others. This service is both preventative and therapeutic in nature and works collaboratively with young people and care givers and the relevant agencies, including the Youth Court. This extra funding provides an additional two full-time equivalents for the Mary Street program.

In order to keep all health staff informed and up to date, an extra $84 000 has been made available to employ an extra staff member who is dedicated to training and implementing Keeping Them Safe. Health staff are also participating in a number of Keeping Them Safe initiatives. There is the Child Death and Serious Injury Committee, which has been established. The Department of Health is represented on that committee. The department is also establishing a register of child deaths and serious injuries.

The screening/monitoring working group is a whole-of-government group, and the Child Safe Organisation subcommittee is setting up policy procedures to ensure that children are protected from harm. Strong Families and Safe Babies is a project of the Department of Families and Communities' Children, Youth and Family Services and has involvement from the hospital-based child protection services at the Flinders Medical Centre. They are providing training support, input into assessing parenting capacity, and participating in joint case management work.

Rapid Response is the government's commitment to improving priority to services for children aged between 0 and 18 years under the minister's guardianship. They now have access to orthodontic and dental services irrespective of school attendance. Rapid Response is in the process of implementing an MOU between health and the Department of Families and Communities to increase collaboration and strengthen the joint responsibility for children within the child protection system. This includes developing protocols for exchange of information and joint planning and delivery of services. So, I think members can see that there has been a comprehensive response by the government and the department in this very important area of child protection.

Mr KOUTSANTONIS: I refer to Budget Paper 4 Volume 2 (page 7.36). The budget papers state that $22 million over four years is being invested by the commonwealth government to offer 176 transition care places. Will the minister provide details of this investment initiative?

The Hon. L. STEVENS: As part of the state government's commitment to health reform and to reduce the demand being placed on metropolitan public hospitals, we have committed over $22 million for the next four years to transition care. This is a mixture of money to continue two programs that are already in place, but it is also to increase the number of transition programs in future years. This $22 million will match the commonwealth's offer for the provision of 176 transition care places for South Australia.

As I just mentioned, it involves the continuation of two highly successful programs: the City Views Transition Care program and the Acute Transition Care Alliance Home Rehabilitation and Support Service. These programs provide intensive post-acute rehabilitation for older people within a specialised unit, a residential setting, or a community program. They aim to improve the transition for older people from hospital back to the community. By improving the transition process we can reduce the likelihood of an inappropriate admission or readmission to a hospital or aged care facility.

Both of these programs are proving very successful. With the new money that the state has put in and the matching money from the commonwealth we will have 90 places occurring this year and a further 86 places will be rolled out in 2006-07. We look forward to working constructively with a range of partners from the non-government sector who have been working with us in providing the best possible transition care that we can, knowing that it will be enormously beneficial to the people themselves. It will also be very important for freeing up our acute hospitals and preventing readmissions which should not be required.

The chief executive has just informed me that he has an answer on the veterans affairs issue that the deputy leader asked.

Mr BIRCH: The situation is that the Department of Health passes on the full price of the equiseps and does not retain any veterans revenue. However, initial indications are that, as the deputy leader indicated, some regions skim veterans revenue off the top. We have only been able to check with a few of the regions at the moment, but we will take the matter up to ensure there is a consistent approach and that there are incentives for health units to treat veterans.

The Hon. DEAN BROWN: By way of clarification, when you say 'a consistent approach', does that mean that the hospitals will get 100 per cent of the DVA money, because they are doing the work and it is additional work that they are taking on?

The Hon. L. STEVENS: That discussion needs to take place in the light of what Mr Birch has said, so we will talk about those issues with the country regional units to make sure that the incentives are in place to treat veterans.

Mr CAICA: I refer to Budget Paper 4 Volume 2 (page 7.14)—transfer of responsibility for the Universal Home Visiting Program and the Sustained Home Visiting Program for the Children, Youth and Women's Health Service. Will the minister inform the committee about the progress of both of these programs and the terms of the Every Chance for Every Child initiative?

The Hon. L. STEVENS: I welcome the opportunity to inform the committee about the progress of the Every Chance for Every Child initiative. Every Chance for Every Child is a major policy initiative arising out of the Generational Health Review. It contains a number of components including: universal home visiting; sustained home visiting for those families with greater support needs; and better integrated community support at the grassroots level for all families. The initial $16 million initiative included the implementation of the universal home visiting program across the state and the rollout of sustained home visiting or family home visiting to families with greater support needs. The program also forms part of the Rann Labor government's commitment to

early intervention. The program provides timely support to parents and families where they need it most, in their own home. We all know the importance of the early years in a child's life. They provide the foundation for healthy development, learning and future wellbeing.

The universal home visiting program has now been rolled out and is well established across the state, with 98 per cent of families receiving this service in the first weeks of a child's life. The government also has allocated extra funding of $325 000 to provide universal hearing screening to all newborns. In 2005-06, this program will be completely rolled out, with 98 per cent of all newborn children also being screened in terms of their hearing. Additional recurrent funding of $1.8 million has been provided from 1 July this year to further expand the sustained home visiting or the family home visiting program which, as I said before, provides longer-term support to those families that have additional needs. Currently, this program is on track to reach 700 families in the outer northern and southern suburbs, the Riverland, Whyalla and Port Augusta. The additional funding of $1.8 million recurrent will enable the program to provide sustained home visiting to over 1 000 families in the next financial year. The programmed rollout of this extra money will include the inner southern areas and the north-eastern metropolitan area stretching up to Gawler. As part of the program, to date, 120 nurses have been employed in these programs.

One of the very pleasing things has been the enrolment and participation in family home visiting by Aboriginal children and their primary caregivers. Their participation has been high. This translates into an acceptance rate for Aboriginal families of 84 per cent with a retention rate of those families, once enrolled, of 86 per cent. We are very pleased about that. As part of the service to Aboriginal families, the nurses are also accompanied by Aboriginal health workers and liaison workers who have been able to provide cultural support. In 2005-06, the universal home visiting service will be further improved with the introduction of the hospital to home referral system, which is an electronic discharge process for all newborns. This will streamline appointments for the initial universal home visits by cutting down on hospital paperwork and administration, and making it easier for families to connect with child and youth health.

As well as those programs, the Rann Labor government has committed $8.1 million to set up 10 early childhood centres to provide family friendly services and support to families and children. One site is already up and running. Children and Families Everywhere at Enfield (also known as Cafe Enfield) brings together services at one location for children from birth to eight years. Those services include child health services, play groups, child care and schooling. By bringing services together we can better support young families and busy working parents.

Further opportunities for the collocation of services with other agencies are currently being examined and business cases developed. Service coordination across government and the non-government sector is a priority. We have formed partnerships with the Department of Education and Children's Services and also the Department for Families and Communities to develop a whole of government approach to providing early childhood services close to where people live and to support families when they need it most. It has been very important and pleasing to be able to work closely with my ministerial colleagues the Minister for Education and Children's Services and the Minister for Families and Communities, as well as the member for Wright, who is Parliamentary Secretary for Children's Education and Children's Health, in developing this whole of government approach.

Earlier in the year Dr Fraser Mustard, who is a member of Canada's hall of fame in terms of health and also an international expert on early intervention and early childhood programs, visited and was highly impressed with the universal home visiting programs and the family home visiting programs. We have also had considerable interest from other parts of Australia and overseas in what we are doing here in South Australia, because what is clear is that, while in other places bits and pieces of excellent work have been done, in South Australia we are putting in place a program which is population wide and which reaches every child who is born here. So, the government is committed to investing in the early years, and this joined-up approach also forms part of our response to the Keeping Them Safe report, which I talked about earlier. Finally, we understand that this investment is very critical because it is key to the future health and well-being of the whole community.

The Hon. DEAN BROWN: I want to refer to the Margaret Tobin mental health facility at Flinders Medical Centre, and to the mental health facility at the Repatriation General Hospital. In the 2002-03 budget papers, the government indicated that the Margaret Tobin Centre would be finished in June 2004 at a total cost of $10.5 million. The most recent budget papers show that that cost has blown out from $10.5 million to $17 million, and also shows that the completion date has blown out from June 2004 to June 2006. I also highlight that, with the Margaret Tobin Centre, this parliament allocated $7.6 million last year for this project but spent only $1 million.

With the Repatriation General Hospital Mental Health Facility, the budget papers of 2002-03 showed that this was going to cost $3 million, and the most recent budget papers show that that has blown out to $10.5 million, which is more than a trebling of the cost. I think it represents a 350 per cent increase. Also, the completion date has blown out from June 2004 to June 2006. In the last budget, 12 months ago, the parliament allocated $7 million for this project and the budget papers indicate this year that only $1.2 million has been spent.

So, my questions are: what is the reason for the doubling in one case and the trebling of the costs; what are the reasons for the two-year delay in both of these projects—that is, if they are finished in June next year—which, I would have thought, because of the delays that have occurred so far, and the little amount of money spent, very unlikely, to spend $12 million on a project over the next 12 months, and to be occupying the facility; and, what is the reason why so little money was spent, of the money allocated to both these projects? In fact, of the money allocated to these projects last year, only 15 per cent of that money was actually spent.

The Hon. L. STEVENS: I invite Mr Derek Exton to provide a response to the deputy leader's question.

Mr EXTON: In response, taking the Repatriation Hospital proposal, at the time that the original budget was established there was very little concept established at that stage, and there was a presumption that the facility could be accommodated with alteration of existing buildings. It has been proven since that time, through detailed analysis, to not be possible, and the concept now—and I would commend people to look at the concept when it is completed—will be a complete new facility replacing previous inadequate

facilities. That resolution took time and we are now tracking, from the Repatriation Hospital point of view, at completion in June 2006. The contract has been let, the area is now cleared, and the construction is well underway.

In regard to the FMC mental health project, at the time that the original funds were allocated, again, the concept was only produced in an outline form. We now, in producing our information to support proposals to government, go into much greater detail in developing those concepts with the intent that at the time we put those proposals up, the issue of feasibility and ability to deliver the project has been much further tested. The FMC project experienced a large amount of difficulties in the tender market. The tender market at the time these projects went, that is, both the RGH and the FMC facility, experienced a large amount of difficulty in the tender market which was short of resources, and where contractors were being very selective around the projects they went for. FMC is a relatively difficult project on a difficult part of the site, and was not enthusiastically—if you like—undertaken by contractors. We now have agreed with government that additional funds should be provided in order to bring that concept into being, and it will be completed on June 2006.

The Hon. DEAN BROWN: When you say additional funds, is that on top of the $17 million, or is that included in the $17 million, minister?

The Hon. L. STEVENS: Yes; that is all up.

The Hon. DEAN BROWN: The other part that was not answered is: why so little? Only 15 per cent of the money allocated 12 months ago has actually been spent.

Mr EXTON: The project at FMC has been quite difficult insofar as the resolution of the facility to balance the new reform requirements, and to move the users in that facility towards an agreed outcome has taken quite a long time to achieve. That is part of the process. There certainly was a delay in the process of achieving additional funds on the outcome of the tender. By and large, the project is the first mental health project that we are delivering of recent years, and it has been more difficult to achieve that. We are expecting that on subsequent mental health projects that will not be a problem.

The Hon. DEAN BROWN: In light of the time, I will reserve the rest of my questions until after lunch.

The Hon. L. STEVENS: One point in relation to the Margaret Tobin Centre: I know that the deputy leader has said at other times that there has been a two-year delay in relation to that program. I would say that there has been a seven-year delay. People need to remember that the project was first announced by the deputy leader in 1998 and nothing had occurred at all when we took over. The whole project delineation was sketchy, and we virtually had to start from scratch; but it is on its way.

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

The Hon. DEAN BROWN: It is normal practice that as we get to the end of each session we have a chance to read the omnibus questions, and I would like to read those now for the Minister for Health.

1. Did all the departments and agencies reporting to the minister meet all required budget savings targets for 2003-04 and 2004-05 set for them in the 2002-03, the 2003-04 and the 2004-05 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 2004-05 for all departments and agencies reporting to the minister 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 as of 30 June 2005; and, for each surplus employee, what is the title or classification of the employee and the total employment cost (TEC) of the employee?

4. In financial year 2004-05, for all the departments and agencies reporting to the minister, what underspending on projects and programs was not approved by cabinet for carryover expenditure in 2004-05?

5. For all departments and agencies reporting to the minister, what is the estimated level of under-expenditure for 2004-05, and has cabinet already approved any carryover expenditure into 2005-06? If so, how much?

6. There are two parts to this question. First, what was the total number of employees with a total employment cost of $100 000 or more per employee and also, as a subcategory, what was the total number of employees with a total employment cost of $200 000 per employee for all departments and agencies reporting to the minister as at 30 June 2004? What is the estimate for 30 June 2005? Secondly, for the period between 30 June 2004 and 20 June 2005, 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. Will the minister provide detailed breakdowns for each of the forward estimate years for the specific administration measures which will lead to a reduction in operating costs in the portfolio?

I just wanted to get those on the record, and I will now return to my remaining questions. I am particularly concerned to find that this morning the minister referred to the most recent *Elective Surgery Bulletin* for the end of March quarter. She has put out a press release on that bulletin but the bulletin itself is still not on the web site—in fact, it specifically says that it will not go up until 2 p.m. I think that is one of the most deceitful steps I have seen a government take in terms of wanting to talk about the issue in the parliament here some two or three hours ago, wanting to put out a press release, but not willing to put out the actual data and the actual bulletin. If ever there was a politicising of the release of government information that would have to be it.

So, we have a press release but we do not have the bulletin with the back up information. I find that totally unacceptable—particularly as the person was clearly instructed to put this out. I might add that journalists who contacted the minister's office about a week ago on this matter were told it would not be available for another two weeks until the end of the month. I would also like to point out that this bulletin is, in fact, getting later and later in its release. If you go back about 12 months, it used to be released within two months of the end of the quarter. The September quarter bulletin was released in early December of last year (just into the third month), and we are now half way through the third month—it was the same last quarter, as well. I find this disturbing.

The other issue is the fact that, for the first time, the most recent bulletin put out for the end of the December quarter deleted the figure that represented a percentage under the heading 'Patients waiting more than 12 months: as of June . . . there were . . . many patients', (in this case, 17.2 per cent, who had waited more than 12 months). So for the first time we could not work out the number of people who were on the elective surgery waiting list.

You can very quickly work out the waiting lists by working out the full percentage. That is how it has traditionally been done for many years—in fact, for as long as I can recall, going back well into the early 1990s. That figure was left out of the December quarter. I just wonder why it was left out, and whether it will be included in this year's quarter when we finally see it, even though you have put out the press release in which you have interestingly quoted a so-called waiting list at the end of April, not the end of March. The bulletin covers the end of March.

No doubt the April figure was a little better than the March figure, and that is why the minister used that figure. We will have to wait until we get the bulletin to confirm, but I can guarantee that that was probably the case. Can the minister explain or give a guarantee that, in the future, that percentage will be put back in so that we can work out the waiting lists exactly? I highlight the fact that if the 11 000 figure (the figure used by the minister earlier) is the figure for the end of March, it is about 20 per cent higher than it was when the Rann government came to government.

The Hon. L. STEVENS: It is such a long question that I can hardly remember the aspects of it. It is now 10 past two, and—

The Hon. DEAN BROWN: I was very specific. I asked whether you would ensure that the percentage of patients waiting more than 12 months (which has been in previous bulletins) will be included in this and future bulletins?

The Hon. L. STEVENS: We will look at what the deputy leader has asked. We are on about transparency, actually. We are looking at making a huge range of improvements in the way in which we manage elective surgery. We will look at what the deputy leader has said. The deputy leader has talked about 30 April. Yes, the government is very pleased. In October last year we put in $10 million extra for elective surgery. Our hospitals have worked hard. They have spent $10 million. They have done a lot of work, and those results are showing. I thought that the deputy leader would be pleased to hear these good results, particularly—

The Hon. DEAN BROWN: I cannot see them yet. I have been waiting for the bulletin to come out.

The Hon. L. STEVENS: I can assure the deputy leader that I always tell the truth. He can read my press release. He can get the bulletin and read it. Let me say, also, that the deputy leader has often complained that we are increasing the amount of surgery because we are doing easy things. Let me tell the deputy leader that this time we did hard things. We have decreased the numbers of people who have been waiting a long time, and they are the people who have had complex issues. The government has not shirked its responsibilities there.

I am pleased with the activity that we have been able to undertake. We still have more work to do to get better at the way we do things. Our regions are working well together. We are bringing in the country hospitals. We will get better at this. The difference between this and the former government is that we are committed to improvement all the time. We are proving that we can do it, and we will continue that.

The Hon. DEAN BROWN: The specific question, so that there is no lack of clarity whatsoever, is that the heading (page four) for the December quarter 2004 is, 'Patients waiting more than 12 months'. It indicates 1 890 as at December 2004. Traditionally, for the last 12 years at least, a percentage has been included. That represents a percentage of the total people on the waiting list. That was not included in the December quarter. True to the department's word, the bulletin went up at 2 o'clock, some three hours after the minister talked about it in here and some hour at least after she had put out a press release.

This quarter's bulletin for the end of March, again, does not put in a figure. We do not know the total waiting list because it cannot be calculated. For the last two bulletins you have removed the figure that allowed that calculation to be made.

The Hon. L. STEVENS: Let me just say—

The Hon. DEAN BROWN: I ask that that figure be given for both the December quarter, for this quarter (which is the March quarter) and for future quarters.

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

The Hon. DEAN BROWN: As a supplementary question, why was it cut out? So that we could not find out the true waiting list?

The Hon. L. STEVENS: No; do not judge others by yourself, deputy leader. We believe that it was an oversight. We will look at that in the interests—

The Hon. DEAN BROWN: The minister has quoted a figure for the total waiting list as at the end of April. I think that we ought to have a figure today for the waiting list as at the end of March. If it was an oversight—

The Hon. L. STEVENS: I have just told you that we will take it on notice and provide the information. I am not going to run out right now and do it. I thought you would like to have the rest of the time. We will get the honourable member the information.

Additional Witness:

The Hon. Carmel Zollo, Minister Assisting in Mental Health.

The Hon. P.L. WHITE: I refer to Budget Paper 4, volume 2 (chapter 7), page 36 and increased investment in Beyond Blue, which is extremely welcome. Will the minister provide the committee with some further detail on this investment?

The Hon. L. STEVENS: I would like to refer this question to the minister assisting me in mental health. I welcome the Hon. Carmel Zollo to the estimates proceedings. I put on the record how pleased I am to have a minister assisting in mental health. I am very pleased that the Premier demonstrated his commitment to mental health, not only in providing a significant boost in funding but also appointing the Hon. Carmel Zollo to assist in the area. I would be pleased to ask her to respond to the question.

The Hon. CARMEL ZOLLO: Thank you, minister. I thank the honourable member for this important question. Mental health is a key priority for this government, and depression is one of the most disabling conditions in Australia today. More than one million adults and 100 000 young people experience depression every year in Australia, and one in five Australians will experience depression at some time in their life. That is why the work of Beyond Blue, the national depression initiative, is so important. As part of our commitment to mental health, we are working with Beyond Blue to address the issue of depression in the South Australian community.

In our 2005-06 budget, we have provided an additional $1 million for Beyond Blue programs focused on prevention, early intervention and the reduction of the stigma associated with mental illness. Work with general practitioners regarding best practice guidelines for the treatment of depression will be taking place as part of this early intervention strategy.

South Australia is providing leadership with respect to the Beyond Blue national schools research initiative, and over 15 South Australian high schools are participating in this important prevention initiatives.

Targeted research is also being undertaken to identify women who may be at risk of antenatal and postnatal depression. This program aims to provide information about and resources for postnatal depression to a total of 100 000 women, and it spans all states and territories. In South Australia, the research includes a focus on fathers and the development of their role in supporting women with postnatal depression.

Another Beyond Blue prevention and early intervention program addresses depression in the workplace. Depression causes over six million working days to be lost each year, and Beyond Blue is assisting us to develop programs in this area. WorkCover South Australia initially applied for the program, and other agencies in South Australia, including the Australian Taxation Office, the Department of Defence, Australian Central Credit Union, the RLM Group and Self-Insurers of South Australia, are picking it up.

Beyond Blue also conducts a range of activities in the areas of community awareness, consumer and carer participation and primary care. South Australia is an active participant in these programs and is pleased to be able to assist Beyond Blue to expand its work in the state. I am pleased to have had the opportunity to meet with the chair, the Hon. Mr Kennett of Beyond Blue, as well as the CEO, Leone Young, to discuss our continuing work with them.

The Hon. P.L. WHITE: I again refer to Volume 2, Chapter 7, page 2. The Generational Health Review recommended the establishment of regional health services, and the government has established three regional health services in the metro area. Can the minister explain the process which has led to those services being established and, in particular, the progress that has been made to date on the new organisational arrangements, including any changes within her department?

The Hon. L. STEVENS: I am very happy to answer the member for Taylor's question. However, I also have an answer to a question asked earlier today by the member for Finniss about the health telephone survey, which I want to put on the record. From the brief information provided by the deputy leader, my department believes that he was referring to a patient evaluation of a hospital services survey. I am advised that these surveys have been conducted in South Australia since 2001, and I am advised that the questions are the same each time the survey is conducted. I must say that I find it interesting that in his remarks the member for Finniss portrayed this survey as asking highly political questions. I guess that, if the questions are political now, they were political when they were first used back in 2001 when he was minister. However, I do not think that they are political, and to have them portrayed as such by the member for Finniss is quite mischievous.

These surveys evaluate various aspects of care, including access, services and amenities, provided to patients by the South Australian public hospital system. The survey also surveys communication issues between providers and patients. The aim of the surveys is to provide a benchmark to identify problem areas and to improve the access to and quality of care and services available in South Australian public hospitals. The procedures and questions for this survey were based on the collections developed in Western Australia in 1996. Similar surveys are conducted in other states and territories across Australia. The last time this survey was conducted, the statewide satisfaction score with the public health system in South Australia was 86.3 per cent.

I also want to say that we are about improving our services, and I think that many of the comments made today illustrate quite clearly what the government is about. One of the very important ways of doing that is to receive feedback from consumers in a variety of different ways. One other very important way will, of course, flow out of the establishment of the health and community services complaints commission. When that commission begins operation in a month or so, there will be another ongoing avenue for feedback to the South Australian public and to the government about the health system and for highlighting various aspects of performance, as well as areas on which we need to focus more attention.

In relation to the question asked by the member for Taylor, I will ask Mr Jim Birch, the Chief Executive, to respond.

Mr BIRCH: Thank you, minister. On 1 July 2004, three new metropolitan health regions assumed full operational responsibility for metropolitan health services, namely, the Children's, Youth and Women's Health Service, the Central and Northern Adelaide Health Service and the Southern Adelaide Health Service. In my answer, I will focus on the changes in the Department of Health which have been necessary to occur at the same time as the regional changes. I will ask the three regional CEs to explain the regional structural changes that are occurring in their regions.

The intent and key objective throughout this exercise are to have a net no increase in administrative costs and, in fact, to attempt to obtain a net decrease in total administrative costs for the whole health system. In our opinion, the new governance arrangements have led to improved coordination of planning and service delivery across regions. In particular, some examples of this are the recent ophthalmology clinical network established in the Central Northern Adelaide Health Service and the implementation of Every Chance for Every Child across the regions.

Earlier, the minister referred to the fact that the department's portfolio executive now consists of not just simply the executive members of the department but also the chief executives of the regions and a representative chief executive of one of the country regions. I will speak about the department restructure, because it is significant that we have to change the role of the department and ensure that resources move from the department to regions to provide, in part, for the additional administrative staff needed at a regional level at no net increase in cost. In addition, regions are required to pull up capacity from within their health system in order not to provide an increase in administrative resources.

In relation to the Department of Health, the total FTE establishment in the department at that time was 1060.4, and we have been fairly hot to trot on this issue since February 2005. At that time, we still retained some 99.5 FTEs in the Department for Families and Communities resources in shared services, and those will move to the Department for Families and Communities in the new financial year. Already, we have moved BreastScreen SA to the Central Northern Adelaide Health Service region, although that does not appear yet in the official figures, as it will occur legally from 1 July this year. That is a 73 FTE movement from the department to the Central Northern Adelaide Health Service.

The drug programs and population strategies unit, comprising 25 FTEs, has now moved to the Southern

Adelaide Area Health Service as part of the old drug and alcohol services council group. The Aboriginal Step Down Unit, with a sum total of eight FTEs, will move to the Central Northern Adelaide Health Service region. The important figure (and this will occur early in the new financial year) is that, as a result of analysing the department functions versus regional functions, we have identified a further 98.4 FTEs within the central agency of the department who are, effectively, regional staff. Some of those staff will remain within the department where there is insufficient critical mass to provide the service regionally, but around 55 will move to regional health services. This leaves around 473 FTEs within the department focused primarily on the administration of running the health care system. This does not include the public health division, which is largely a service agency and does not include the centralised information and communications technology services, which are for the entire system. We are yet to benchmark those 473 FTEs against other states, but early indications are that it is a very effective number of FTEs for a central agency with an expenditure of around $3 billion per annum.

The regions are establishing their own regional health services, and I will call upon Dr Rima Staugas, Associate Professor Kaye Challinger, and Mr David Swan from the Southern Adelaide Health Service, to indicate what is happening in their particular regions.

Dr STAUGAS: In the establishment of the regions, we have taken on the Generational Health Review agenda very seriously, and it is our objective to return as much as we can find in terms of administration into the service. In building the executive structure, which has only just been completed, there has been an increase of only one executive classified position, and there has been no change in the number of executive administrative support positions within the region. The primary benefits of our structure, and structuring it around the executive director structure, are for the improved integration of health services, a stronger statewide focus and better coordination of services. We have set ourselves some key indicators to ensure that we keep returning services, rather than building administrative capacity, which is not what is required.

The figures we have to date, just prior to regionalisation on 30 June 2004, indicate that 295 doctors were employed across our region, and as of 15 June this year 342 doctors are employed, which is an increase of 47. As of 30 June 2004, 1 298 nurses and midwives were employed and, as of 15 June, there were 1 373, an increase of 75. We believe that, on one crude indicator, we are increasing services to the constituents within our regions, and we want to continue to do so.

Assoc. Prof. CHALLINGER: As you are aware, the Central Northern Adelaide Health Service was created late last year, with the appointment of the Chief Executive Officer, Dr David Panter, who arrived in October. Subsequent to that time, there had been considerable work on developing the structure, which has been released in a newsletter and which I am sure many members will have seen. Within the context of that structure we have done as Jim Birch has indicated, that is, we have considered the people who may be available in terms of the executive positions in the Department of Health restructure, but there has also been a drawing-up of people and a diminution of the number of executive roles within the health unit facilities of the central northern structure.

Our view is that the creation of the regional structure will provide us with opportunities for realignment of policy and operational responsibilities between the department and the health unit facilities. It will improve integration of health services, particularly planning across acute primary and mental health services, and we already have evidence of that in regard to the winter bed management strategies. Our experience to date would suggest that the projected staffing outcomes for our full restructuring, as has been published, would indicate an opportunity to achieve close to a neutral outcome in terms of total numbers of executive level employees across the whole of our region.

Mr SWAN: The Southern Adelaide Health Service has implemented a regional executive structure that primarily is based on using the existing executive positions within the region. Overall, the executives within the region have grown by one, and the cost of this additional position will be found through the devolution of positions from the Department of Health's restructure arrangements. In addition, other streaming of the senior positions is in progress. We are developing a single mental health service for the region that will combine four mental health services into one, incorporating acute adult, community, Child and Adolescent Mental Health Services and services for older people.

We are also looking at developing a single emergency department through the appointment of a single director across Noarlunga and Flinders Medical Centre, which will enhance supply and demand, particularly during the winter months. The establishment of the Southern Adelaide Health Service region has allowed us to undertake many functions that were difficult under the previous hospital structure. For example, I have talked about mental health with all services being incorporated under one umbrella. This has also allowed us to develop better consultation with consumers within our region, through the establishment of a mental health advisory group that has incorporated into its membership consumers, NGOs, general practitioners and our staff, all working towards enhancing mental health service for the community.

We are also able to do a lot of work in relation to primary health care and addressing chronic disease in our community. We already have been able on a regional basis to incorporate better relationships with a range of partners, once again consultants within our health system, consumers, GPs, the department and NGOs, all working together to have a common view about the provision of primary health care and better management of chronic disease within our community. We have established a network of self management providers who will be working with the region in providing a range of chronic disease strategy services for the community.

Our ability to have hospital avoidance programs has also been enhanced by the region and, working with agencies such as the Advanced Community Care Association, we have improved our discharge arrangements from our institutions. Also, working with Metropolitan Home Link to maximise the uptake of GP referrals in our hospital avoidance program has been excellent and above target. The emergency department between Noarlunga and Flinders is now in place (as of last Monday), and we believe there will be better rotations of staff between the two departments and our recruitment or retention of staff, particularly medical staff, will be enhanced.

Also, the links between those two facilities through the regional structure will assist us with our winter bed strategy as we try to optimise the use of Noarlunga hospital with better support from medical and nursing staff from Flinders Medical Centre.

The Hon. L. STEVENS: Mr Birch may want to finish off.

Mr BIRCH: The final issue I want to discuss is how we ensure performance within the system. There are health service agreements established with each of the regions. Those regions consist of a number of key performance indicators. If I use elective surgery as an example, there are payments made in arrears based on the achievement of elective surgical targets but there are also other targets that actually include things such as low birth weight for Aboriginal populations, and also the contracts of employment for chief executives between their boards and the chief executives include these targets.

In some cases I am involved personally in the performance management processes with board chairs in relation to the achievement of the required targets within each of the regions, and to date I have to say that we have been extremely pleased with the outcomes we have received.

Mr CAICA: I refer to page 7.47 of Budget Paper 4, Volume 2. What progress has been made on the development of clinical networks now that the new governance arrangements are in place across the metropolitan area?

The Hon. L. STEVENS: These are very important new measures being taken in relation to better services and certainly better returns in terms of use of taxpayers' money. As a consequence of the new metropolitan governance arrangements, we have been able to explore the potential benefits of clinical networks. This particularly applies in the Central Northern Region of Adelaide where we have a number of acute hospital facilities. We have the Queen Elizabeth Hospital, the Royal Adelaide, Modbury and the Lyell McEwin, all acute hospital facilities. These networks are being developed to coordinate activity across a number of hospital sites, to reduce duplication and to ensure appropriate service coverage across the region.

The Central Northern Adelaide Health Service has worked hard to establish the first of its clinical networks, and that is the Central Northern Ophthalmology network. This has been done with the support of clinicians across the region, which is in itself a major step forward for cross-hospital collaboration. It means that hospitals are now beginning to work together rather than working in competition with one another. A chairperson and director for the ophthalmology network were appointed in early April this year, following a merit based selection process.

Ophthalmology services at the Lyell McEwin Health Service have since been expanded as part of the elective surgery strategy. This has involved: the purchase of additional ophthalmology equipment to support the extended service; the introduction of weekly operating sessions and additional outpatient sessions, with additional anaesthesia support provided by the Royal Adelaide Hospital; the establishment of agreed principles for transferring patients across hospital sites; and the agreement of 81 RAH patients (as at May 2005) to transfer their care to the Lyell McEwin Health Service. These patients were on the Royal Adelaide Hospital surgical waiting list but were identified as residing in the Lyell McEwin Health Service catchment area. Patients have been very supportive of this initiative, and it is anticipated that the transfer of (in total) 100 patients will be achieved by 30 June 2005.

Just harking back to the health reform strategy in the Generational Health Review, one of the major aims and objectives is to provide services closer to where people live. In forming the Central Northern Adelaide region, the Generational Health Review pointed out that the whole service provision to residents in the outer northern areas needed to improve by shifting services closer to where people live. This is a prime example of how this can be achieved without conflict through a process of collaboration and working through problems with clinicians.

Work has also commenced on the establishment of a maternity network. The Central Northern Adelaide Health Service and the Children, Youth and Women's Health Service's obstetric network—a joint midwifery and advisory committee of the Queen Elizabeth Hospital and the Women's and Children's Hospital—have proposed a maternity network service for women of the west from 1 July 2005. I know that the member for Colton is aware of this new maternity network service. This network will provide: campus team midwifery, antenatal clinics, and shared care with general practitioners through the Queen Elizabeth Hospital. Four beds will be available for women who are delivered of their babies at the Women's and Children's Hospital and who then wish to transfer to the Queen Elizabeth Hospital for their postnatal care.

A memorandum of understanding between the Central Northern Adelaide Health Service and the Children, Youth and Women's Health Service is being drafted. This memorandum will outline the costing based on the activity levels of the services to be transferred from the Queen Elizabeth Hospital to the Women's and Children's Hospital. I am looking forward to this new arrangement in the western suburbs, particularly as it focuses on new midwife-led birthing and support services.

In the south, the Southern Adelaide Health Service has developed a framework for the development of a single emergency service, to which David Swan alluded. This brings together the emergency departments of both the Flinders Medical Centre and the Noarlunga Health Service. This single service will focus on achieving a sustainable, efficient and effective emergency service across the two hospitals and increasing the retention of emergency patients at Noarlunga. It should be remembered, of course, that the government has put significant new funding into the Noarlunga Health Service of $1.5 million per year to support services in that emergency department. The single service will also create enhanced opportunities for further training and education of emergency staff.

Again, as David Swan mentioned, a proposal has also been completed on the development of a single service for mental health in the south. This brings together all adult, child and adolescent mental health services; community health services; mental health services for older people; and mental health services for veterans. This will create a fully integrated mental health service for the southern community with a single director and ensure continuity of care across services.

Work has also commenced on the development of an adult statewide neurosurgical service. The Southern Adelaide Health Service and the Central Northern Adelaide Health Service are working together to develop this clinical network. This service will operate between the Royal Adelaide and Flinders and will ensure that both hospitals maintain adequate neurosurgical services to meet requirements for emergency surgery provision, elective surgery provision and medical staff training. It is anticipated that this service will be in place by 1 July 2005.

As identified in the budget papers at page 7.47, during 2005-06 we will be progressing the development of the

following networks: maternity, anaesthesia, emergency services, cardiology, retrieval and trauma, and neurosurgical. These networks continue our reform process as we work towards establishing more cooperative approaches across multiple sites to provide consistency, efficiencies and, most importantly, improved accessibility.

The Hon. DEAN BROWN: During that very long answer which has been going for half an hour, I took the opportunity to look at the bulletins. In some ways, I have appreciated this opportunity to go through the bulletins and make a comparison with previous figures. I understand why the bulletin was sat on and withheld in the hope that it would be buried beneath other publicity, because if we look at the percentage of patients who have received surgery in accordance with the national standards of urgent, semi-urgent and non-urgent surgery, these are the worst percentages ever recorded in South Australia.

During the life of this government, in terms of meeting the national standard for urgent surgery, South Australia has dropped from 89.9 per cent to 76 per cent; for semi-urgent surgery, it has dropped from 89.8 per cent to 70.2 per cent; and for non-urgent surgery, it has dropped from 95.2 per cent to 89.6 per cent. Those are the worst figures ever recorded. I have bulletins going back well into the 1990s, and these appear to be the worst figures ever recorded in South Australia in terms of meeting the national standards.

Equally, if we look at the average or medium waiting period for urgent, semi-urgent and non-urgent surgery, we will see that they are also the worst waits ever recorded in South Australia. In some cases they are equal worst, but never, in all three categories, have there been such long waits. In fact, during the life of this government the average wait for urgent surgery has gone from 10 days to 13 days (that is the average, so we know that there will be others that are well beyond that), which is a 30 per cent increase in waits; for semi-urgent surgery it has gone from 38 days to 55 days, which is a 44 per cent average increase in waits; and for non-urgent surgery it has gone from 54 days to 77 days, which is a 43 per cent average increase in waits.

How the minister could put out a press release stating that things have improved when, in fact, these are the worst figures ever recorded in South Australia is beyond my comprehension. The figures are there for anyone to look at and, therefore, I ask the minister: why did she not acknowledge in her press release that these are the worst performing figures in terms of medium waits for surgery ever recorded in this state and, equally, the biggest deterioration in figures with respect to meeting the national standards for surgery ever recorded in this state?

The Hon. L. STEVENS: I will make a few brief comments and then hand over to Tom Stubbs, the Executive Director of Health System Management, to address some of the details. The government knows that there is always work to be done to improve all parts of the health system. I made these points before, but I will repeat them briefly now. In terms of a comparison between the deputy leader's time as health minister and mine, the overarching comparison is of course that he reduced the amount of elective surgery every year that he was minister. We have reversed that downward trend and we are increasing the amount of surgery that is being performed year on year. There is no backing away from that fact. The deputy leader does not like to acknowledge that, but that is exactly what happened over his time as minister. Perhaps if he had not let things go down so much in each year of his time in office, we would not have had to start at the point at which we did and be faced with a nurse crisis at the same time back in 2002. The government acknowledges that there is always work to do to improve elective surgery and the flowthrough of work, but we have made considerable improvements and we will continue to work on it. I will now hand over to Dr Tom Stubbs.

Dr STUBBS: One of the unfortunate things about the elective surgery bulletin is that it comes out about three months in arrears, so I will be able to give the member for Finniss the more up-to-date figures for people on the waiting list from December through to April. In December we embarked on a four-year elective surgery strategy. That strategy was aimed at investing not simply in procedures but also in things to improve the system on the basis that we felt that putting more money into a system that was not performing optimally was probably not a good use of money. In particular, I would like to point out that we involved the surgeons.

Management of elective surgery generally has been a bit of a neverland for surgeons, because they carry out the procedures but they do not understand the background in terms of the lists, so we felt that things were not optimally managed. We therefore invested in a system called checklist, a computer system which enables surgeons to properly manage their lists and to improve performance greatly. We were worried that if we brought in a computer system without the surgical involvement it would become something of a white elephant. So, we can now show surgeons who is on whose list and the manner in which that can be reduced, as well as resourcing measures such as theatres and how they can best be used.

The improvements have been quite dramatic since that time. At the end of December 11 399 people were on the waiting list, and that has improved steadily. At the end of January the figure was 11 354; at the end of February it was 11 242; at the end of March it was 11 033; and at the end of April it was 10 692, which is the lowest since November 2003. Perhaps even more significantly, we have reduced the percentage of people waiting longer than three years for surgery (which has been a real problem) by 66 per cent as at the end of April. Whilst it is certainly true that we should keep on improving (for all these people on the waiting list the wait is inconvenient and, in some cases, painful), the performance has improved in almost all categories.

One of the downsides of targeting the long waits has been a slight change in the waits for those who are newly arriving on the list. However, as the minister pointed out before, we are performing a lot more surgery than previously. We have also tried to use hospitals in the best possible way. While some people would associate the Repatriation General Hospital with a particular focus on people returning from Gallipoli, Vietnam or those sorts of campaigns, it performs a function in the health system that is quite complementary to other hospitals. Whereas Flinders has a record number of emergency patients coming in, the repat is often able to complement that by performing elective surgery when Flinders is unable to do so. I think we will see a continued improvement as a result of this strategy.

Another thing we should point out is that the bulletin that comes out every three months is not a very satisfactory way of informing the public, or anyone else, about progress in elective surgery, and we plan to set up an internet site where the figures can be updated as soon as we receive the new ones. Hopefully, we will shortly be able to have available to the public an internet site showing progress in elective

surgery that we can update on a monthly basis. We have to try to make that more timely so there is not a three-month wait to see this progress.

The Hon. L. STEVENS: I also wonder whether Dr Stubbs might make some reference to the country involvement.

Dr STUBBS: Yes, we are trying to improve the use of country. Ultimately, we would like to stop the people from the country having to go through the process of getting on a metropolitan list, and have their surgery done in their local area, because the capacity in some areas such as Mount Gambier is such that they are quite able to have surgery done there, but there has been a bit of a tradition of them going onto metropolitan lists, and having to wait for vacancies in the metropolitan area. For example, there was a case of 50 abdominoplasties, which is a form of plastic surgery in the long-wait area, and we found that there was a surgeon who was prepared to do that work in the country, even though those people would have had to wait much longer in the metropolitan area. So, we now have a series of initiatives which we are trying to work through, which will hopefully result in country patients getting a much improved service.

The Hon. DEAN BROWN: I appreciate that answer, though I would ask that if there is to be a change in the way in which this is done, that we still continue to get the quarterly bulletin so that we can go back and make a fair and reasonable comparison, because I think that it is important for historic purposes to be able to make that true comparison. I also pick up the point that, yes, you can manipulate to try to shorten the waiting list marginally, which has been done, if you take to the end of the March quarter, and I appreciate those figures. It has dropped from about 11 240 to about 11 033. But, in doing that, if you blow-out the average wait for every form of surgery, and fail the national standard by a much greater percentage, I do not see that as progress. I see that as a retrograde step, particularly if we now have the longest waits for all three categories of surgery (which is what the situation is) and if we have the poorest achievement percentage for the national standard, then I think that that is a significant deterioration, and I think that that has to be taken into account as well.

The other issue that concerns me is that we are talking about 11 033 people on the waiting list, but on the figures released by the minister a couple of months ago, there are another 3 700 people waiting to get on to the waiting list—and the minister has acknowledged in the parliament that that is only for orthopaedic surgery, let alone for ear, nose and throat surgery. So, frankly, these figures do not reflect the true situation if there are another 3 700 waiting to get on to the waiting list, and they cannot get on to the waiting list, because they do not get on to the waiting list until they have seen the medical specialist. I know of cases, and I have the form from the hospital involved. One person has been asked to wait three years and eight months to see the medical specialist to get onto the waiting list. It is not uncommon to see cases of three years or more. So you can understand that we are looking here at a very small picture of a much bigger picture, and the bigger picture is even more horrifying than the rather disastrous picture that we are seeing here, particularly if you are asking 70 and 80 year olds to wait more than three years to see the specialist, then get on the waiting list, and then wait another six to twelve months to get their surgery, which means that they are waiting—

The Hon. L. STEVENS: On a point of order, sir: is this a question or is this another speech?

The Hon. DEAN BROWN: I am highlighting the point—

The Hon. L. STEVENS: Can we have the question?

The CHAIRMAN: The deputy leader has a few more minutes.

The Hon. DEAN BROWN: You can have the question, that is, can you give more information about total numbers of people waiting to get on to the waiting list? It was 3 700 for orthopaedic surgery. What is the total for all other forms of surgery as well, especially ear, nose and throat surgery, because we know that there are very long waits there to see a specialist as well as some other forms of surgery?

The Hon. L. STEVENS: First of all, we do not keep waiting lists for outpatients, neither did the deputy leader when he was minister. The whole issue of the waiting list behind the waiting list is something that the deputy leader has a run-on in the media, knowing full well that under him exactly the same situation applied. I would also like to make another point there. He mentioned the people waiting longer than three years for surgery. We have just said, that as of April 2005, the number of people waiting greater than three years for surgery in South Australia has been reduced by 66 per cent, so I do not think that that is a bad effort in terms of those long-wait patients. With the issue of the deputy leader's waiting list behind the waiting list: he has mentioned it before in terms of orthopaedic surgery, and we know full well that not everybody waiting to see an orthopaedic surgeon will eventually go on to the waiting list. That is an assumption, and that is something that the deputy leader does not acknowledge, but that is a fact.

The other thing is that there is a whole range of issues that affect our ability to do elective surgery in a more timely fashion. A number of those are part of the federal government's responsibility, and I would really appreciate it if, perhaps, just occasionally, the deputy leader might use any influence that he has with his federal colleagues to improve the work force in terms of shortages in orthopaedic specialists, other specialities, and GPs. Also, that he might use any influence he might have—I am not sure how much he has, but any that he has would be helpful—to deal with the issue of the bed blockage that we have in our public hospitals in terms of aged care beds.

I need to ask the deputy leader why on earth he and the Leader of the Opposition in South Australia supported the last Australian Health Care Agreement which saw South Australia dudded out of $75 million over five years, and that would have been a lot of extra dollars that we could have put in to doing more elective surgery. The government will continue its efforts on elective surgery, and we will continue to try to work as efficiently and effectively, cooperating with clinicians to do that work in the best way that we can. The government has already put in an additional $21 million on top of a base load of approximately $140 million every year that goes towards elective surgery. We will continue our efforts and always look to improve our systems and services over the coming months and years.

The CHAIRMAN: The time for examination of this line having expired, I declare the examination of the Department of Health completed.

Attorney-General's Department, $68 761 000
Administered Items for the Attorney-General's Department, $47 046 000

Administered Items for Police and Emergency Services, $5 306 000

Witness:

The Hon. Carmel Zollo, Minister for Emergency Services.

Membership:

The Hon. W.A. Matthew substituted for the Hon. D.C. Brown.

Departmental Advisers:

Mr V. Monterola, Chief Executive, Emergency Services Administrative Unit.

Mr T. Pearce, Finance Manager, Emergency Services Administrative Unit.

Mr R. Mathews, Fund Manager, Department of Justice.

The CHAIRMAN: I declare the proposed payments reopened for examination and open the additional payment 'Administered Items for Police and Emergency Services', $5 306 000. I refer members to Appendix C, page 2 in the Budget Statement and Portfolio Statements, Volume 1, Part 4, pages 13 to 38. Does the minister wish to make a statement?

The Hon. CARMEL ZOLLO: I will make a short opening statement. It is with great pleasure that I begin my first estimates committee as the Minister for Emergency Services by advising the committee of the additional funding approved by the government for 2005-06. Initiatives include:

- $370 000 to extend aerial bushfire firefighting capabilities, which will increase the aerial firefighting capacity of the CFS, especially for communities in the state's South-East and on the West Coast;
- $612 000 for the CFS for operational planning and preparedness, which will increase operational planning support and preparedness across the state through the provision of four additional operational planning officers;
- $303 000 to the CFS for the replacement of emergency services vehicles, which will allow the CFS to replace a number of its four wheel drive group command and group logistic vehicles;
- $327 000 to the SES for the replacement of emergency services vehicles, which will allow the SES to replace a number of its four wheel drive vehicles that are used for the provision of emergency response and recovery throughout the state; and
- $514 000 for SES workers' compensation, which will enable the SES to employ an additional 0.5 FTE staff member on an ongoing basis to coordinate occupational health and safety programs. The funding also enables the SES to purchase necessary equipment and deliver safety training programs. Following the closure of the government's workers' compensation fund in July 2004, funding also allows the SES to recognise its obligations for workers' compensation.

The Rann government is proud of South Australia's emergency services organisations, which are magnificently served by the many staff and volunteers, especially during times of need and major incidents. Indeed, the dedication and commitment of our emergency service workers has never been more obvious than during January's devastating Eyre Peninsula bushfire, and just last weekend when the town of Karoonda was hard hit by a severe thunderstorm. The government has now appointed Mr Vince Monterola (who was also the initial Chairman of the West Coast Recovery Committee) to head a high level committee to coordinate the recovery activity in the Karoonda area.

The range of incidents to which the emergency services respond is extremely varied. While fires, road crashes and storm damage are, perhaps, the most prominent of activities for our emergency services, the range of call-outs also includes sea searches and sea rescues, gas leaks, missing person searches and cliff rescues—and the list goes on. For example, throughout the 2004-05 financial year the Metropolitan Fire Service has attended a range of major incidents, including the fire at the Mitcham Shopping Centre; two incidents at the ACI glass factory; flooding at the Adelaide University; and several fires at the Wingfield dump, which required a commitment over several days to ensure that the fire was completely extinguished and to minimise environmental hazards.

It is also most appropriate that I take this opportunity to acknowledge several members of our emergency services who were recognised in the recent Queen's Birthday Honours. Awarded the Australian Fire Service Medal were station officer Gregory Howard, SAMFS; Samuel Mitchell, a volunteer firefighter with the Clare CFS brigade; and Mark Thomason, a Regional Commander with the CFS. The Emergency Services Medal was awarded to Alan Cormack, a volunteer marine rescue coordinator with the SES and Robert Klemm, a volunteer with the Laura SES unit.

On behalf of the Rann government, I would like to thank the staff and volunteers of the emergency services organisations for their valuable commitment of time and effort to our community. The salaried staff and the thousands of volunteers around the state who are members of emergency services play one of the most important safety and security roles in our community. Their high level of skill and dedication is respected throughout the state and is warmly acknowledged by the government and, I am certain, all of us here today.

The CHAIRMAN: Does the member for Bright wish to make an opening statement or simply launch straight into questions?

The Hon. W.A. MATTHEW: I will briefly say that I congratulate the minister on her first budget estimates in this place. In fact, this is my sixteenth and final estimates, and it is fitting that I lead the opposition questions on emergency services. I have just calculated that this is my seventh estimates committee in which I had been either a government minister or the opposition spokesman on emergency services. We have the case of a minister coming in and an opposition member very happily going out. I am pleased to launch into my first question.

An honourable member interjecting:

The Hon. W.A. MATTHEW: What was that? That is the nicest I will be all day. Page 4.136 relates to the budget of the Emergency Services Administration Unit. In particular, I refer to the 'Program net cost of services summary'. I note that the cost of services has increased from $9 832 000 in 2003-04 to $12 621 000 in 2005-06. By my calculations, that is an increase of 28.4 per cent in just two years. Will the minister explain to the committee the reasons for this large increase?

The Hon. CARMEL ZOLLO: The net cost of services shows the cost of SES and ESAU, excluding the contribution from the Community Emergency Services Fund. The increase of $922 000 from 2003-04 actual to the 2004-05 budget is due mainly to the enterprise bargaining increases of $240 000 and CPI increases of $74 000, additional funding for SES

asset management of $250 000 and SES GRN, $220 000, and under-expenditure in the 2003-04 actual result. The increase of $1.011 million from the 2004-05 budget to the 2004-05 estimated result (that is, the revised budget) is due mainly to additional funding for the transfer of workers' compensation for SES volunteers from DAIS ($872 000) and funding for a rescue vessel at Port Pirie ($250 000). The increase of $856 000 from the 2004-05 estimated result to the 2005-06 budget is due mainly to additional funding provided for enterprise bargaining and CPI increases, the lease of the SES vehicles from Fleet South Australia ($327 000), and funding to the SES for management of the call and dispatch centre ($400 000). The 2005-06 budget also includes reductions in relation to the once-off funding for the SES Port Pirie rescue vessel, past cost recovery of Microsoft access licences to be managed by DAIS on a cost neutral basis, and the reversal of Justice Business Reform Unit savings and efficiency savings in relation to operating costs.

The Hon. W.A. MATTHEW: I have a supplementary question. The initial part of the minister's answer to my question indicated that a proportion in relation to enterprise bargaining increases is a little larger than I thought. Can the minister say how many full-time equivalents there are in ESAU now versus 2003-04 and how many of those are earning in excess of $100 000 per annum?

The Hon. CARMEL ZOLLO: There has been no increase in that period.

The Hon. W.A. MATTHEW: And there are how many staff?

The Hon. CARMEL ZOLLO: In the last financial year, seven ESAU staff earned more than $100 000. We need to remember that this is comprised of four SES and three ESAU staff. We are, of course, looking at both the ESAU and SES budgets. Two SES staff are due for retirement and superannuation pay-out.

The Hon. W.A. MATTHEW: The first part of my question was: how many staff overall are there in ESAU?

The Hon. CARMEL ZOLLO: There is a total of 152 staff, which includes 32 SES staff.

The Hon. W.A. MATTHEW: It has been a growing organisation. My next question relates to supplies and services, and I refer to page 4.138. I note from that the allocation for ESAU for supplies and services increased from $7.5 million in 2003-04 to $10.3 million in 2005-06, an increase of more than 37 per cent in two years. Can the minister explain why that has occurred?

The Hon. CARMEL ZOLLO: I ask Mr Pearce to explain that to the committee.

Mr PEARCE: Basically, all the items the minister read out previously and, in addition, in 2003-04 there was an under-spend against budget of about half a million dollars, account for the increase. The majority of those increases relate to workers' compensation transfers, the SES call receipt dispatch centre, funding for the Port Pirie vessel, the government radio network costs of $151 000, and $327 000 for motor vehicle leasing. The enterprise bargaining and CPI increases have been kept at 4 per cent or 3½ per cent, depending on the year involved, and 2 or 2½ per cent, depending on the Treasury inflation that was allowed in that particular period.

The Hon. W.A. MATTHEW: My next question relates to the fourth dot point in the highlights of 2004-05 on page 4.135, which states:

- Developed an 'all risks' approach to mitigating and treating community risk by working in partnership with the community.

That is quite a mouthful. Will the minister explain briefly to the committee this new approach and how it has been communicated to the community to encourage them to participate in the partnership?

The Hon. CARMEL ZOLLO: I invite Mr Vincent Monterola to respond to that question.

Mr MONTEROLA: This refers to the CERM (Community Emergency Risk Management) program. At the moment, it is being trialled in two ways: first, with Riverland communities, primarily through the State Emergency Service and, secondly, through some work with remote indigenous communities in two parts of the state. At this stage, the trials are proceeding, with all members of the community working through the local government in the Riverland and with the community councils in the two Aboriginal lands areas. The reference to 'all risks' relates to our extending the planning beyond the automatic response to fire (and, in some cases, flood) to work with the communities to identify all the risks that may need some form of response by a wide range of emergency services. Once the pilots have been proved, it is our intention to slowly develop the program throughout the state.

The Hon. P.L. WHITE: I refer to Budget Paper 4 Volume 1, page 4.144. Will the minister inform the committee of the progress that has occurred in upgrading the buildings occupied by the State Emergency Service?

The Hon. CARMEL ZOLLO: Since the introduction of the Emergency Services Funding Act 1998, the state government has acquired the responsibility for the ownership and control of the maintenance, replacement and management of 64 SES units throughout South Australia. As these stations were acquired for no consideration or leased on a peppercorn rental basis, they were received in their existing condition, and many of them showed signs of neglect. The majority of the buildings required substantial upgrade, repair or replacement. A number of the SES units are collocated with other emergency service agencies, sharing common training and community facilities. Previous funding levels have allowed the replacement or major upgrade of facilities for one or two units each year. This has required a significant maintenance program to extend the operational life of current facilities until funding becomes unavailable for major upgrade or replacement.

During the 2004-05 financial year, $172 000 was allocated for minor works to upgrade and maintain the existing buildings. The cooperation of local government authorities, in relation to the transfer of assets or the long-term leases on existing facilities, is very much appreciated by the SES. The funding available for the SES has now allowed for the replacement of buildings past their useful life, with a number of major projects commencing this financial year. The 2004-05 budget saw the commencement and/or completion of major building projects at the following units:

- the Tea Tree Gully unit replacement has commenced;
- the Kapunda unit replacement has commenced;
- the Clare unit replacement has commenced;
- the Mount Gambier unit refurbishment has commenced;
- the Snowtown unit has commenced;
- the Port Pirie regional headquarters have been completed; and
- the Kingston South-East unit replacement has been completed.

Mr CAICA: In her introductory statement, the minister mentioned aerial fire bombing and, indeed, the fact that the capacity to fight bushfires from the air was becoming an

important tool for the regional volunteer fire service around Australia, including our Country Fire Service. Will the minister explain to the committee what action the government has taken to increase the aerial firebombing capacity of South Australia's CFS?

The Hon. CARMEL ZOLLO: The Rann government has committed $2.4 million in extra funding over four years to increase the aerial firefighting capacity of the South Australian Country Fire Service. The 2005 state budget includes allocations of $370 000 in 2005-06; $670 000 in 2006-07; $687 000 in 2007-08; and $704 000 in 2008-09 for increased aerial firefighting capacity. This extra funding will especially be of benefit to communities in the state's South-East and West Coast regions and will provide the CFS with an ability to engage an additional aircraft as required for statewide firebombing operations. The additional aircraft will integrate with the existing fire bombing fleet and the National Aerial Firefighting Centre Fleet aircraft. This will give the Country Fire Service the ability to strategically place aircraft at locations beyond the Mount Lofty Ranges, such as the South-East and West Coast, during times of extreme bushfire risk.

In addition, the extra funding will mean that, when required, the Country Fire Service will be able to engage additional helicopters via the new State Rescue Helicopter Service contractor. The funding will allow a fixed-wing aerial observation platform to be established on days of extreme fire danger to provide the Country Fire Service with strategic intelligence on the fire areas. The additional resources being provided by this government will also allow the Country Fire Service to provide training and accreditation for volunteer aerial firefighting personnel. Aircraft are a very effective suppression tool during the early stages of a bushfire.

However, as we are often reminded, it is important to remember that aircraft alone rarely put out fires. Fire bombing aircraft are but one tool in the overall fire suppression force. At the end of the day, it is the amount of fire prevention and the preparedness of the community combined with the firefighters on the ground that dictate the impact of a major bushfire. The provision of extra aircraft should not be seen as a substitute for good planning and preparedness, and we need to emphasise that. However, negotiations are under way in the Lower South-East and on the West Coast to develop specific proposals for aerial fire bombing services for the next bushfire season, and I am sure that everyone in the chamber welcomes this extra funding provided by this government for aerial fire fighting capacity.

The Hon. P.L. WHITE: Will the minister inform the committee of community safety programs undertaken by the CFS?

The Hon. CARMEL ZOLLO: The two community safety programs delivered by the South Australian Country Fire Service are Community FireSafe and Bushfire Blitz. Community FireSafe commenced in 1998-99, and the program targets groups of residents living in high bushfire threat areas within the Mount Lofty Ranges. The aim of the program is to encourage self reliance, increase levels of preparedness and provide participants with the necessary skills to make independent judgments about what is necessary and appropriate in the event of a bushfire. Each Community FireSafe group meets with a CFS facilitator three to four times during the fire danger season, spending an average of nine hours learning about bushfire behaviour and personal safety strategies.

Bushfire Blitz was introduced into South Australia in 2002, primarily as an awareness-raising initiative to be delivered during high bushfire risk seasons. Bushfire Blitz provides information to residents living in high to medium-threat areas by conducting street corner meetings. The program aims to raise awareness and provide avenues for participants to increase their knowledge of bushfires and how to be better prepared if a bushfire were to occur. During the 2004-05 fire danger season, CFS Community FireSafe facilitators conducted 120 community group meetings. The program initiated 37 new Community FireSafe groups, representing 727 households. To date, 207 community groups have formed since the program's inception.

In relation to Bushfire Blitz, Bushfire Blitz project officers conducted 50 street corner meetings. Over 1 100 residents living in high to medium-threat areas attended a Bushfire Blitz meeting during the 2004-05 bushfire season. I welcome at the table Mr Euan Ferguson, the Chief Officer of the Country Fire Service.

The Hon. W.A. MATTHEW: My next question relates to volunteer numbers. I note from the budget papers that there are 2 000 registered volunteers in 66 State Emergency Service units, although I am aware that in 2002-03 the SES changed its criteria for counting volunteers so that reserve members were also counted as operational volunteers, so that number is probably inflated a bit when looking at previous years. I also note that there are 15 500 CFS volunteers. My recollection is that volunteer numbers used to be a lot higher than that.

I am conscious of the fact that emergency service volunteer organisations are having the same problem that many other service organisations in our community are having. What has been the fate of volunteer numbers over the past three years and what can be done to address the present numbers, which appear to be in decline?

The Hon. CARMEL ZOLLO: The Volunteer Management Branch of ESAU has developed a range of strategies for the recruitment and retention of CFS and SES volunteers. The major activities have been support for 81 SES units and CFS brigades with recruitment campaigns to attract local participation in emergency services, and the production of community service announcements videos for CFS and SES, which have been shown on regional television. We have seen the production of the recruitment handbook, which details the ways in which brigades and units can run recruitment campaigns with finance provided through the Volunteer Management budget.

A major focus has been on retaining volunteers in the SES and CFS and, to facilitate this, ESAU has produced an exit interview procedure. This allows us to identify the reason why volunteers have left the unit or brigade and what action can be taken in the future to reduce the turnover of volunteers. The program has concentrated on volunteers who have left in the past two years. A total of 500 volunteers have been interviewed in the past 12 months, and seven recruitment workshops have been conducted throughout South Australia for the CFS and SES.

The workshops provide volunteers with the tools to manage local recruitment campaigns. We have also established the recruitment line, which is a free call number operated by the Volunteer Management Branch of ESAU. I invite Mr Monterola to comment further.

Mr MONTEROLA: Just in relation to numbers, what has happened in both services has been a fairly rigorous review of the actual registered numbers of volunteers on the books.

In past years, people may have been a member of a CFS brigade or an SES unit and, at the time they leave, for any number of reasons, the name has not necessarily been deleted from the books. What both CFS and SES have been doing in the past two years is addressing that issue, because clearly they both wish to know how many volunteers they have at the time of a particular emergency. For that reason it appears that the numbers have been dropping over that two-year period. In actual fact—Mr Ferguson may wish to comment on behalf of the CFS—the numbers have been increasing in the past 12 to 18 months but, sadly, not necessarily in the right areas of the state for reasons that we can discuss separately.

The Hon. CARMEL ZOLLO: I ask Mr Ferguson to comment.

Additional Departmental Advisers:

Mr E. Ferguson, Chief Officer, Country Fire Service.

Mr D. Place, Chief Officer, State Emergency Service.

Mr FERGUSON: The first point is that the CFS views any movement of volunteers away from the service very seriously. In the past 12 months we have initiated an exit interview process. Prior to this current process, there was a tick the box process that was done at brigade level, but we never really knew why volunteers were leaving. There is now a process whereby an external party rings volunteers and, if they can contact them, talks them through a questionnaire to try to determine their exact reasons for leaving. It is early days yet. Obviously, our attrition rate is not large, but every six months a report will go through to the board so that we can analyse those reasons.

Perhaps I can expand on some of the volunteer recruitment issues a little further. We looked very carefully at a number of the rural strategies which are in place. We took particular note of the South Australian Farmers Federation's strategic paper on bush issues which was released about 12 months ago. Clearly, the number of volunteers in the Country Fire Service is a reflection of the general economic health and the demographics outside the built-up areas. So, we are working closely with organisations such as the LGA and the Farmers Federation.

We are also trying to anticipate the sorts of problems that ongoing drought and climate change can cause as well as changes in demographics. For example, we know that there are certain parts of the state (such as Yorke Peninsula and, in particular, coastal areas) to which the baby boomers are retiring. The impact for agencies such as the CFS, the SES and the SAS is that that increases our workload. It also increases the pool of volunteers available, but they may not necessarily be the type of volunteers that we have at the moment. We are taking on board some of these strategic changes in the community so that we can offer volunteering opportunities which meet that profile of the community. We are also looking forward to the future, to things such as energy costs. It is our view that as the cost of energy increases we may see a return to greater population in villages and rural communities which may, in turn, see an increase in the number of volunteers.

The Hon. W.A. MATTHEW: All that was very interesting, but I still have not got the figures I was after. Can some figures be provided on the volunteer numbers that we had three years ago versus those of today? I heard Mr Monterola's comments that the numbers three years ago may have been flimsy and that there has not been a rigorous auditing of those on the list; nevertheless, it would give us an indication of how many we had and how many we have.

Mr Caica interjecting:

The Hon. W.A. MATTHEW: By my reckoning, the volunteer numbers have dropped by more than 3 000 in recent years, and I am trying to confirm that.

Mr FERGUSON: I cannot give you the exact figures, but three years ago the Country Fire Service had about 16 500 volunteers and today we have about 15 500. The loss of those volunteers over those three years has not been in operational firefighters but in the brigade auxiliary and, to a lesser degree, in the brigade cadets. We know that over that three year period there has been a correction of numbers on our database. There are a number of areas in the state where they have basically cleaned up the list to take into account people who have died or moved away from the district. We believe that our current figure of about 15 500 is pretty accurate, and we know what sort of volunteers they are. There are about 11 300 active firefighters; 3 300 brigade auxiliaries; and 940 cadets.

The Hon. CARMEL ZOLLO: I will invite Mr David Place, the Chief Officer of the State Emergency Service, to come forward and talk about his volunteers.

Mr PLACE: On behalf of the State Emergency Service, I guess I reflect most of the major background issues to which Mr Ferguson referred. Our units are spread across the state, predominantly in regional areas, so the same demographic changes impact on our organisation as well. There has been a small-scale decline in our numbers in the last three years. It has been difficult to ascertain the accuracy of the database given that some members might have passed away but are still on the records.

Taking that into account and doing a rigorous analysis we would estimate that in the last year we have had a decline of about 500 to 600 volunteers in the State Emergency Service, but at the same time we have incorporated volunteer rescue organisations which, although they operate under their own right, do add to the overall numbers. I could get some detail of the exact numbers, but roughly there has been a decline in the SES of a marginal nature. We have undergone a restructure of the organisation and we are looking at focusing a lot more on recruiting and retention and the placing of the SES as a volunteer organisation of choice.

The Hon. W.A. MATTHEW: My next question relates to aerial expenditure. I note that in the 2004-05 budget papers there was a reference to an additional helicopter being purchased and the improved ability that that would provide for the state rescue helicopter service. I have looked through the budget papers, and it may be that I have missed an obscure line in the papers, but I have been unable to find any evidence of expenditure in this budget for an additional helicopter. Some $1 009 000 was allocated for 2004-05. It was outlined as a new initiative for a whole range of things, including medical retrievals and police surveillance and, within the minister's portfolio, fire fighting. Can the minister explain whether that helicopter was purchased and, if so, what were the delays in that occurring?

The Hon. CARMEL ZOLLO: I invite Mr Ferguson to speak to this matter. My understanding is that it is part of the SAPOL budget, but he will explain further.

Mr FERGUSON: I will give the member the short answer and I will then check that what I have said does cover it. The reference to the third helicopter concerns the state rescue helicopter contract, which is currently what we call a two helicopter contract. There was a recent announcement

about a new contract which involves a new contractor. The new contract allows for an expanded service and up to three helicopters, particularly at peak usage times. Traditionally, there has been a conflict regarding requests for the use of the state rescue helicopter between the Country Fire Service and the police over summer. The reference to a third helicopter is not in fact the purchase of a helicopter: it is a lease under that contract. It is yet to be announced when that new contract will commence, but we expect that it will be in the next six months. Since the announcement of the new contract detailed discussions have been taking place with the new contractor about the commencement date for that contract.

The Hon. W.A. MATTHEW: My next question relates to the MFS. I may come back to the other agencies soon, but I am conscious of the limited amount of time we have for questioning on this line. So, with the minister's indulgence, I would like to move into the MFS. I would hate for the Chief Officer to come all this way to parliament and miss out on the opportunity to advise his minister! I note that recently a company called Philmac Pty Ltd purchased land from the Metropolitan Fire Service at Deeds Road, North Plympton. That site has been under scrutiny for some time; I am aware of that. Did the minister or her predecessor authorise the sale of that property and, in doing so, was an independent valuation obtained for whomever approved it prior to the sale; and, was the property sold by auction or by tender?

Additional Departmental Adviser:

Mr G. Lupton, Chief Officer, Metropolitan Fire Service.

The Hon. CARMEL ZOLLO: I will take the opportunity to introduce to the estimates committee Mr Grant Lupton, the Chief Officer of the South Australian Metropolitan Fire Service (I can assure the committee that he is delighted to be here with us and that he did not have to travel very far). In relation to Philmac, the member is correct: the government has approved the sale of the Deeds Road site, which SAMFS currently uses as its engineering workshop facility, to Philmac Pty Ltd. We see this as a win-win situation for us. SAMFS and the award winning manufacturer Philmac Pty Ltd are both set to benefit significantly from the sale of this key parcel of land at North Plympton. The sale will enable Philmac to consolidate its South Australian operations, while funds generated by the sale will be used to help SAMFS to establish a new engineering facility at Angle Park.

Philmac approached SAMFS about the possibility of a sale after the company identified the land as its only immediate option in South Australia for consolidation. I am sure everyone would know that Philmac is a world leader in the design, manufacture and distribution of products for the plumbing industry and is a major South Australian exporter, with more than $12 million in exports last financial year. The company employs more than 260 people in South Australia and directly supplies more than 530 customers from its North Plympton distribution centre.

As I said, the purchase of the land will allow Philmac to consolidate its national distribution and call centre operations adjacent to its production facilities. The fire service has sufficient space at its Angle Park training centre to build a new engineering workshop, with the construction costs significantly offset by the proceeds of the sale. The sale was approved by cabinet prior to my becoming a cabinet minister, and an independent valuation was obtained. I invite Mr Lupton to add further to my comments if he wishes to do so.

Mr LUPTON: I think the minister has covered it well. As she mentioned, the sale was approved by cabinet. Under the authority of the previous minister, an independent market evaluation was conducted, and the sale of the property was handled by the Land Management Corporation, which acted on behalf of the Metropolitan Fire Service.

The Hon. W.A. MATTHEW: The minister indicated that the sale is a win-win situation in that it enables SAMFS to cover the cost of relocation of equipment to another site. Can the minister reveal how much was received for the sale of the property and what the cost will be, or has been, for the relocation of the SAMFS facility elsewhere, particularly as it involves a lot of heavy and expensive equipment?

The Hon. CARMEL ZOLLO: Initially I would say that it is a win-win situation because it has allowed Philmac to stay in South Australia, and I am certain that that expansion will mean that we will see more jobs in the state. The temporary relocation cost for SAMFS is $38 000, which includes minor upgrade work on the leasehold premises, that is, things like electricity and security, and the rental is $22 750 per annum.

The Hon. W.A. MATTHEW: The other question I asked was about the sale price of the facility, minister.

The Hon. CARMEL ZOLLO: It was $2 050 000.

The Hon. W.A. MATTHEW: Can I ask if that figure was paid by Philmac itself, or was it sold by private tender to a third party that then on-leased it to Philmac?

The Hon. CARMEL ZOLLO: I invite Mr Lupton to respond to that.

Mr LUPTON: An independent company bid on the property and then arranged to have a long-term lease with Philmac, so Philmac is leasing the property from the purchaser. It paid the amount referenced by the minister.

The Hon. W.A. MATTHEW: I ask the minister whether she is able to reveal the identity of that independent company, and advise how many other companies tendered for the sale of that property?

The Hon. CARMEL ZOLLO: The Land Management Corporation arranged it on our behalf, so I am not able to tell the member.

The Hon. W.A. MATTHEW: Thank you. I will continue that line of inquiry with a different minister with some interest. My next question relates to the net cost of services for the Metropolitan Fire Service, and I note from page 4.149 of the budget papers that the net cost of services increased from $69.89 million in 2003-04 to $81.5 million in 2005-06, an increase of almost 17 per cent in just two years. Can the minister say why the cost of MFS services increased by so much in such a short period of time?

The Hon. CARMEL ZOLLO: In relation to additional funding provided during 2004-05, SAMFS's estimated 2004-05 operating revenue of $78.832 million is exceeded by the original (as you have mentioned) 2004-05 operating revenue budget by $1.374 million, and is used to fund the items explained: funding for the engineering workshop transfer at Angle Park, $0.648 million; district officer and commander ranks restructuring, over $0.2 million; AMS project funding, $0.29 million; and SAFECOM set-up costs, $1.68 million.

Regarding the member's other question in relation to budget increases from 2004-05 to 2005-06, the revised 2004-05 operating revenue budget by $4.822 million is primarily to fund the following items: enterprise bargaining and CPI increases, $2.8 million; funding for new breathing apparatus

kits, $1 million; and, justice funded communications capital projects, $0.859 million.

The ACTING CHAIRMAN (Mr Koutsantonis): Before we go back to the member for Bright, our expert on the MFS, the member for Colton, would like to ask a few questions.

Mr CAICA: We do not have too many more questions but, as this one was asked, minister (and I think it is from the same line that the member for Bright referred to, and you did mention breathing apparatus), can you inform the committee of the new developments in the provision of personal safety equipment for firefighters in the South Australian Metropolitan Fire Service?

The Hon. CARMEL ZOLLO: I thank the member for Colton for his question. As I mentioned, one of the reasons for that variation was the additional capital funding of $1 million, which has been included in the 2005-06 Capital Investing Budget for this new breathing apparatus (BA) program to ensure that SAMFS has the operational capacity and meets occupational health and safety standards for the future. The three manufacturers met the SAMFS compressed air breathing apparatus specifications and submitted apparatus for evaluation. Four hundred firefighters took part in the evaluation of new BA in the metropolitan area with trials of the BA now commencing in country command, and expected to be finalised in mid-June 2005.

Evaluation trials of the telemetry systems have been finalised, with three brands being tested and a review of all appliances taking place to identify any modifications that need to occur. After completion of the country command evaluation trials, all information will be collated and will determine which manufacturer has been successful. Ongoing assistance throughout the tender process is being provided by the Asset Services Branch of the Emergency Services Administrative Unit to ensure compliance with South Australian government accounting guidelines. Completion of the project is expected by May 2006, and costs have been met from additional approved capital funding.

The Hon. W.A. MATTHEW: In answer to my previous question, the minister, if I heard her correctly, mentioned amongst the reasons for the increase in costs was an amount of $1.6 million for the set-up of SAFECOM. Did I hear that figure correctly, minister?

The Hon. CARMEL ZOLLO: $0.168 million.

The Hon. W.A. MATTHEW: That is certainly a little better. So, we are looking at $168 000. Is the minister able to tell the committee what other costs have been incurred by other parts of the emergency services sector in the establishment of SAFECOM?

The Hon. CARMEL ZOLLO: I invite Mr Vincent Monterola to respond to that.

Mr MONTEROLA: SAMFS has paid that amount of money because, clearly, the Emergency Services administration unit does not get any money directly from the community emergency services fund, so whenever we have a project—such as the development of the new commission—the money must be paid to us in a cross-charge from the three emergency services; hence, the $168 000 that came from SAMFS. Essentially, the money has been designed for a number of people who were assigned to the project and who needed to be back-filled for a little over a 12-month period. The implementation team had six people working on various elements of reviewing the recommendations that came from the Dawkins report and for doing the various tasks to get ready for this new commission, which included the drafting of the legislation. So the money was primarily used for those purposes.

The Hon. W.A. MATTHEW: Has the fund also been drawn on in any way for the recent changes to the communications and dispatch systems for emergency services? I am aware, for example, that the Metropolitan Fire Service has included expenditure through having communications and dispatch transferred back to them, and I ask where in particular the funds were drawn from for that project and what was the cost.

The Hon. CARMEL ZOLLO: I can advise the member that it has all been handled from existing operational funds of the three services with the idea, obviously, of improving the efficiency of the call and dispatch centre for our emergency services.

The Hon. W.A. MATTHEW: In a similar vein, I note that in 2005-06 the CFS intends to enhance and upgrade the CFS state coordination centre. I ask the minister what is the likely cost of this work and from where will the moneys for this work be drawn.

The Hon. CARMEL ZOLLO: I invite Mr Ferguson to come to the table at this time.

Mr FERGUSON: The need to enhance our state coordination centre has been identified over three consecutive fire seasons after debriefs. We are currently exploring a number of options, one of which includes the possibility of relocating our state coordination centre closer to the state emergency operations centre in the police building in Carrington Street. The Police Commissioner has identified some floor space in that building, and we are now investigating whether the technology and functionality of the building will meet our needs. We have had a number of meetings with senior police and have formed a project team, which met twice this week and which also met last week. That team will produce a proposal or, effectively, a business case, including costings.

So, at this time there is no specific response to your question, except that we believe that the costs will be able to be borne within our normal recurrent and capital works budget, given that we have part of our capital works budget devoted to an IT refresh program. The police have indicated that the information technology infrastructure in the police building in Carrington Street is already at the high end, so we do not believe there is going to be a significant cost in rewiring or bringing extra IT or telephone cables into the building.

The Hon. W.A. MATTHEW: While Mr Ferguson is there I will ask another CFS question. I note from page 4.164 of the estimates papers that the number of major firefighting appliances held by the CFS remains at 427—the same as last year. How many appliances are intended to be replaced during the next year, and does the CFS have any contractual arrangements in place for the provision of any new appliances? If so, with which companies?

Mr CAICA: Wayne, that was the brigades you were referring to, not the appliances; the appliances are 529. You just made a mistake with the brigades versus the appliances.

The Hon. W.A. MATTHEW: Thank you for that; I much appreciate it.

Mr CAICA: That is all right; it is an easy mistake.

The ACTING CHAIRMAN: Perhaps we will have the minister answer the questions rather than the two experts on the side—and I say 'experts' in the loosest possible definition of the term.

The Hon. CARMEL ZOLLO: I invite Mr Ferguson to respond to the member for Bright.

Mr FERGUSON: The budget for 2005-06 is in the order of $5.6 million. This includes the replacement of 14 3/4 vehicles. The 3/4 is a standard rule vehicle—a 3 000 litre four-wheel drive. Currently, we have a contract for the construction of these vehicles with Moore Engineering, Murray Bridge. Also, there are two urban pumpers, which are specifically designed for high risk in urban areas. They will be constructed at the Skilled Equipment Manufacturing plant in Ballarat. We have two 34Ps, which are 3 000 litre four wheel drive pumpers (or pumper tankers, as we sometimes call them). They will also be constructed at Skilled Engineering at Ballarat. There will be one specialist air operation support vehicle, which will be supplied to Stirling North, and one bulk water carrier will be constructed as a prototype to evaluate more effective design features. I cannot recall who is constructing that vehicle, but I do know that it is a South Australian company. From memory, it might be based in Murray Bridge. Would you like me to outline where the vehicles are destined?

The Hon. W.A. MATTHEW: Yes, please. That would be very useful.

Mr FERGUSON: Those vehicles will be going to Stirling North, Kapunda, Port Clinton, Athelstone, Roseworthy, Bordertown, Ardrossan, Karoonda, Nangwarry, Maitland, Coonawarra, Strathalbyn, Glossop, Happy Valley, Hahndorf, Burnside, Murray Bridge, Belair and Birdwood. In addition to those new vehicles, in the last three years we have changed our policy. When some vehicles get to what we call a 'mid life', they are taken from those brigades that are getting new vehicles and we do what is called a 'mid life' refurbishment. We have found not only that this is a useful way of upgrading those vehicles with new technology but also that it has the capacity to extend the life of those vehicles.

In addition to the new vehicles I have just outlined, and within that budget of $5.6 million, the plan is that there will be 21 existing appliances, and these are mainly drawn from those brigades that are getting new vehicles. They will be taken out of line, refurbished and then supplied on to other brigades. Whilst it is not a hard and fast rule, generally those refurbished appliances will go to brigades of lower activity. That is not to say that we never provide them with new vehicles, but we have found that it is a very economic and efficient way of doing it.

I should treat with some caution that figure of 21 existing appliances, because sometimes during the refurbishment process we find that rust is deeper than it looks from the surface. Sometimes we have to scrap a vehicle. About 21 vehicles are on our refurbishment program.

The Hon. CARMEL ZOLLO: In the 2004-05 financial year for emergency services we have seen 66 new emergency vehicles, 15 refurbishments to vehicles, four specialist Usar trailers and various appliances, storage kits and bull bars. I will not be so cruel as to read out every single vehicle.

The Hon. W.A. MATTHEW: I was particularly interested in the list of brigades that had vehicles, because I note that one of the brigades is Burnside. I am aware that the Burnside brigade—and it may well apply to others—has declined its new vehicle, claiming that it is inferior to its existing 25-year old appliance. I understand that the replacement vehicle, as Mr Ferguson has indicated, is an interstate-manufactured vehicle. Is the minister aware of any problems with this vehicle and whether any other brigades have similarly refused to take delivery of a new vehicle?

The Hon. CARMEL ZOLLO: I invite Mr Ferguson to respond.

Mr FERGUSON: I will compare the old Volvo to the current technology vehicle. The old Volvo was designed at a time quite different to the present which involves substantial emission requirements on vehicles. It is a sad fact that the emission technology reduces the performance of the vehicle. I am aware that the style of vehicle intended for Burnside may have a reduced performance, particularly when going up the freeway. That is an issue about which we are in dialogue with the brigade. Obviously, we must manage our budget.

However, I can advise that the brigade has set up a working party with our regional commander to look at the specific needs of this brigade. I am also aware that the brigade may have some funds that are under the control of the brigade. We need to await the outcome of that committee which has been formed to determine the best way of going. Certainly, the performance of the Volvo will be difficult to match (mainly from the emission technology point of view) because it was built in a different generation that had different requirements. The exact configuration of the cab chassis is still under discussion.

The Hon. W.A. MATTHEW: Can the minister advise the committee of the original estimated cost of each of the Elizabeth and Golden Grove fire stations, and what was the final cost of each of those stations?

The Hon. CARMEL ZOLLO: I am advised that they both delivered on budget, but I will take some further advice. The cost of the development of the Golden Grove Station was $3.75 million, excluding GST. This includes the land acquisition cost and the subdivision and earthworks costs. The total project cost of the Elizabeth Fire Station was $2.88 million, excluding GST. I will take the rest of the member's question in relation to the land cost on notice. Both those stations came in on budget and on time.advice.

The Hon. W.A. MATTHEW: Will the minister also take on notice the reasons why the cost of the Golden Grove Station was so much higher than that for the Elizabeth Fire Station? It was not so long ago that you could build an entire primary school for $3.75 million, and we have one very small fire station built for that price.

The Hon. CARMEL ZOLLO: I ask Mr Lupton to answer that question.

Mr LUPTON: First of all, land in Golden Grove is quite scarce and, as you might be aware, it is also quite hilly, whereas the Elizabeth station site is flat, down on the Parafield plains. It was also built on the existing site of the previous station. There were costs involved in moving to a temporary location while we rebuilt on the site, but the construction costs were less, first, because of the flatter site and, secondly, because it was built on property owned by the corporation.

We spent a long time searching for a suitable property in Golden Grove. As you would be aware, the site on which the station is being built has quite a slope on it. So, some considerable costs were involved in getting a level site for the station to blend it into the community. The buildings themselves were parallel; it was the site costs that made the difference.

The Hon. CARMEL ZOLLO: Obviously, the Elizabeth station was built on the existing site, so we did not have the cost of the land.

The Hon. W.A. MATTHEW: I appreciate the site difficulties being pointed out. However, my colleague the member for Newland (Hon. Dorothy Kotz), who knows that area well, has been very concerned by the siting of the Golden Grove Station, which is actually not sited at Golden

Grove but in a different suburb. Putting that aside, the appliances will need to travel regularly on Golden Grove Road towards North East Road. I understand that there is a 1.6 kilometre single-lane section on that section of Golden Grove Road, between Yatala Vale and Greenwith roads, and the verges on either side are dirt and slope verges. Can the minister advise whether consideration was given to the difficulty in getting a fire appliance along that road in peak hour, with a single lane either way and verges that are not capable of allowing vehicles to leave the road in order to let the fire appliance through?

The Hon. CARMEL ZOLLO: Obviously, the station is built right on the corner of Golden Grove Road. I ask Mr Lupton to respond further.

Mr LUPTON: As you would appreciate, the Metropolitan Fire Service appliance operators go through an extensive training program and are highly trained. Because of the nature of our response patterns, they are required to respond anywhere within the metropolitan area. As far as a change of quarters and that type of thing is concerned, when we site a station, obviously it is important that we take into consideration the response routes. We also take into consideration that it is really the training of the drivers that affects an efficient and safe response. That would have been one of the considerations, but transport routes in general can be an issue wherever stations are located. We looked at that, but it was still the best available site we could find in Golden Grove.

The Hon. W.A. MATTHEW: So, not the ideal site, but the best available site?

Mr LUPTON: That is correct.

The Hon. W.A. MATTHEW: My next question relates to Metropolitan Fire Service salaries. I note on page 4.153 of program estimates that salaries and wages have increased from $46.8 million in 2003-04 to almost $51.7 million in 2005-06, which appears to be an increase of 10½ per cent in two years. Will the minister advise why the increase has been by this amount and whether that includes coverage for the latest round of enterprise bargaining negotiations?

The Hon. CARMEL ZOLLO: The variance reflects the cost of a restructure of SAMFS officers (the commanders and district officers), as approved by cabinet in 2003-04. Additional funding was provided for 2003-04 and 2004-05, with forward budgets adjusted to cover the projected costs. We see in the 2005-06 budget $62.55 million and for 2004-05 the estimate is $60.218 million, with that variance of $2.341 million. So, it comprises a projection of salaries in line with the enterprise agreement in 2005-06, with the provision of a 4 per cent EB.

The Hon. W.A. MATTHEW: In conjunction with that answer, I ask the minister whether she is able to provide to the committee the number of staff of the Metropolitan Fire Service who, in 2003-04, earned in excess of $100 000, inclusive of overtime, and how many are expected to be in that salary bracket in 2004-05?

The Hon. CARMEL ZOLLO: I ask Mr Trevor Pearce to respond to that question.

Mr PEARCE: In relation to the year ended 30 June 2003, five employees in the Metropolitan Fire Service were in the $100 000 plus category. In the year ended June 2004, that figure had increased to 25 employees and, of those 25 employees, 18 were in the $100 000-$110 000 bracket. Essentially, it was a bracket creep through the 4 per cent enterprise bargaining. I cannot recall whether you asked for this year's figures.

The Hon. W.A. MATTHEW: Yes—if they are available.

Mr PEARCE: This year, we have done an estimate and, based on the assumption of 4 per cent enterprise bargaining, approximately 15 additional staff will most likely increase from the $95 000 category to the $100 000 category. That includes all their superannuation, fringe benefits tax and all the other employee entitlements.

The Hon. W.A. MATTHEW: Is that inclusive of those who received overtime?

Mr PEARCE: Yes; it is inclusive. The calculation is done in accordance with the Department of Treasury accounting policy statement No. 13, and it picks up the salary and the employee benefit for superannuation derived from fringe benefits tax on car parking, any vehicle allocation and housing assistance, which I do not think applies to the MFS. It is all fringe benefits, including, as I said, employer superannuation.

The Hon. W.A. MATTHEW: I may be incorrect, but it was my understanding that the Treasury Instruction was that it was the base salary of the employee with those add-ons and not the overtime component. I want to be sure that no additional staff in the MFS are in that salary bracket but would not be counted in.

The Hon. CARMEL ZOLLO: It is the gross salary or wage.

The Hon. W.A. MATTHEW: Yes—but it is inclusive of overtime they earned that year and based on the salary received, not the substantive level. That is the differentiating point.

Mr PEARCE: The numbers we have given include overtime.

The Hon. W.A. MATTHEW: I will divert my questioning to the member for Kavel.

Mr GOLDSWORTHY: I have some questions relating to the CFS. Will the minister advise what upgrades or innovation of new CFS stations are programmed for the next 12 months? If the upgrade, renovation or rebuild of the Nairne and Mount Torrens stations are not included in the proposed works for the next 12 months, where do they sit on the current priority list?

The Hon. CARMEL ZOLLO: I advise the honourable member that new CFS stations are currently to be constructed in Strathalbyn, Jamestown, Melrose, Inman Valley, Callington and Clare. All office accommodation buildings for these projects will be architecturally designed and constructed, applying a modular building system with an integrated appliance bay building attached. New office and accommodation buildings are currently being constructed at Coober Pedy and Parndana. Office and communications room additions are currently being constructed on site to existing appliance bay buildings at Kongorong and Glencoe East, and a new appliance bay is also being constructed at Haines. The CFS has also purchased an existing building within the township of Tanunda, and it will be refurbished to meet CFS operational requirements. All the projects I have mentioned are part of the CFS's rolling 18-month program for building construction and will be completed in late 2005.

In relation to the 2005-06 capital program, the CFS has allocated approximately $2.35 million towards the upgrade or replacement of 14 key CFS stations as part of the 2005-06 per capital program, including the following stations:

- Aldgate—an engineer's report has been received relating to the current station;
- Stirling;
- Birdwood;
- Roseworthy;

- Lameroo—a major upgrade, with a budget of $250 000;
- Hallett—a joint CFS-SES four-bay facility;
- Andamooka—a joint CFS-SES facility;
- Mount Gambier/Compton;
- Port Lincoln—new regional headquarters and a three-bay station; and
- Cummins—a total budget of $465 000 has been set aside.

I invite Mr Ferguson to speak to members about the Nairne station and Mount Torrens.

Mr FERGUSON: In relation to Nairne, some urgent repairs are currently under way. We did seek some additional funding this financial year and a contractor commenced work about three weeks ago. If you drive past Nairne fire station today, you will see that the front is boarded up and work is under way. We are advised that that work will be completed in the next few weeks. With respect to Mount Torrens, I have had a look five years forward, but Mount Torrens is not on our forward capital works program, and I would be interested to get further information about the expectations of the brigade.

In making the decisions about which stations go on our capital works program, we rely very much on an audit process. We have an independent person who has building qualifications who visits the station, makes an assessment as to the expected useful life and functionality of the station and a number of other features. That then gets put on our database and that is the primary method that we use to rate our various fire stations. I do not have the data with me for Mount Torrens but I will certainly check, so I will take that part of the question on notice to get back to the honourable member.

Mr GOLDSWORTHY: Just going on with that issue with Mount Torrens, the minister may not be aware of this, but I am sure that the chief officer is. The township actually had been heritage listed under the local government scheme, and a new building had been delivered on site to the Mount Torrens brigade but did not meet those requirements so was then removed. The issue is not necessarily the construction of a whole new station but the progress being made on a revised plan for that new building to meet the heritage requirements of the township.

The Hon. CARMEL ZOLLO: We will take that on notice.

Mr GOLDSWORTHY: As a supplementary question, Mr Ferguson has advised that the renovations of the Nairne station started just this week. I was actually in the township last week, in the post office, which is right next door to the station, and there was no evident work occurring then.

Mr FERGUSON: I have travelled to Brukunga, our state training centre, twice in the past 10 days, and I can assure the honourable member that the front of the station has temporary barricading on it to stop any entrance and exit of members of the public. In fact, I made a mental note that I must ask where the temporary housing of the vehicles is. But that work has commenced. We had discussions with one of the deputy group officers on the day of the Brukunga 50th and I had a delegation from the group the very next working day. That same day, I was able to sign a contract with a contractor to commence work. It is an assumption of mine that the work has been undertaken, but it certainly looks that way. The vehicles are out and there was hoarding last time I passed.

Mr Goldsworthy interjecting:

Mr FERGUSON: One of those temporary wire fences was around engine bays. The last time I passed by was Saturday afternoon, and it was there then, and that is the second time I have observed it.

Mr GOLDSWORTHY: Inside?

Mr FERGUSON: No, outside the station, and there are no vehicles inside the station.

The Hon. P.L. WHITE: I understand that the commonwealth and South Australian governments have entered into an agreement to develop Urban Search and Rescue capability in South Australia. Can the minister advise the nature of this agreement and what will be South Australia's capability in Urban Search and Rescue?

The Hon. CARMEL ZOLLO: Following a recommendation of the National Counter-Terrorism Committee, the commonwealth government has offered the states and territories $15 million in matched funds to ensure that the nation is adequately prepared for a major structural collapse, such as might arise from a terrorist attack. This capability is known as Urban Search and Rescue, or USAR. A USAR capability involves a multi-agency task force of specially trained rescuers operating as an independent unit. They use special cutting and rescue equipment to dig beneath a collapsed building. This USAR model is based on that of the United States, the world leader in USAR.

With the war on terror and the advent of highly destructive car bombs and the like, South Australia needs a greater capacity to deal with a major structural collapse, and is therefore keen to join other states and territories in developing a subterranean rescue capability. On 30 August 2004 the South Australian government allocated $1.5 million to match the commonwealth government's offer and to implement a USAR capability in this state over three years. A fully trained USAR task force is scheduled to be fully operational by July 2007 with specialised equipment and plans in place. At present South Australian has to rely on interstate capability in a major collapse. USAR is different from the normal day-to-day rescue work performed by police, fire and emergency services, which most commonly deal with surface rescues such as, for example, cars and trees crashing into houses, minor building collapses, and vehicle road crashes.

The USAR task force of some 100 personnel will be drawn from the Metropolitan Fire Service, the Country Fire Service, the State Emergency Service, the SA Ambulance Service, the Department of Health, South Australia Police, and the Department of Transport, Energy and Infrastructure. SAMFS was nominated as the lead agency by the then minister for emergency services to oversee the implementation of the task force. The MFS was given the task of managing the project's implementation.

In February 2005 a USAR training course was conducted by the University of Adelaide. This was attended by 20 civil and structural engineers from the private sector as well as from the Department of Transport and Urban Planning. In May 2005, 16 emergency service staff received advanced USAR training in Brisbane. These staff will, in turn, train other emergency personnel for the USAR task force in Adelaide when training facilities are established later this year. When South Australia develops its task force we will be able to undertake all forms of structural collapse rescues and play our part in mutual aid arrangements with other states should a major building collapse occur interstate.

Mr GOLDSWORTHY: I ask a further question about the refurbishment of the Nairne station. What is the scope of the works and what is the dollar amount being spent?

Mr FERGUSON: The dollar amount is approximately $100 000. The scope of the works relates, as I understand and recall, to repairs to the roof and replacement of the front

doors. This would include motorised doors. Unfortunately, they are not cheap.

The Hon. W.A. MATTHEW: My next question relates to page 4.163—the performance commentary in relation to the Country Fire Service. I refer particularly to the percentage of building development assessments that have been undertaken by the CFS. The minister may be aware that the CFS undertakes a large number of building assessments each year, and it aims to do those within 42 days or within legislative requirements. I note that the estimated result for 2004-05 is that only 50 per cent of inspections have been done within the required period of time. That is down from 52 per cent in the previous year and well down from the 90 per cent target for each of those years. Why has the target failed, and failed to a worse extent than in the previous year, and what is being done to improve performance in this area?

The Hon. CARMEL ZOLLO: I will make some initial comments and then invite Mr Ferguson to continue. The CFS is the relevant authority under the Development Act to provide technical advice to local government planning officers in relation to the construction of new residential and tourist accommodation in bushfire prone areas. The CFS Development Assessment Unit inspects every development application (approximately 600 per annum) forwarded by the planning authority and provides comment. It is estimated that there will be a 21 per cent increase in the total number of applications from last year. As I said, I will invite Mr Ferguson to make some further comments.

Mr FERGUSON: This is an area of business which is always difficult for us to forecast. There are quite often contentious views between the planning authority, the applicant and ourselves. In the last 12 months, I know of a very small handful of applicants who have challenged the CFS's advice to the planning authority and have in fact appealed or registered a formal complaint and put in freedom of information requests, all of which they are entitled to do but all of which take our officers away from normal processing.

We acknowledge that there have been some resourcing problems in the Bushfire Development Assessment Unit. We have recently (internally) put in additional resources. The minister announced earlier that the budget for the next financial year will include additional people for operational planning. Included in that are additional resources for administrative work in operational planning. Indeed, we are going to apply one of those positions to the Bushfire Development Assessment Unit to try to ease the workload, particularly the peak workload. This is an area where a high degree of professionalism is required.

Often when our people recommend additional costs or that buildings should not be built in an area, people want to engage us in different viewpoints. We also recognise that, following the Premier's Bushfire Summit in 2003, a large proportion of our officers' time has been spent working with Planning SA in a planning amendment report amendment, which has involved lengthy discussions with Planning SA and, more likely, lengthy consultation with local government. We understand that Planning SA will be in a position for that amendment to go before the planning minister in October this year.

Our officers also have been involved in the review of the Australian standard for construction in bushfire prone areas. The member may not be aware, but the Council of Australian Government's recently released report of the inquiry into bushfire mitigation and management drew attention to the fact that the Australian standard 3959 was, in fact, out of date. Our officers have participated in the national review of that Australian standard. So, there have been a number of other activities that have taken our officers away from their normal servicing role. However, I note that, in the last three months, there has been a significant improvement. My advice is that, in that time, only eight applications have not been able to be processed within the legislative time frame. In that time period, that represents only 4 per cent. I hope that our performance in the next 12 months will see us well within the targets that we have stipulated for 2005-06.

The Hon. W.A. MATTHEW: Mr Chairman, we are coming to the end of the designated amount of time that was allocated and I have a number of omnibus questions. I ask the minister whether anyone has read those questions into the record with respect to all her areas of responsibility?

The Hon. CARMEL ZOLLO: That is not the case, no. However, I can advise the member for Bright that I probably can respond to all of them if he wishes, other than perhaps one, because I am aware that they have been asked in other estimates committees.

The Hon. W.A. MATTHEW: It depends on how long the minister wishes to be here. I am very happy for her to take them on notice.

The Hon. CARMEL ZOLLO: We can go through them very quickly.

The Hon. W.A. MATTHEW: Did all departments and agencies reporting to the minister meet all required budget savings targets for 2003-04 and 2004-05 set for them in the 2002-03, 2003-04 and 2004-05 budgets and, if not, what specific proposed project and program cuts were not implemented?

The Hon. CARMEL ZOLLO: The emergency services agencies have met all budget cuts required in 2002-03, 2003-04 and 2004-05. In 2003-04, savings of $235 000 were identified within the CFS budget in recognition of efficiencies gained by transferring CFS's emergency reporting system (ERS) from a Telstra managed product called ERS-7 to the ALERTS system managed by ADTEC. Savings related mainly to the elimination of Telstra service fees. In 2004-05 these cuts related to EDS market price review savings of $9 000 per annum.

The Hon. W.A. MATTHEW: Will the minister provide a detailed breakdown of expenditure on consultants in 2004-05 for all departments and agencies reporting to the minister listing the name of the consultant, cost, work undertaken and method of appointment?

The Hon. CARMEL ZOLLO: I will take that question on notice.

The Hon. W.A. MATTHEW: For each department or agency reporting to the minister, how many surplus employees are there as at 30 June 2005, and for each surplus employee what is the title or classification of the employee and the total employment cost of the employee?

The Hon. CARMEL ZOLLO: Within the emergency services sector there are currently three surplus employees. The employees were previously employees of Fire Equipment Services SA (FESSA), which is part of the Department of Administrative and Information Services. All have been placed in positions in other government departments on a temporary basis. Their classifications are Operational Services Officer levels 2, 3 and 5. The total employment cost for 2004-05 is estimated at $145 000.

The Hon. W.A. MATTHEW: In the financial year 2003-04, for all departments and agencies reporting to the

minister, what underspending on projects and programs was not approved by cabinet for carryover expenditure in 2004-05?

The Hon. CARMEL ZOLLO: In 2003-04 all under-expenditure on investing projects and programs were approved by cabinet for carryover to 2004-05.

The Hon. W.A. MATTHEW: For all departments and agencies reporting to the minister, what is the estimated level of underexpenditure for 2004-05, and has cabinet already approved any carryover expenditure into 2005-06 and, if so, how much?

The Hon. CARMEL ZOLLO: For the emergency services sector all agencies are forecasting balanced operating budgets, with the exception of ESAU, which has an operating carryover of $300 000 relating to the commonwealth risk management studies program grant. This project will be completed in 2005-06 and is included in the cabinet approved budget for 2005-06. Cabinet approved carryover has been advised for each emergency service agency for the following investing (capital) totals: ESAU/SES, investing (capital) carryover of $640 000; MFS, investing (capital) of $741 000; and CFS, investing (capital) of $585 000.

The Hon. W.A. MATTHEW: The next questions relate to employees with total employment costs of $100 000 or more per employee. Some of this the minister has already answered in part. What was the total number of employees with a total employment cost of $100 000 or more per employee and, as a sub-category, the total number of employees with a total employment cost of $200 000 or more, for all departments and agencies reporting to the minister, as at 30 June 2004? In relation to the same information, I ask for an estimate to 30 June 2005.

The Hon. CARMEL ZOLLO: As reported in the Auditor-General's Report for the year ended 30 June 2004, there were 37 employees in ESAU, SES, CFS and MFS, with a total employment cost exceeding $100 000. One of these positions exceeded $200 000. The calculation of employment costs is prepared in accordance with Treasury Accounting Policy, Statement No 13, and includes the gross salary or wage, and benefits including employer superannuation contribution, fringe benefits tax, and private use of motor vehicles. The estimate for 2004-05 is that an additional 26 employees will proceed to the above $100 000 category due to bracket creep. There have not been any new positions created or abolished for employees in the range requested in 2004-05.

The Hon. W.A. MATTHEW: I thank the minister for anticipating the next question and answering it in advance. That makes my task much easier, so I can get to the last of the omnibus questions, which asks: can the minister provide a detailed breakdown for each of the forward estimate years of the specific administration measures which will lead to a reduction in operating costs in the portfolio?

The Hon. CARMEL ZOLLO: The emergency services sector is currently undergoing changes in preparation for the Fire and Emergency Services Bill. This legislation will create governance and management arrangements that will provide for more efficient and effective use of resources across the emergency services sector. Until the board is in place, specific administration measures will not be able to be provided.

Mr Chairman, could I also advise that we have a response to one of the answers in relation to Philmac—probably the only answer left outstanding. Philmac, the purchaser of the MFS, Deeds Road engineering workshop, has a 15-year lease with their nominee, Dyda Property Service Pty Ltd, and Dyda Property Management Pty Ltd.

The CHAIRMAN: That concludes the time allocated to the committee for questions on this line of the budget.

ADJOURNMENT

At 4.56 p.m. the committee adjourned until Monday 20 June at 11 a.m.