HOUSE OF ASSEMBLY

Tuesday 29 June 1999

ESTIMATES COMMITTEE B

Acting Chairman:
The Hon. G.M. Gunn

Members:
Ms F.E. Bedford
Mr M.R. De Laine
Mr M.L.J. Hamilton-Smith
Hon. G.A. Ingerson
Mrs K.A. Maywald
Ms L. Stevens

The Committee met at 11 a.m.

Department of Human Services, $1 295 206 000
Department of Human Services—Other Items, $2 650 000

Witness:
The Hon. Dean Brown, Minister for Human Services.

Departmental Advisers:
Ms C. Charles, Chief Executive Officer, Department of Human Services.
Ms J. O'Callaghan, Acting Executive Director, Statewide.
Ms R. Ramsey, Executive Director, Country Division.
Dr A. van Deth, Executive Director, Metropolitan Division.
Ms V. Deegan, Director, Financial Risk Management.
Ms J. Murray, Manager, Executive Services.
Mr F. Turner, Director, Budgets.
Ms L. Rundle, Project Officer.
Ms M. Menadue, Senior Health Liaison Officer.

The ACTING CHAIRMAN: I think all members are aware of the procedures of the Committee. It is a relatively informal operation. The Chair will endeavour to ensure that everyone gets a fair go, and hopefully a great deal of goodwill will be exhibited in the Committee today.

The Minister's replies to questions should be supplied no later than 16 July. I will allow the Minister and the lead speaker for the Opposition the opportunity to make an opening address. The Chair will be flexible regarding other matters. I declare the proposed payments open for examination and refer members to page 60 of the Estimates Statement and Volume 1, Part 5 of the Portfolio Statements. Minister, do you wish to make an opening statement?

The Hon. Dean Brown: Yes, Mr Chairman. I wish to make some brief introductory remarks. It will be seen from the budget papers that, although the allocation for the Department of Human Services has increased this year, expenditure will have to be reduced next year by $46 million compared with expenditure for this year (1998-99). The reason for that is that, this year, the department was allocated funds in the budget, but it also had significant unspent reserves amounting to about $81 million, which have been spent over a two year period. In addition, there were some one-off funding amounts available which have also been spent over the past two years.

Members need to appreciate that we are talking about an increase in funding that has been allocated to the Department of Human Services, but because we were able to spend extra money this current year, 1998-99, there will have to be a reduction in the actual spending next year even though the allocation has increased. I say that so that there is not a great deal of confusion. It is wrong to claim that there has been a cut in funding, because there has not been: there has been an increase in funding.

Human Services spending for 1999-2000 is projected to fall by about 0.1 per cent, so it is virtually line-ball, principally due to the impact of one-off expenditure that has occurred previously out of those reserves. All areas of the Human Services portfolio are experiencing a very significant increase in demand. Factors contributing to this are the higher levels of poverty within the community, especially involving single parents, young single people and families with children. The other group that is expanding very quickly is the ageing group within the community. They are increasing the demand on services, particularly in the health area, but at the same time that group is growing as a significant group within the community. They are becoming a more dominant group; therefore, we see that this increase in demand is likely to occur for a number of years—in fact, clearly for the next 40 or 50 years in Australia.

Demand for hospital services has increased by about 4 per cent on a compound basis over the last couple of years. In 1998-99, the current year, about 6 500 people were admitted to a public hospital each week. Whilst that 4 per cent perhaps does not sound a great deal, it equates to an average increase of over 12 000 additional hospital admissions per year. That does not include increases for outpatient services, accident and emergency treatments. I point out to members that South Australia's hospital separation rate—and this is a very interesting fact—is 220 per 1 000 people, which is almost 12 per cent above the national average of 196.6 separations per 1 000 people in the community. We are looking at the reasons for this.

Part of that is due to the aged population, the higher proportion of aged people within our community. For the whole of Australia, the average is 12 per cent over 65 years of age, whilst here in South Australia it is 14 per cent. It is even more interesting when you get to the 80 plus group, and this is the group that really does have a higher demand on hospital services. We find that in South Australia the proportion of people aged 80 years plus is much higher than the proportion nationally, and that proportion is increasing at a faster rate.

In fact, the fastest growing age group within the community is the 80 plus age group. Good health care is allowing them to live longer. The longer they live, the more they therefore demand services, and that is good, because people are able to live longer, healthier lives. As we all know, life expectancy over the last 100 years has increased by 20 years. We are going into a phase where that life expectancy is increasing quite dramatically. Some people have estimated that there will be a further 20 year increase in life expectancy over the next 100 years. Professor Grant Sutherland, in his Australia Lecture, made that point very effectively. What all of this does is put increasing pressure and demand on the area of Human Services, whether they be health services, dental

services, home care, mental health demand, or whatever. All of those services are increasing in demand because of that.

As I said earlier, in the past two years we have spent $81 million of reserves that we had within the department in the clear belief that we felt that if we had the money we should spend it and at least try to reduce waiting lists for elective surgery. With the run down of cash reserves, the portfolio now must come back and spend the money which has been allocated within the budget for the 1999-2000 year. As I said, that means we will need to achieve savings across the portfolio of $46 million compared to the real level of expenditure in this current financial year.

Around $6 million of these savings will come from country hospitals; $30 million will come from metropolitan hospitals; and $10 million will come from other areas of the human services portfolio. It is to be understood that there is much less flexibility in the housing area because that is covered by the Commonwealth-State Housing Agreement, and therefore those moneys are tied up within that agreement within that part of the portfolio.

While total Commonwealth funding under the health care agreement has risen for 1999-2000, the increase only partially meets the cost and demand pressures and salary increases that have occurred within our hospitals. Activity at South Australia's public hospitals will be maintained at last year's budgeted levels—and that is this current year's budgeted levels. So I stress the point that we budgeted for an activity level this year and we have exceeded it because we had the extra money. Next year we are putting out to hospitals the same activity level as we have had in the original budget for this year. As detailed in the Budget Papers, this will result in about 14 000 fewer admissions for elective surgery and a significant reduction in non-admitted patient services in 1999-2000 compared with the activity levels of 1998-99, the present year.

Hospitals will need to look at their individual cost structures and overheads and not simply target patient services. Careful decisions will need to be made about where savings can be made. Overhead expenses, management practices and cost centres will now come under very close scrutiny indeed. There is room for improvement, with some hospitals performing better than others in terms of their workload, patient management and budget management. We are working with the support of the board and the senior management of those hospitals that are not performing as well to put better management teams in place and to have a greater understanding of how to better manage the demand on the hospital with the budgets that they have. That requires significant skills because you need to alter that demand throughout the year. For instance, in wintertime when the winter ills are upon us, the demand for acute hospital beds tends to rise, so you then cut back on elective surgery at that time of the year.

I have asked the department to look at some of those cost centres where there is no impact on patient care, in particular, motor vehicles, travel and use of consultants, so that we can achieve significant savings in these non-service areas. In fact, I have asked the department to cut the number of motor vehicles by 10 per cent. The department has about 2 300 vehicles. It is the biggest user of vehicles within the whole of Government, and one would expect that because it is the biggest department within Government. I believe that, in areas that do not impact on the delivery of service, it is feasible to achieve a 10 per cent reduction in motor vehicles across the department. We need to do that at any rate because the cost of the vehicles is increasing because the resale value is dropping.

The human services portfolio will continue initiatives aimed at keeping people healthy and out of hospitals. It is a major thrust that we are developing. We will continue its focus in terms of illness prevention and early intervention—because that invariably means that we are able to then deal with the health problems sooner and more effectively and with less intervention—and also to encourage people to live healthier lifestyles. Prevention is a key area with a renewed focus on health promotion, screening programs, immunisation programs, child abuse prevention and parenting programs, in addition to other programs such as quitting smoking.

A health promotion focus on children and young people is essential because improvements in health and health outlook will have a significant impact on future health needs over the next 40 to 50 years. In other words, we should tackle some of the problems such as obesity in children today. I am concerned at the alarming increase in the level of obesity: 25 per cent of all school children are now regarded as obese or overweight because they have reduced their activity levels—they are watching too much television. If we get in and tackle some of these problems today we will find we have a healthier Australian and South Australian population in the next 40 to 50 years. The chance of diseases such as diabetes will be reduced if we deal with this today.

Ms STEVENS: My first question relates to hospital funding, and I refer members to Portfolio Budget Paper 4, Volume 1, page 534. Will the Minister confirm that during the March quarter the Federal Government's strategy of allowing a rebate of 30 per cent on private health insurance premiums had no effect on the percentage of South Australians covered by health insurance and, while the decline in numbers leaving private health insurance in South Australia was halted, the results were much less than the Commonwealth expected?

The Hon. Dean Brown: This is an issue which I have talked about frequently over the past few months and which I have taken up at the health summit. What has occurred has been a dramatic drop in private health insurance in Australia. In South Australia I think the figures are that 63 per cent of South Australians were covered by private health insurance in 1983; under what was then largely Federal Labor Governments, it dropped dramatically over the next 10 years until at about the beginning of this year the figure was 30.5 per cent. The national figure was very similar. Since the introduction of the 30 per cent rebate, effectively there has been little change here in South Australia; the situation appears to have stabilised. Perhaps it is still a little early, because we are looking at the figures for only one quarter. Now that there has been a further move in the Federal budget there could be some change as a result of the new age differential that the Federal Government has introduced as we develop into subsequent quarters.

The figures here in South Australia largely reflect what has happened nationally: I think there has been a slight increase of half or 1 per cent nationally. I have already made the point that those now taking out private insurance tend to be younger people, and they are not those who are using the public hospital system. So, my projections are that, partly because of new medical technology, partly because of the ageing population and partly because of the drop-out in private insurance, the 4 per cent increase in demand that has been occurring will continue in the future. It has occurred for the past two years.

Ms STEVENS: As a supplementary question, I repeat: to this point, the 30 per cent rebate has had no effect on the percentage of South Australians covered by health insurance?

The Hon. Dean Brown: I have answered the question: it has stabilised, with a very slight increase in South Australia, but that is based only on one quarter since its introduction.

Ms STEVENS: Is the failure to increase the percentage of people with private health insurance, and therefore increase the number of people using private hospitals, the reason for a shortfall of $46 million in hospital funding this coming year that has resulted in the decision to cut patient numbers in our hospitals?

The Hon. Dean Brown: I have already explained in quite considerable detail why we have to make savings in expenditure of $46 million this coming year. It is not a cut in the appropriation or the allocation of funds. It is the fact that we have deliberately lifted the level of activity over the past two years because we had reserve funds. We have used those reserve funds and now we have to fall back to the same budgeted level of activity next year as we had for this year.

Ms STEVENS: Surely, if more people had joined up in private health insurance, we would have less demand and, therefore, the cuts would not be needed; the effect of those cuts would not be so great in our hospitals.

The Hon. Dean Brown: That depends on the people who sign up. I have made the point already. If younger people sign up, that will have only a marginal impact on the number of people coming into the hospitals. It is the aged people within the community who create the demand in the public hospital system. Someone who is 65 years of age uses the health system about four times more than the average for the rest of the population; someone who is 75 years of age uses the health system about six times more. It is summed up most effectively in looking at some figures. In the past six years in South Australia, the South Australian population has hardly changed. It has grown in that six year period by 1.5 per cent over the full six year period. In that same six year period, the number of people in South Australia in the 50 to 65 age group has grown by 14 per cent, but the use of the public hospital system by that 50 to 65 age group has grown by 37 per cent in the same period. The bubble of baby boomers is coming through. They are now getting to the crucial age of 50 plus and their demand on the public hospital system is increasing because, as they get older, they use public hospital services more.

Ms STEVENS: Given today's media report in the *Australian* of your concerns about breaking election promises and that you were reprimanded in Cabinet for speaking out against health cuts, is the funding crisis in our hospitals the result of the Premier accepting an offer from the Prime Minister of funding under the new Medicare agreement which you warned was less than the State needed and less than required to fund our hospitals?

The Hon. Dean Brown: I think you have grabbed various things and thrown them into the one bag and some of them do not relate to each other. First, the article in the *Australian* this morning related to a speech that I gave several weeks ago to the John Stuart Mill Society. I was talking amongst Liberals—people who uphold the principles of John Stuart Mill, because it was his society to whom I was talking—and I was highlighting the growing gap between the 'haves' and the 'have nots'. In particular, I was highlighting that, if you take the 200 wealthiest people within Australia, their proportion of the national wealth has doubled in the past 15 years.

I highlighted the growing differential between the salaries paid to executives and the salaries paid to people under award wages or the equivalent of award wages. I also highlighted the change that has occurred in this State. In 1991, the average income in South Australia was 92 per cent of the national average income; by 1996, that had fallen to 82 per cent. That is a very dramatic change, a 10 per cent drop, in the average income in South Australia compared with the national average. I highlighted the difference between the bigger States, particularly Sydney, New South Wales, where salaries have gone up dramatically and other parts of Australia where they have not.

In that speech I also highlighted the difference between the haves and the have-nots and between city and country where the gap has widened significantly within Australia over the past 10 years. As the honourable member has raised the issue, I point out that I said that, for much of this period for which there has been a widening gap between the haves and the have-nots, there was a Labor Government in Canberra. The point I highlighted was the need for Liberal Government policies to make sure that we narrow the gap, not widen it. As that gap widens, people fall into it because they cannot get essential services, be it health, housing, food to eat or other services such as that.

In terms of the Medicare agreement, an issue that the honourable member raised, members may recall that I was one of those Health Ministers around Australia who took a firm stand against the Federal Government by saying that we needed more money, that the money that had been allocated to the States did not adequately compensate the States for the drop in private health insurance that had occurred. My main concern in that respect, given that the honourable member has raised it, was that the Labor Ministers who signed that Medicare agreement in April 1993, I believe just prior to a Federal election, failed to ensure that in that Medicare agreement there was any adjustment for a drop in private health insurance. Hence, for five years State Governments around Australia saw a significant drop in private health insurance, a significant increase in the number of people going through the public hospital system as a result, but not one extra dollar.

I wanted to make sure that the same mistakes were not made in the next five years. The last thing I want to be accused of is being a Health Minister who failed to understand changes in health care demand that were occurring. We stood out and we got an increase in funding, but it was still less. I pointed out at the time of the signing that, although there had been a significant increase in funding, the level of funding we received was still 2 per cent less than the demand that I anticipated for 1998-99.

It is fair to say that we have largely compensated for that 2 per cent demand by putting in the reserve funds. However, now we need to go back to the same level of activity in 1999-2000 that we had in this current year (1998-99), even though I project there will be a further increase in demand within the community.

Ms STEVENS: Minister, I remind you of your comments in the House on 4 August 1998 when in relation to the Medicare agreement you said:

> . . . the offer falls far short of what the State Health Ministers asked for and I believe that it falls short of what funds we need for the operation of our public hospital system, particularly because of the crash in private health insurance and the additional demand that is therefore being placed on our public hospitals.

Minister, I think you were quite clear about the situation on 4 August 1998. The Premier signed up on that deal before the Federal election when the Prime Minister needed an agreement before he called an election. I ask my question again: is the funding crisis in our hospitals the result of the Premier accepting an offer from the Prime Minister of funding under the new Medicare agreement which you warned was less than the State needed and less than required to fund our hospitals?

The Hon. Dean Brown: The honourable member has simply repeated the point that I have just made. That point—and I will not repeat it—was that I said at the time—and I said it earlier today—that we acknowledged that the funds allocated by the Federal Government were an increase on what had been previously offered by the Federal Government—

Ms Stevens interjecting:

The Hon. Dean Brown: They fell far short of what we needed. What I said then is now coming to fruition around the whole of Australia. It has been found in every State of Australia, and I have argued that we had to have more money.

Ms STEVENS: Why didn't the Premier sign up?

The Hon. Dean Brown: Because all the State Premiers decided that they would not get any additional money. The honourable member may recall that we were already two months into the agreement period. We finally signed in August, but there had been strong negotiations since about November 1997. We ran that negotiation fairly effectively, and we got the additional money. It was not enough, and I acknowledged that at the time—and I continue to acknowledge that. It is no secret. I will send the honourable member a copy of the speech that I gave recently to the National Health Summit and what I said when I opened the AMA's conference in Canberra recently, which reinforced that message. I will continue to campaign the fact that Australia is in a very delicate position, that it needs to make sure that it has a better structure for the whole of its health care, and that more money needs to be put into the public hospital system to cope with the ageing of the population and new technology.

Ms STEVENS: It seems to me that the Prime Minister, on the basis of a new deal to increase private health insurance membership, persuaded our Premier that the money that he was offering would be enough—and our Premier fell for it and signed on. The private health insurance rebate has not brought the dividends expected, and the people of South Australia will now bear the brunt of that wrong decision by the Premier.

The Hon. Dean Brown: I do not think that the Estimates Committee is the place in which to air the honourable member's fertile imagination about what went on in the discussions between the Prime Minister and the Premiers of Australia. The Premiers made the point that the funds offered by the Federal Government, although an increase, were inadequate to meet the expected and increasing demands of the public hospital system.

That fact has been reinforced. Other State Premiers, including Premier Richard Court and Premier Kennett, have recently acknowledged it. So, this is not unique to South Australia. All the Premiers understood that the Federal Government would offer only this amount of money. So, the Federal Government now must wear the responsibility for the shortfall in funding that we predicted at the time.

Ms STEVENS: Or the Premier will have to wear the shortfall for giving in.

The Hon. Dean Brown: I cannot help but smile when I hear the honourable member's assertions about what went on during those talks. My understanding is that there was a pretty heated debate between all the State Premiers and the Prime Minister over the need for additional funding.

Ms STEVENS: I wish to pursue the details of the budget cuts. In the Minister's opening remarks, he broke down the amount of $46 million into: $6 million to be cut from country hospitals, $30 million from metropolitan hospitals, and $10 million from other areas of the portfolio. The Minister mentioned that housing is less flexible—presumably in the administration of that cut. I ask the Minister to break down further that amount of $10 million for 'other areas'.

The Hon. Dean Brown: The honourable member is jumping ahead to what is set down for discussion this afternoon, because 'other areas' includes: FACS, disabilities and ageing, etc. So that the honourable member will know when to ask this question this afternoon, I point out the following: there will be a reduction of $1.449 million in the FAYS area; there will be an increase in Aboriginal services of almost $500 000; a reduction in strategic planning and the planning part of the department of almost $600 000; a reduction of $789 000 in the financial area of the department; corporate services will be reduced by $1.896 million; the Information Management Division will be reduced by $647 000; and the Central Office of the South Australian Health Commission (which is relevant to what we are discussing at the moment) will be reduced by $2.192 million. I think that covers the situation. There is also the Metropolitan Division (outside of major hospitals) which will be reduced by $1.898 million.

Ms STEVENS: Will the Minister provide details of overruns for 1998-99 for each of the major metropolitan hospitals, and what is the total accumulated debt that is being carried by each of the major metropolitan hospitals?

The Hon. Dean Brown: I cannot provide that information yet, because we have not come to the end of the financial year. It will take some time after the end of the financial year to compile those figures. Some hospitals are within their budget whilst at the same time being over budget on activities: so, those hospitals have done more work but within budget, which is very good. Other hospitals are over budget. As I have said, we are working with those hospitals to help them to implement better management strategies and to understand where their costs lie so that they are able to deliver the same service levels at a reduced cost. That is our target.

Ms STEVENS: But the department must have some indication.

The Hon. Dean Brown: There is some indication, but I ask the honourable member to deal with these figures with some caution: the Flinders Medical Centre—$2.6 million over budget; the Lyell McEwen Health Service—$1.6 million over budget (this week, the department identified that the Lyell McEwen Health Service had overpaid its superannuation contribution—after that adjustment has been made, the department believes that it may be running close to line ball, but we have not had a chance to work through the details yet); the Queen Elizabeth Hospital—$800 000; the Repatriation General Hospital—$2.7 million; the Women's and Children's Hospital—$1.3 million; the Noarlunga Hospital—$400 000; and the Royal Adelaide Hospital—$1.7 million under budget but over in activities. That is the hospital to which I referred earlier. Some of those hospitals believe that they may bring in a better result, but those figures are a broad estimate.

Apparently the issue, which came up only yesterday, involving the Lyell McEwin Hospital overpayment on its superannuation, has been factored in, so it is likely to be about $1.6 million.

Ms STEVENS: I also asked about the total accumulated debt being carried by each of the major metropolitan hospitals. I know that some of that would have come from previous years.

The Hon. Dean Brown: I will obtain that information for the honourable member.

Mr HAMILTON-SMITH: The Daw Park Repatriation General Hospital, which is located on the border of my electorate of Waite, is a facility that provides vital care to the aged, and the Minister has spoken about that, but particularly to the veteran community. The whole of the community in my area is anxiously awaiting news as to the future of the repatriation hospital. I note that page 5.8 of the Portfolio Statements refers to negotiations between the Commonwealth and the State relating to future funding for health at that hospital. As I understand that there has been an agreement on the repatriation hospital recently, could the Minister outline the impact that might have on veterans who live in the Adelaide area?

The Hon. Dean Brown: That question is very timely, because at 10 o'clock this morning both the Federal Minister and I made a statement about the future of the repatriation hospital. You will recall that back in March we put out an options paper, option 1 being to maintain the hospital with all its present activities, while option 2 was to scale down the hospital and deal with just some specialised areas, such as rehabilitation, psychiatric services and palliative care. We have been able to announce a very good funding package for South Australia from the Federal Government's Department of Veterans Affairs.

Under that, we will be able to adopt option 1, which is to keep the repatriation hospital here in South Australia with all its services, and at the same time the vets will have the choice of going off and using private hospitals with their gold card. I met with the consultative committee for an hour this morning and told it of the outcome of the negotiations in detail, and the President of the RSL said that this is an absolute win-win situation for the vets. They have their specialist hospital there which will continue to provide the full range of services, and at the same time they have the choice to go off and use private hospitals. So the consultative committee, which covers the broad spectrum of veterans' organisations here in South Australia, was very pleased indeed. From a State perspective, it is a very good deal as well.

As we are funded for all our activity level on a casemix type basis or fee for service basis within the public hospital system, the more gold card people who use our public hospital system, the more funds we get. In the country, we have secured a special 20 per cent loading because, for procedures in the country, we pay doctors 20 per cent above the standard rate to maintain medical services in the country. In the past, as the gold card did not entitle that extra 20 per cent to the doctors, we found that they were tending to put patients in as public patients rather than using the gold card. Now the Department of Vets will pay a 20 per cent loading for procedures in the country as well. That is a really good outcome for us in the country.

Even more importantly, we have secured guaranteed funding at the present level for the repatriation general hospital for the next 21 months. So, instead of now facing any adjustment immediately from 1 July, in three days there will be no adjustment to the funding level at the repatriation hospital for 21 months. For the trigger to occur within the first two years for even a change in funding, there has to be a drop of more than one third. You may recall some articles in the newspaper expressing concern about previous references in the options paper to a 10 per cent drop. We have been able to negotiate that 10 per cent out to one third.

Even at the end of that period, if there had been a drop, during or after the fourth quarter of this year, of more than 30 per cent, any adjustment in funding would only be 50 per cent of what otherwise would have been the drop. So, you can see that we have effectively secured funding for the hospital on a guaranteed level for almost two years, and any reduction in funding will be softened, being only half of what otherwise would have occurred under casemix. In addition, there is $200 000 for the repatriation hospital for research purposes and a further $200 000 to maintain some specialist services at the hospital for veterans, such as maintaining medical records, the chapel and a chaplaincy.

I do not want to go into the full detail of it because of time, but you will see that this achieves all of what we set out to achieve at the beginning of this whole period some three or four months ago. It gave us security for the funding of the hospital, absolute security for the first 21 months, and a great deal of security for the next five years. This is an agreement that I think you will find is worth about $265 million plus inflation over the next five years, over the totality of the agreement. Very importantly for the repatriation hospital, it gives it certainty about where it is heading.

Under this agreement, anyone with a gold card will be able to present themselves to any public hospital in South Australia; or, if they choose, they can go to a private hospital. The other important improvement under this agreement is that for the first time we have specific funding for outpatients. Whereas in the past we have not been funded on demand for outpatients, we now have funding for those outpatients. That is important because of the growth that is occurring in day surgery.

I would have to say that I am very pleased indeed. There has been a great deal of goodwill shown by the Federal Minister, Bruce Scott, and the Department of Veterans Affairs. I put down what our goal and vision should be for the vets, and they came along with that and finally agreed. I think you will find that we now have a better funding arrangement than any other State in Australia.

Mr HAMILTON-SMITH: We have heard in recent days of yet another tragedy in regard to drug abuse, with which all members of the Committee would be familiar. I refer to page 5.5 of the Portfolio Statements, particularly the provision of quality care as it pertains to drug treatment. This is an issue that has seen leadership from both sides of the House, the Government and the Opposition, but in particular from the Minister who I know has taken it as one of the priorities within his portfolio area. Can the Minister indicate how the trial he has initiated involving rapid opiate detoxification is progressing and what future it offers us in respect of tackling this terrible problem of drugs?

The Hon. Dean Brown: I acknowledge the particular interest of the member for Waite in this area as Chairman of the Select Committee on a Heroin Rehabilitation Trial. More than 12 months ago I expressed concern that I felt that we ought to be offering a greater range of treatment services here in South Australia. We have certainly been a leader in the area of methadone treatment, but I felt there was validity in

trying naltrexone, a number of people having approached me specifically about the success of naltrexone treatment overseas. As a result of that, we decided to set up a random controlled trial involving 100 heroin addicts, half of whom will go under a normal detoxification program, and the other half going under a rapid detoxification program with full anaesthetic at the Royal Adelaide Hospital.

It was designed to do it over a fairly long period. We are now able to say that, by the end of next week, all 100 people will have undergone detoxification. They are then on naltrexone for a specific period. It will be at least 12 months before we know the results of that. The member needs to understand that the first issue is to achieve effective detoxification, but then the important thing is whether we achieve effective rehabilitation of the person by using either of those methods of detoxification. I do not want to jump in and try to pre-empt those results. It will be 12 months before we know what they are. The important thing is the trial. In terms of the number of participants in the trial, by the end of next week we will have all the participants in the trial as we planned. I am sure the member will be looking as I will be at the outcome of those trials with a great deal of interest.

It is part of what is a broadening range of treatments for heroin addiction. My concern is that we have about 5 500 heroin addicts in South Australia. Only 2 000 of those are on methadone. We are trialing a number of other programs as well in South Australia. I would like to see a greater range of treatments, and I would like to ensure that we have the resources to treat everyone who has an addiction and who is willing to participate in a treatment program.

Mrs MAYWALD: In the Minister's opening statement he mentioned the reduction in real spending of $46 million, and it is also referred to on page 5.1 of the Portfolio Statements. The Minister mentioned that funding for regional hospitals will be reduced by $6 million. Will the Minister further elaborate on what impact it will have on elective surgery waiting lists?

The Hon. Dean Brown: I will take specifically country hospitals where there will be a reduction of $6 million. We have tried to work on the basis of maintaining all those hospitals as viable units. Some of our smaller country hospitals are what we call minimum funded hospitals, and we have made sure that we have maintained that level of funding for those minimum funded hospitals. Hospitals now are providing acute care, high level of dependency care for aged people such as those with dementia and, in many cases, a lower level of aged care and, in some cases, independent living and also community health services and the medical services. So a very broad range of services are now being offered by these hospitals and we are trying to ensure that this continues. For instance, there are no planned hospital closures. We gave a commitment not to close hospitals and we are sticking by that. So all those hospitals will continue and their type of service will continue.

There will be some impact in some of the larger country hospitals. We think some of these larger country hospitals, particularly where the population is declining—for example, Whyalla and Port Pirie—need to look at the overhead costs of their hospitals. They have been set up as bigger hospitals with perhaps a more formal personnel and organisational structure, yet the size of the community is decreasing and therefore we need to ensure that they more accurately reflect the size of the community. As well, some parts of the country have growing populations. We have a dichotomy within South Australia where some areas have a declining population, particularly the Upper Spencer Gulf region—Whyalla and Port Pirie—and other areas are static, such as Mount Gambier. I think the Riverland is one area that is increasing in population.

Despite the overall increase in admissions across the State, admissions in rural hospitals have been marginally reducing in recent years. This, together with the potential for further productivity improvements, will enable savings of $6 million to be achieved without a severe impact on certainly the level of health care that we are providing in country areas. We want to achieve a better outcome in Whyalla Hospital, and for some months we have been looking at some of the budget problems within that hospital. I think in the next financial year we can eliminate those inefficiencies.

Mount Gambier is another hospital where there has been over expenditure, and we are looking at where extra costs have been incurred compared with its activity levels. The Mid North area, that is, Port Pirie, is one area again where work needs to be done, particularly in the Port Pirie Hospital. Costs have been incurred at the Gawler Hospital. The Gawler Private Hospital has now closed its doors and there will be some reduction in activity in the Gawler Hospital.

The rest of the member's question relates to general waiting periods. The member has to appreciate that in a hospital there are acute services and we have to provide the service, particularly if it is accident-emergency or a crisis. However, about 17 per cent of our total admissions are what we call elective surgery. A lot of people think that it is much higher. Elective surgery is a fairly small part of our admissions. In other words, there is a choice. In terms of the waiting list for elective surgery, in July 1994, shortly after we came to Government, the waiting list was 9 364. We have progressively reduced that each year. In July 1995 it was 8 510; July 1996, 7 697; July 1997, 7 240; July 1998, 6 891; and up to March this year it had increased to 8 094, which relates to what we were talking about earlier. That is, the fact that even with the additional Federal money we were not meeting the increase in demand for hospital services, and so the waiting list has started to increase.

It is very hard to project where the waiting list will be in 12 months. As I said, we are expecting to reduce elective surgery by about 14 000 procedures. I do not know how that will impact, because it will not be just a straight adding of the 14 000 to the 8 000 at present. By the end of this current year—in other words, by the end of June this year when we have had a chance to check—we think the figure will be up to 9 000. I think that it would be wrong to add 9 000 to 14 000 and say that it will be 23 000, but I do believe that it will be somewhere between perhaps 18 000 and 25 000. Assuming the demand continues to increase and assuming that people do not start using their private health insurance or take up private insurance, I think there will be a significant increase in the waiting times for elective surgery. As I said, there will probably be a doubling of the present waiting list.

Mrs MAYWALD: I refer to the bottom of page 5.4 of the Portfolio Statements where it mentions the enterprise bargaining outcomes for nursing and medical staff. After the creation of the new super departments, including the Department of Human Services, Premier Olsen announced that his Government would provide wages parity across the public sector. Will the Minister give us details of the expected cost to the Department of Human Services to implement the Olsen Government's public sector wages parity policy?

The Hon. Dean Brown: I will have to get that figure for the honourable member. First, we have the enterprise

agreement for the nurses which we negotiated earlier and which covered just the nursing staff; that was within the ball park of what had been offered in across the board increases. Then we have the Public Service salaries, which is the issue you have now raised, and the figure is $40.3 million. So, across the department, we expect the extra cost for parity wage increases this coming year to be $40.3 million.

Mrs MAYWALD: As a supplementary question: what were the unfunded salary increases in the health portfolio for 1998-99, in other words, the salary increases which were not included in the budget and for which there is no adjustment?

The Hon. Dean Brown: A small component of the enterprise agreement with the nurses dealt particularly with whether or not they got some compensation at lunchtime in smaller hospitals where they had to stay on because of changed circumstances within the hospital. Across the system, the cost of what we call the unfunded component of the nurses' enterprise agreement is $4.4 million.

Ms STEVENS: I refer to pages 5.33 and 5.34 in relation to hospital funding cuts. In the Minister's own statement he has detailed thousands of cuts to inpatient, outpatient, outreach and A&E services. I want to focus on how this will impact on staffing and how the $36 million in cuts will affect those services. My calculations show that, if there is a $36 million cut to hospitals in metropolitan and country areas, and if we agree that about 70 per cent of hospital budgeting is in staff, then 70 per cent of the $36 million is about $25 million. Will the Minister give us an idea of just how many staff positions are likely to be lost in delivering those cuts in services?

The Hon. Dean Brown: First, I will outline where the increase in activity has been; in other words, we need to look at the activity pressures. I will give some examples of activity pressures, inpatient services that were experienced in the first six months of this financial year, just finishing, that is, from July to December 1998. During that period, intensive care activity grew by about 7 per cent above the funded base workload, acute activity increased by 7 per cent, rehabilitation activity increased by 4 per cent and mental health activity increased by 7 per cent. These activity types are varied but, converted to a common factor, they show an increase of about 14 000 admissions in the past year. Given that we handle about 300 000 admissions, you can see that it is a 4 per cent to 4.5 per cent increase in admissions.

We have various categories of general admission, and the following are the figures to the end of March. First, in Category 1, which involves the more urgent cases requiring admission within 30 days, 88.5 per cent of admissions were dealt with in that period, and in fact 92.6 per cent were dealt with within the extra seven days. These are emergency or more urgent elective surgery cases. In Category 2, about 83 per cent of patients are being admitted within the 90 day period nominated under the national standard, and with an additional seven days it is 86.3 per cent admission. In Category 3, where there is no immediate time pressure and no time is specified within which they should be dealt with, such as for hip replacements and cataract surgery, 97.5 per cent of patients are treated within 12 months.

Ms STEVENS: What about job losses?

The Hon. Dean Brown: I thought that was relevant, because you asked a question about the demand and activity level. There are 23 600 full-time equivalent employees in the portfolio, and 21 900 full-time equivalents are employed in health positions predominantly in health units, in other words, in hospitals or community health centres. Employment has been relatively static over the past 12 months; there has been some increase in employment in country hospitals and in some of the city hospitals. At this stage I cannot give specific details of what changes will have to occur as a result of this budget because, first, we have given the hospitals indicative budgets only at this stage; we expect to give them final budgets in July. They are working through the impact of that on those hospitals and they have not come back to us yet—and you would not expect them to.

Ms STEVENS: That is incredible.

The Hon. Dean Brown: It is nothing incredible.

Ms STEVENS: It is incredible. You budgeted a $36 million cut: you do not know how it is going to impact.

The ACTING CHAIRMAN: The honourable member must let the Minister answer and then she will have her chance.

The Hon. Dean Brown: We have highlighted areas, for instance, in administration, where I believe we ought to try to make the savings. You are right that about 70 per cent of our costs are in staffing. However, we see the possibility of achieving improvements in other areas such as drugs, theatre costs and so on. We have been negotiating with doctors for fee-for-service in country areas and we have taken a very hard line in negotiating so that we do not have unexpected increases in costs. If anything, we are trying to keep our increases in service costs, particularly the motel type costs, below the cost of inflation or actually reduced, and in some areas we have been able to achieve significant savings.

I stress the point that we must wait for the individual hospitals to come back, and we will work on that probably over the next month or so. We are putting management teams into some country hospitals to help them better relate their activity levels to their budgets and to have better financial control, and the Repatriation General Hospital is an example of this. Until those reports are finished as an ongoing exercise with the people who have been put in there, we will not know the impact on staffing levels. You would be wrong to try to jump to any conclusion; and I would say it would be very mischievous of anyone to try to jump to conclusions.

Ms STEVENS: Just like it was mischievous in relation to the Queen Elizabeth Hospital's maternity services, which ended up being the case. I want to return to the issue of staffing. A total of $36 million is cut; 70 per cent of the funding of hospitals, as the Minister acknowledges, is tied up in staffing resources. In the salary ranges between $50 000 and $70 000 *per annum*, I calculate that about $25 million spent on staffing means that we will be looking at staff cuts in our hospital sector of up to 500 jobs this year. I am astounded that the Minister has a cut of $36 million, and he acknowledges 70 per cent of that will be staffing costs, yet he has not thought about how much this will be and how this will impact. Has the Minister made any provision in this budget for TVSPs to deal with staffing reductions that will occur as a result of these cuts?

The Hon. Dean Brown: The honourable member needs to appreciate—and I think if she gave more thought to it she would realise—that the biggest area of demand in terms of staff is nursing—and I think the honourable member would agree with that. It varies from hospital to hospital, but quite a few of the hospitals work on engaging the last 20 per cent of their staff requirements through employment agencies on a day service basis, so that they are not employees within the department. Therefore, TVSPs would not be relevant to those people. Clearly, if you are going to reduce the level of staffing, I see that it would be across a range of different

areas—some of it nursing; some of it may be doctors; it may be a reduction in visiting specialists; it may be a reduction in administrators and financial controllers, and so on. If you put all those together, the biggest single area will be in the area of nursing, but I believe that most of the impact of that will be in the engagement of nurses from employment agencies. Within our department we have about 9 000 staff engaged from employment agencies. The member mentioned a figure of 500: that 500 is a portion of the 9 000 that we have. It is a very small portion of just the temporary staff brought in through nursing agencies.

Ms STEVENS: What about doctors, technicians, administrators and other areas?

The Hon. Dean Brown: They are being worked through by the hospitals over the next month or so.

Ms STEVENS: In terms of cuts to activity in hospitals, will there be any areas of activity that are quarantined—in particular, I ask that question in relation to mental health services—or will we see a reduction in casualty, inpatient and outpatient services in mental health as well?

The Hon. Dean Brown: Mental health has been absolutely quarantined, as it has been ever since this Liberal Government has been in office. In fact, I can give the honourable member the figures for the change in mental health services. I gave some figures last year, and I will make sure that we get those so that the honourable member can have them shortly. I can assure the honourable member that we have quarantined mental health from any cut or reduction in services. In fact, we have put additional money into mental health.

The honourable member will recall that last year I announced an ongoing $5 million, which had been there as a one-off previously. I committed that $5 million to be ongoing. On top of that, I committed another $3 million a year. As a result of that, over four years I have committed an extra $33 million, approximately. I have recently announced where that additional $3 million will be spent. In fact, it came out to about $3.4 million. It will be spent primarily in areas such as rural mental health services and engaging more staff in that area, and adolescent services, particularly for those at risk from suicide. I urge the honourable member to look at the press statement that I made for the other detail of that. That shows that we are increasing the funding for mental health this coming year.

In fact, the priority areas are Aboriginal mental health, an extra $250 000, plus another $200 000 for another program in the city; youth suicide, $540 000; $1.2 million for high demand areas of community mental health services, such as crisis services, community forensic mental health, and accommodation support and respite; $550 000 will be directed to adult rural and remote health services, including putting extra people into those areas; and $362 000 will be spent on mental health prevention and promotion projects.

Mr HAMILTON-SMITH: I would like to return to the issue of funding for the war on drugs and the treatment of people with drugs of addiction. I refer to page 5.5 of the Portfolio Statements and the aim to safeguard the health and wellbeing of all South Australians. Will the Minister please explain what the department is doing to address what I understand is the growing problem across South Australia of misuse of prescription drugs?

The Hon. Dean Brown: This is becoming a big issue and, whilst all the attention of the community tends to be directed towards illicit drugs, such as heroin and marijuana, as a community we should be aware of what are some very dramatic changes occurring in the use and, perhaps, misuse of prescription drugs. There is a growing problem in this area across the whole of Australia, but let me give figures for South Australia. There are now 10 000 people in South Australia, that is, more people than with heroin addiction (about 5 500 with heroin addiction) on drugs of dependency. A total of 2 000 of those people are on the methadone program, the rehabilitation program for heroin addiction about which I talked earlier; 3 000 are receiving opioids for malignancies and pain syndromes; and 5 000 children—and this is the part that concerns me—are receiving amphetamines for the treatment of attention deficit disorders.

If you break down that list of 5 000 children receiving amphetamines, in 1991 there were 60 children on amphetamines for ADD; and as at May 1999, there were 5 000. That is an alarming increase and accounts for approximately 2.3 per cent of children in South Australia between the ages of five and 18. The Medical Board of South Australia and the National Health and Medical Research Council have developed reports and guidelines to start dealing with this rapid rise in diagnosis and the use of these prescription drugs.

The general view is that, previously, ADD had been under-diagnosed. Sometimes, there was pressure on prescribers to diagnose this condition and prescribe these drugs. Unnecessary prescribing and drug use results in unacceptable risks of abuse as well as side effects and diversion of amphetamines to the illicit trade. Of course, there was an example very recently where a doctor was stood down from practising by the medical board as a result of excessive use of prescribed drugs. A number of other cases are about to come before the appropriate tribunal in those terms.

There has been some concern in relation to some doctors over-prescribing and abusing prescription drugs, particularly those where there is an addiction. Clearly, it is an area that we need to look at very carefully and monitor. I am sure that the member for Bragg as a pharmacist would understand the ramifications of that; but I just draw the Committee's attention to the alarming figure that shows that escalation.

The number of drugs of dependency prescriptions forwarded to the Drugs and Poisons Section of the Environmental Health Branch increased from 7 000 per month in 1992 to 18 000 per month in October 1998. Therefore, in six years there was a 150 per cent increase. That highlights the alarming situation that is occurring.

Mr HAMILTON-SMITH: I refer to hepatitis C and to page 5.5 of the Portfolio Statements where the stated aim is 'to. . . safeguard the health and wellbeing of South Australians'. Will the Minister give an indication of the incidence of hepatitis C and what action this budget proposes in relation to it?

The Hon. Dean Brown: A lot of attention has been given to HIV-AIDS and, of course, there has been a very public profile and campaign in that area. Less attention has been given to hepatitis C, which is also a blood-borne virus of increasing significance. Since testing first became available in the early 1990s, a large number of people were diagnosed each year. From 1993 to 1998 hepatitis C antibodies were identified in 7 920 individuals in South Australia. For the period January to September 1998, 452 men and 282 women, totalling 734 people, were identified as being hepatitis C antibody positive. Of these 734 cases, 535 people had their first positive test during 1998; of these, 45 are consistent with being new cases.

In the third quarter of 1998 there was medical notification of hepatitis C antibody tests regarding 379 individuals. Some 19 incident cases were identified during this quarter.

Amongst the women the most common age group is 20 to 24 years, and six males under 20 years of age were identified with hepatitis C. Some 53 400 tests for hepatitis C were performed in laboratories in 1998.

My concern is that hepatitis C is a disease that in most cases stays with people for their life. The costs of treatment are very high. The health impact on individuals is potentially very severe, and it becomes even more severe the older they are. Although the number of new cases of hepatitis C each year in South Australia is relatively static and slightly declining, all this becomes cumulative. So, the total number of people with hepatitis C is on the increase, and that is quite alarming. It is one of the high costs of drug use within the community; it is one of the most prevalent areas. Whilst we have largely controlled the transmission of HIV-AIDS in drug users, hepatitis C is still a significant problem in that area.

The Hon. G.A. INGERSON: The Minister has already touched briefly on some activity level increases and the effect of being required to stay within budgets. In giving a more detailed explanation of that, could the Minister also explain how important it is to continue the development of our clinical service plans?

The Hon. Dean Brown: Before I answer that question, let me say that the member for Elizabeth's question about the number of temporary staff engaged through agencies was misunderstood. I used the figure of 20 per cent, and the department thinks that figure is about right. The 9 000 figure is probably not right. The question was misunderstood. Departmental officers are trying to get the correct figure. I believe that the figure is generally around 20 per cent, but it does vary from hospital to hospital. I ask that the 9 000 figure not be used. We will try to get a figure for the Committee today. As I said, I know that some hospitals are running at around 20 per cent.

In terms of the clinical services planning reviews, this process was started in 1997 when it was set out how the clinical reviews would be done. The work was started in 1998. A number of those have already been well advanced, obstetrics being one. We are looking at 19 different areas of clinical reviews. They are all staggered, because you would not want to try to do them all at once. The first four were obstetrics, cancer, renal and cardiac. The ones to be done this year include emergency services, intensive care and rehabilitation.

First, it breaks out of the thinking that individual hospitals in the metropolitan area work on a stand-alone basis. That has been one of the big problems of the public health system not just here in South Australia but in other States. For the first time we are saying, 'There needs to be planning as to what specialist services are provided at which hospitals, and there needs to be a vision about where the demand and those specialist services will be in 10 to 20 years.' This does not mean that the people in, say, the western suburbs who have a cancer or something such as that will not be able to get services at the Queen Elizabeth Hospital, because the vast majority of our large hospitals in the metropolitan area provide a comprehensive range of services. What it does mean is that, at the very high end of the spectrum where you need to be able to match dedicated teams of specialists with sophisticated equipment and technology, that will be available in a number of specialist hospitals. These clinical reviews are designed to identify where the demand is based on population, age profile and socioeconomic status, etc. We will look at where the demand is likely to be and where to place these specialist services.

As the honourable member knows, it was determined that there should be three obstetrics specialist centres: one at the Lyell McEwen Hospital to cover the north where births are on the increase; one at the Women's and Children's Hospital to cover the broad State and country areas; and the third at the Flinders Medical Centre to cover the south. This does not mean that only those hospitals will have obstetric services—I have already indicated that all major hospitals will provide prenatal and postnatal services.

The member for Elizabeth earlier referred to the fact that, two months ago, I announced that the department would look at the possibility of providing ongoing obstetrics services for women with a lower level of risk at the Queen Elizabeth Hospital, the Modbury Hospital and the Noarlunga Hospital. I can say that the preliminary results of that study indicate that it will be feasible to maintain level 1 obstetrics at the Queen Elizabeth Hospital and, we believe, at Modbury. We are still doing some work on Modbury, and I do not want to pre-empt that, but we expect to have level 1 obstetrics or perhaps higher at Modbury.

We also expect to provide prenatal and postnatal services and to set up a network of specialists across these hospitals. For instance, at the Queen Elizabeth Hospital we will increase midwifery capability and services for lower risk births. However, where higher risk is involved, people will be directed to one of the three specialist hospitals.

Over and above that, there will be a network of obstetrics specialists in the other hospitals to provide a back-up service if an emergency arises—of course, some of these hospitals are situated only 10 minutes apart. So, I think it is fair to say that we will provide these areas of specialisation and, equally, we will be able to maintain a broad community service throughout all our hospitals.

The Hon. G.A. INGERSON: What direction is the department taking in respect of competitive tendering and contracting out, and what initiatives are likely to be undertaken regarding the reduction of hospital costs? Although I do not have any specific monetary interest in this area, I suggest that the outsourcing of pharmaceuticals and pharmaceutical services could bring about significant savings to the Government.

The Hon. Dean Brown: The department believes that it is achieving $5 million worth of savings each year in recurrent expenditure as a result of outsourcing. This varies from hospital to hospital. The Royal Adelaide Hospital has contracted out cleaning, grounds maintenance, security and orderly services. The North West Adelaide Health Service (that is, the Queen Elizabeth Hospital and the Lyell McEwen Hospital) has contracted out security, engineering and building services and catering services.

The Flinders Medical Centre has contracted out non-ward cleaning, catering, security, grounds maintenance, and warehousing and distribution. The Women's and Children's Hospital has contracted out cleaning and orderly services. The Repatriation Hospital has contracted out engineering and building maintenance and security services. Modbury Hospital has contracted out engineering and building, biomedical engineering and grounds maintenance services. Of course, the whole of the medical and health treatment at Modbury is being contracted out to Healthscope.

The South Australian Dental Service has contracted out cleaning and grounds maintenance. The South-East Regional Health Service has contracted out engineering, building maintenance and management services (particularly at Mount Gambier). The Northern and Far Western Regional Health

Service has contracted out engineering, building maintenance and management services. That will give the honourable member some idea of this comprehensive program. Where it is found to be of benefit to continue to do this, we will. We will continue to offer a TVSP or redeployment of public employees involved. That answers the point raised earlier by the member for Elizabeth.

This is an effective way of making sure that, where we need to make savings, those savings are achieved without reducing the provision of health care. There are also some budget issues involved. One matter that I have raised with Treasury officials is that enterprise agreements are adjusted when people are employed within government. For instance, if there is an increase in salary for Government employees, we get the salary adjustment (within limits). However, where services are contracted out, we do not get those same adjustments.

So, whilst there is a benefit in terms of contracting out to achieve a reduction in costs, ongoing funding tends to be penalised. That problem must be tackled. This probably occurs across the whole of Government, but it occurs particularly within the Department of Human Services, because it then does not receive the 3 per cent EB adjustment for contracted out services. What it is likely to receive is only an adjustment for inflation or 1 per cent off inflation, which amounts to .5 per cent. That puts real pressure on maintaining those services. The only way that we can do that is by continuing to gain efficiencies through those contracted out services.

There is a problem with this in other parts of the portfolio other than health. Apart from the contracting out within the hospital system, to which I have just referred, the department puts $145 million a year worth of services out to other non-government organisations, much of it in the family and community services area. Those services are put out to about 450 organisations, but again no adjustment is made for that, apart from the 1 per cent off inflation for which the forward estimates provide.

This puts real pressure on those organisations. It is fine to do this for one year but, if you do it year after year on a compound basis, you are reducing your real expenditure in those areas. This is an issue which both the Federal Government and State Governments (particularly South Australia) need to address, because you cannot expect outside organisations, which are being starved of funds, to deliver the same services. Something must give.

The Hon. G.A. INGERSON: I think the contracting out of pharmaceutical services would be an interesting exercise.

The Hon. Dean Brown: We are doing a number of things regarding pharmaceutical services. A trial is being conducted at the Royal Adelaide Hospital of some fancy electronic machines for the dispensing of pharmaceuticals. I launched that trial last year, and we are now assessing how successful it has been in reducing demand.

The advantage is that we are finding we get a lower level of mistakes. Where you have a machine that tells you that this patient is allowed to be given only these drugs and at this dosage level, if along comes a pharmacist and makes a mistake, the machine will tell them they have made a mistake and to go back and re-check. We are looking at not only at how we procure our pharmacy services but also the generic supplies and also the supply on an ongoing basis of materials and how we manage that. As I said, we have a trial at the Royal Adelaide Hospital at present which is now at the point of being assessed.

Mrs MAYWALD: At page 5.48 of the Human Services budget operating statement I note that the expenditure line shows an increase of only .69 per cent in 1999-2000 over the 1998-99 budget. Looking through the budget statement, I see that education will increase by only .86 per cent, and at the same time the State budget shows an increase in spending of 8.9 per cent for the Department of Premier and Cabinet and an increase of more than 33 per cent for the SA Tourism Commission. Would you care to comment on the concerns I have that there appears to be I guess an interesting priority in respect of which portfolios receive budget increases?

The Hon. Dean Brown: The honourable member has obviously been scrounging through her budget papers in a great deal of detail. I can only comment on my own areas. It is inappropriate for me—and not within my jurisdiction—to comment on what has occurred in other portfolio areas. The figure quoted by the honourable member in terms of specific expenditure expected under the budget sounds about right. I think the figure she quoted was .69 per cent, which sounds about right and is in the ball park of the sorts of figures I was talking about earlier.

In terms of a .8 per cent increase for education, an 8.9 per cent increase for Premier and Cabinet and 33 per cent for the SA Tourism Commission, I cannot comment on that as it is inappropriate to do so. It is an area with demand, and it naturally concerns me that we have to be out there meeting that demand within the community. If the service requirement in the community were static, that would make life much easier, but the facts are that we have this ageing population, this new medical technology and changing circumstances that are creating increasing pressure.

One of the areas I have not touched on where we are finding this is being driven is in the southern suburbs, for instance, but it even reflects across all the metropolitan area where it is becoming increasingly difficult to access after hours GP services. Many of the large GP practices in metropolitan Adelaide are now no longer providing after hours services: they close at either 8 or 10 p.m. If someone is feeling ill at 8 or 9 p.m. and cannot get to their GP—and some close even earlier than 8 p.m.—what do they do? There is now only one locum service for the whole metropolitan area, and that service is under enormous stress.

It is difficult to get doctors who are willing to work during the night and make home visits. There was the murder several years ago of the doctor on the locum service after hours, and the expectation of doctors in terms of lifestyle has changed as well. The other thing to consider is the change in the nature of the new graduates coming into medicine. Many more are women who have families and who are therefore unable to provide the after hours services. Put all of those together, and in some areas like the southern suburbs there are quite significant problems in providing these after hours services: hence people are attending public hospitals, like the Noarlunga Hospital, where there has been quite a dramatic increase in accident and emergency presentations. The same applies to the Flinders Medical Centre.

Simply, these people who are feeling ill would normally see their GP, but they cannot, and they want treatment immediately rather than having to wait until the following day. We are looking at how to tackle that matter. That is just part of this growing demand and pressure. You have highlighted in terms of the level of expenditure the fact that there is virtually no change in expenditure this coming year compared to what was budgeted this present year, yet we have this growing demand. That is the very difficult problem,

involving how you administer health systems around Australia: how we make sure that we are dealing with those people who need more urgent treatment; how we make sure that our resources, which are limiting, are going to those who need the most rapid treatment; and how we make sure that the quality of the service that we are providing is not breaking down.

I talked earlier about the increase in the waiting lists for elective surgery and how they could blow out from the present number of approximately 8 800 to as high as 18 000 or 25 000. That concerns me, because many of those people will suffer whilst they are waiting for their surgery. It might be someone sitting in a wheelchair because their hip has collapsed, and they have little mobility; yet, if they had a hip replacement, they could get out of their wheelchair and be independent again. People requiring cataract surgery is another classic example.

As a community, we have to be very careful that we do not allow the quality of health care that people receive to deteriorate, or the quality of the health system of Australia to deteriorate, by allowing these waiting lists to blow out. So far, we have handled that fairly well in South Australia. I gave those figures earlier, and we are within almost acceptable limits, but the danger signs are there that that will blow out fairly substantially. Certainly, as Health Minister, I will be watching it very closely, but that would concern me if it did, because I believe that any further blow-out would cause an unacceptable deterioration in the quality of health care we are providing.

Ms STEVENS: Returning to the topic of budget cuts to hospitals, the Minister's own documents on pages 5.33 and 5.34 indicate that there will be a reduction of 102 800 outpatient services in metropolitan hospitals, 34 400 fewer outreach home visits in the metropolitan area, 5 200 fewer outpatient occasions in country hospitals, a reduction of 28 800 occasions in accident and emergency areas in metropolitan hospitals and, of course, the reduction of 14 000 inpatient procedures leading to the waiting list blow-out of up to 25 000 that you just mentioned. Have you considered the potential conflict for hospital staff members, as they try to implement these cuts, between your budget direction and their duty of care to patients?

The Hon. Dean Brown: The member has picked up from the very points I was just making in answer to the last question and therefore I guess has asked a question that tends to take that further. The hospital system currently undertakes quite a significant level of what we would call unfunded non-admitted patient services. We will have to review and reduce those unfunded non-admitted patient services as part of achieving our targets for the next financial year. Priority will continue to be given to emergency cases that require that emergency or urgent care. There will be a blow-out in waiting times, even in emergency departments.

I think it is fair to say that there are five categories in emergency departments. The high demand category requires treatment within a certain period. We expect the waiting times in emergency departments for priorities 4 and 5 to increase by up to four or five hours. These are priority areas that often would be treated by a GP. They are not life threatening. Let us be quite clear: we are not putting lives at risk but there is an inconvenience factor and people will have to sit around and wait at emergency departments longer. I acknowledge that, and again I think that is an area of some concern which we will have to monitor very carefully and which will certainly not come within the quality parameters that we would hope to be able to achieve within our health system.

I have dealt with emergency. The medium waiting time for an outpatient appointment will also increase. However, I stress again that urgent patients such as those with cancer will be given priority. The target for outpatient services has been decreased in the coming financial year with a slight increase for emergency occasions to be targeted. So, we expect more emergencies, and we will deal with those within the required time limits as far as possible. This recognises that the level of funding available needs to be directed to those higher priority emergency cases. However, the targets reflect that service levels in all areas of non-admitted services will need to reduce, and that is the only way we can meet our budget.

The member mentioned some figures, and in relation to that we are expecting reductions. I come back to the emergency departments. In relation to categories 4 and 5, people who would normally be seen by their GP, I mentioned that an increasing number of these people are coming into our emergency departments because they cannot access a GP service. They may have to wait up to five hours in the hospital accident emergency department instead of seeing their GP. As a result of what I see as a better solution to this, I have talked to the Federal Minister, Dr Michael Wooldridge. First, I am very critical of the number of GPs being trained. There are just not enough GPs being trained to meet the increasing demand, especially with an ageing population.

I have been calling for more doctors to be trained in our universities, especially in South Australia. I have called for more GPs to be trained, because they do their medical degree first, then they do specialist training to become a GP. Only 400 positions are allocated for the whole of Australia, of which South Australia gets only 24. I find that totally unsatisfactory. That allocation is made by the Royal Australian College of GPs. I question the authority under which it does that. I see that it has no constitutional authority within Australia to make that allocation. I believe it should be the responsibility of the Federal Minister and, if the Federal Government does it, it is about time we were allocated a per capita share. If we were allocated a per capita share, we would have approximately 34 training positions instead of 24 training positions for GPs in South Australia.

The Federal Minister has not cooperated in that area yet, but I am continuing to put the pressure on him. However, he has agreed that in the southern suburbs—in areas where we know there is a shortage of doctors, particularly for after hour services—we can take some trained doctors out of hospitals and put them into, say, the Noarlunga Health Service, the hospital at Noarlunga, or into a medical practice and give them a GP provider number for after hours services. It would be a restricted provider number. They need that provider number to be able to access the medical benefit scheme out of Canberra. What is occurring at present is that there is a significant transfer of costs from the Federal Government under the MBS scheme—that is, when people see their GP—to a cost under our hospital budget system because we are using the hospital system to try to provide GP services.

It is a misuse of the hospital system, and it is a misuse of the accident and emergency section. What is more important is to look at the structure of our health care and the number of doctors available and to ensure that it is the GPs who provide that after hours care, not the public hospital system. I will continue to lobby heavily with Canberra and campaign publicly to bring about a more realistic structure and certainly

to ensure that we do not continue to pick up cost increases on behalf the Commonwealth Government.

[Sitting suspended from 12.58 to 2 p.m.]

Membership:

Mr Scalzi substituted for Mr Hamilton-Smith.

Mr Koutsantonis substituted for Ms Bedford.

The ACTING CHAIRMAN: I understand that members wish to ask questions which I anticipate will be taken on notice, and I am happy to allow that to take place now. I would suggest that a copy be given to *Hansard*, and I will give the Minister a chance to make any comments he wishes following them. I hope we will not have to sit here for 15 or 20 minutes; the Chair has tried to be tolerant, but I will not allow this procedure to be abused.

Mr KOUTSANTONIS: In relation to all departments and agencies for which the Premier and Minister have responsibility, including relevant junior Ministers:

· List all consultancies let during 1998-99, indicating to whom—

The ACTING CHAIRMAN: Order! The honourable member can raise here matters that are the responsibility of this Minister, not another Minister.

Mr KOUTSANTONIS: In relation to all departments and agencies for which the Minister has responsibility, including relevant junior Ministers:

· List all consultancies let during 1998-99 indicating to whom the consultancy was awarded, whether tenders or expressions of interest were called for each consultancy and, if not, why not, and the terms of reference and cost of each consultancy.
· Which consultants submitted reports during 1998-99, what was the date on which each report was received by the Government, and was the report made public?
· What was the cost for the financial year 1998-99 of all services provided by EDS, including the costs of processing data, installation and/or maintenance of equipment, including the cost of any new equipment either purchased or leased through EDS, and all other payments related to the Government's contract to outsource information technology to EDS?
· During 1998-99 were there any disputes with EDS concerning the availability, level or timeliness of services provided under the whole of Government contract with EDS and, if so, what were the details and how were they resolved?
· Which of your agencies are buying new desk top computers prior to year 2000 and, if so, how many, at what cost, what is the manufacturer of the product, and what models are being purchased? What is the hardware and software that has been replaced or identified for replacement due to achieving Y2K compliance, and at what cost? Did or will these replacement purchases go to tender?
· How much did agencies within the Minister's portfolio spend in contracting the services of Internet providers during 1998-99, and which Internet providers were involved?
· Detail how many FTEs are employed by agency in 1998-99 for information technology services, and detail the figures for 1995-96, 1996-97 and 1997-98.
· What are the names and titles of all executives with salary and benefit packages exceeding an annual value of $100 000, which executives have contracts which entitle them to bonus payments and what are the details of all bonuses paid in 1998-99?
· What are the names and titles of staff who have been issued with or have access to Government credit cards, for what purpose was each of these cards issued and what was the expenditure on each card for 1998-99?
· What are the names and titles of all officers who have been issued with Government owned mobile telephones, what arrangements apply for the payment of mobile telephone accounts and what restrictions apply to the use of Government mobile telephones for private purposes?
· What was the total number and cost of separation packages finalised in 1998-99?
· What is the target number of staff separations in the 1999-2000 budget, how many TVSPs have been approved by the Commissioner for Public Employment for 1998-99 and what classifications of employee have been approved for TVSPs in 1999-2000?
· How many vehicles by classification were hired in 1998-99 and what was the cost of vehicle hire and maintenance in that year?
· List all employees with use of a privately plated car in 1998-99 and outline what conditions are attached to the use of the car by the employee.
· Did any of the Minister's agencies rent vacant and unused office space during 1998-99 and, if so, what was the cost of rent or lease of this unused office space to the taxpayer?
· Are there any Government owned premises within the Minister's portfolios that are not currently occupied, what is the cost of holding these properties and where are they located?
· Will the Minister detail all executive and staff development exercises undertaken by the Minister's agencies during 1998-99?
· Will the Minister list all occasions during 1998-99 on which executive staff of the agencies under his portfolio entertained guests at taxpayers' expense, all those present on the occasion, the purpose of the occasion and the cost to the taxpayer?
· How many staff originally from within the Minister's portfolios were on the redeployment list in 1998-99, for how long have they been on redeployment and what are their classifications?
· How many public help lines did the Minister's agencies operate during 1998-99, which were located in South Australia and which were operated from interstate; can the Committee have information about what issue(s) each help line was intended to provide and what was the cost to the taxpayer of operating each help line?
· What are the names of the public servants in your portfolio and which, if any, of your ministerial staff currently serve as Government representatives on boards of management of other bodies? What is the category of the board in question, what is the remuneration paid to these individuals for service on each board, and at what level of classification are these employees?
· Detail all interstate and overseas travel undertaken during 1998-99 by members of Government boards, their destination, purpose, cost and all individuals who travelled.
· Detail all advertising and promotional activities and campaigns undertaken by all agencies within your portfolio for 1998-99, what issue(s) were the concerns of these activities, of what did these activities consist, how

much did they cost, and what activities are planned for 1999-2000?

- Detail all local, interstate and overseas conferences attended during 1999-2000 by the Minister, his or her staff and public servants within the Minister's portfolio, including the cost, location and purpose of the conference?
- Provide the name(s) of any former members of State or Federal Parliament within the Minister's portfolio currently serving as a board member, a member of the Minister's staff or a public servant, and detail their duties and remuneration.
- Have any agencies within your portfolio 're-badged' or otherwise made presentational changes during 1998-99, through changes in letterheads or other stationery, signage, etc; what was the reason for the change?

The ACTING CHAIRMAN: Order! I point out to the honourable member that in the view of the Chair some of these questions are quite irrelevant. The honourable member has the facility to put questions on notice. I also point out to the honourable member that there will be a very considerable cost to the department in having to supply this material by the nineteenth. Other important areas of administration should not be interrupted to answer these by 16 July. I point out to the honourable member that this range of questions, going into what I would class as trivia and nonsense, does nothing for the standing of these Committees or the standing of members of Parliament in the community. I ask the honourable member to bear that in mind or I will have to rule his questions out of order.

Mr KOUTSANTONIS: As a point of order, Mr Chairman, these questions, to be taken on notice, have been asked in every other Committee. Are you saying now that you will not cooperate with the Opposition in letting us read these questions into the record?

The ACTING CHAIRMAN: If you want to take on the Chair, this Committee will come to an abrupt end. I am now saying to the honourable member—

Mr KOUTSANTONIS: What are you afraid of?

The ACTING CHAIRMAN: Order! I am not afraid of anything. The honourable member is taking up a considerable amount of time in the Committee and is reading out questions which in the view of 90 per cent of the public of South Australia are a nonsense.

Mr Koutsantonis interjecting:

The ACTING CHAIRMAN: Order! If you want to argue with the Chair, I happen to know the Standing Orders and know the procedures, and I will apply them without fear or favour and you will not be here—nor will the Committee. It may suit everyone and be in the interest of the taxpayers, too. I am saying that a better procedure would be to put those questions on the Notice Paper. I will give the honourable member another three minutes and then I will call him to order.

Mr KOUTSANTONIS: I will continue:

- Has there been any refurbishment of your ministerial office or any of your CEOs' during 1998-99, what was the reason for the refurbishment, and what was the cost?
- Since the 1997 State election, have any of your ministerial staff taken up permanent employment in the SA public sector, name the individuals concerned and indicate the vacancy for which they applied? Were these positions advertised and, if so, when and where?
- Name all of your ministerial staff and their classification and remuneration.
- Name all staff attached to junior ministers and their classification and remuneration, and advise whether they have ministerial cars with drivers, cars without drivers, or access to ministerial cars or drivers and on what basis?
- During 1998-99 what Government land or other real estate has been disposed of, where were these properties located, did the sale involve a tender process, for how much was each property sold, who purchased the property and who acted as agent and/or legal adviser to the sale?
- What are the names and titles of officers who have been given the use of laptop computers and free home Internet access?

The ACTING CHAIRMAN: The Chair tomorrow will not be as lenient in respect of this sort of matter because I do not believe it is in the spirit of the arrangements for Budget Estimates Committees.

The Hon. Dean Brown: Before we proceed with further questions, I point out that I will attempt to answer those questions and, if you like, I will take out details of how much it costs to answer those questions.

The ACTING CHAIRMAN: We would like to know that.

The Hon. Dean Brown: Before lunch I promised to get further detailed information, first, in terms of moneys for mental health in each respective year. The member for Elizabeth asked this question. In 1993-94 we spent $85.3 million; in 1995-96, $95.6 million; 1996-97, $98.6 million; 1997-98, $103.4 million; and in 1998-99, $106.2 million. There has been a substantial increase of over $20 million since this Government has been in office, an increase which comes close to about 23 per cent in expenditure. I do not have the figure for this coming year but, as I said, we have put in extra money.

The second issue relates to the member for Chaffey's questions about health budgets and interstate comparisons. The member for Elizabeth might also have asked some questions. I have the details for other States. New South Wales increased its health budget by 4.6 per cent for 1999-2000, which was a real increase of 2.3 per cent. The Victorian Department of Human Services budget for this coming year was increased 3 per cent, which was on top of what it describes as the 'historic budget boost of last year'. It put in an extra $147 million for health and welfare services, including $82.7 million extra for hospitals. Western Australia put in $153 million more this year, or a 9.3 per cent increase, compared with this current year's budget. Western Australia is about the same size as South Australia, but its increase was 9.3 per cent.

In Tasmania, the funding for health and human services increased by $44 million or 7.3 per cent for this coming year compared with 1998-99. The Tasmanian Government is providing over $235 million in extra funding for health and human services in 1998-99 and the following three years. The Northern Territory has put in an extra $18 million, or a 4.3 per cent increase in health. I think the honourable member asked whether these sorts of budget pressures were reflected across the whole of Australia. The facts show that there has been a substantial increase in funding across Australia, and that is justified by the remarks I made earlier. The member for Elizabeth asked a question in relation to the accumulated debt levels within the hospitals. As at 30 June 1998, the accumulated debt for North Western Adelaide Health Service was $13.25 million, which it has elected to pay off over 10 years. The accumulated debt for Whyalla Hospital as at 30 June 1998 was $1.57 million, which it has agreed to pay off

over 10 years. All other hospitals at the end of last year asked for any accumulated debt to be carried into this year's budget and to be dealt with as part of this year's budget. That is reflected in the figures I gave earlier in terms of any deficit within the hospitals.

The next issue concerns the number of nursing temps versus permanent staff. The question earlier was misunderstood and my staff gave me a figure of 9 000. In fact, there are 8 000 full-time equivalent nursing positions in South Australia. It would be very difficult to tell how many of those are temp nurses through agencies. However, if we can give an example, the Royal Adelaide Hospital in wintertime has about 30 to 35 temp nurses each day. In summer that drops back to between nought and nine. There are about 1 140 full-time equivalent nursing positions at the Royal Adelaide Hospital, and up to about 20 of those are full-time equivalents through nursing temps. The number of people being engaged would be higher than that, but that reflects the actual number in full-time equivalent positions.

The member for Chaffey also asked a question about the cost of the South Australian Government wages parity enterprise agreement. I gave the figure of about $40 million for this coming year. The figure for 1998-99 is $16.9 million. I gave a figure of $40.3 million; it is very close to $40 million, approximately. That agreement expires on 1 October 2001 and will provide for wage increases that vary between 11.1 per cent and 15.5 per cent. It varies because different people from different agencies have been brought together under human services and some have more catching up to do than others. The figure for wage increases for just over 2½ years is between 11.1 per cent and 15.5 per cent. I did notice that a press release was put out at lunchtime in which the member for Elizabeth talked about private health insurance figures. There are no new facts at all in terms of the figures I gave in a press release this morning.

Ms STEVENS: I want to return to the budget cuts and their effect on hospitals in the coming year. How will these cuts be managed across the system? Exactly how will they be determined in each category of the cuts? How will they be coordinated against all the hospitals that will have to apply them? How will priorities for treatment of patients be determined?

The Hon. Dean Brown: In relation to how they will be allocated across the health system, I have indicated in broad figures that there will be $6 million for the country and $30 million for the metropolitan hospitals. That is broken down hospital by hospital so that there is a detailed budget. The hospitals have their preliminary budgets, but we are still working to give them their final budget, because we need to find out how they went this year in terms of their end of year figures. We expect to be able to give them their final budgets by about mid July.

Ms STEVENS: It was done in December last year.

The Hon. Dean Brown: It was in September, because the Medicare agreement had not been signed. If the honourable member remembers rightly, the Medicare agreement was signed on the last day of August last year, and we gave the hospitals their final budgets by the end of September. They had indicative budgets before that, but this year I promised to give them indicative budgets in June. We have met that target, and we will give them the final budgets by about the second week of July. So, they are in a very good position in terms of good management practice in that regard. The same applies to country hospitals in that on Thursday this week the country regions will be allocated their budgets. It is then up to the individual regions to allocate the budgets to their hospitals, but they normally do that fairly quickly—within about a fortnight. I expect country hospitals to have budgets also by about the middle of July.

Ms STEVENS: How will you coordinate it across the metropolitan area? We need a few more specifics.

The Hon. Dean Brown: It is allocated and coordinated by the statewide group headed by Professor Kearney. Professor Kearney is in the process of allocating budgets and, as I said, preliminary figures have been given to the hospitals already. We then ask for a response from the hospitals in terms of those figures, and we will sit down in about a fortnight to finalise it. Roxanne Ramsey heads up the country division, and she is responsible for allocating out the budgets.

With respect to the priorities in terms of how hospitals allocate those funds, we are developing the standards but, very importantly, we work with individual hospitals. Some hospitals do not have the same difficulties as others. The Royal Adelaide Hospital, as I said, has provided more activity than it was expected to this year, and it still has a budget surplus of $1.7 million. We try to help other hospitals ensure that they meet not only their budgets but also their priorities. Of course, the priorities will be in areas such as accident and emergency. I have already talked about the priority in terms of emergencies and about higher priorities in relation to categories 1, 2 and 3 in order.

Elective surgery is dealt with in the categories, and I have given details of them. I do not think the honourable member would want me to go back over them, but I talked about those that should be done within 30 days for elective surgery, those that should be done within 90 days and those that should be done where no time is specified. Clearly, it is up to the hospitals to make sure that they deal with the 31 day targets first as they are the highest priority—perhaps the cancer patients. Then they would deal with the 90 day targets and make sure that people who are likely to be running over 90 days receive priority; and there are those on the non-time specified elective surgery list. Therefore, those areas where there is no direct, immediate threat to health but where there is an ongoing medical problem would have the lowest priority.

In terms of how hospitals implement that, we work through with them. For instance, we are just finishing a utilisation study rate, which looks at rates of utilisation of different health treatments among hospitals. If we find that a hospital carries out, for instance, more caesarean births than another, we will work with that hospital to highlight some of the problems and suggest that it look at some of its clinical procedures. A classic example where that has been done very effectively is the Port Pirie Hospital. The level of caesarean births at that hospital was very high.

A GP at Crystal Brook who is also an obstetrics specialist has taken on the task of working with the GPs at Port Pirie. As a result, the rate of caesarean births has been reduced. We look at those areas where we think there is lesser priority and, in some areas, particularly where some of the hospitals are doing experimental surgery, we question whether they should give any priority to that at all. I will not go into specific cases, but there are some cases where some fairly expensive surgical procedure has been carried out with no proven clinical benefit—or questionable clinical benefit. In those areas we would ask the hospitals to give that the lowest priority of all.

Ms STEVENS: I have a supplementary question: what does the Minister mean by 'experimental surgery'?

The Hon. Dean Brown: Surgery which is experimental from the point of view that they are new procedures.

Ms STEVENS: What would they be?

The Hon. Dean Brown: Lung volume reduction surgery is what you would describe as innovative or experimental surgery. That does not mean that it is experimental in that you are putting the patients at risk: it is not a widely accepted surgical procedure, and it is still being trialled.

Ms STEVENS: How many of those would be done per year?

The Hon. Dean Brown: We will take that question on notice.

Ms STEVENS: Not many?

The Hon. Dean Brown: We will obtain the figure for the honourable member.

Ms STEVENS: What action will be taken against health units that are unwilling or unable to control the demand according to what you have prescribed?

The Hon. Dean Brown: We ask the individual hospitals to work very closely with us. I believe that we are building up real cooperation in that respect. I now meet on a regular basis with the chairs of the individual hospital boards in the metropolitan area and with the CEOs. I have senior departmental staff—Christine Charles and other senior staff—and we find those meetings a good opportunity to compare notes in terms of the demand in the community and to identify individual areas of pressure. Then I visit individual hospitals and, invariably, the senior staff, the CEO of the hospital, some of the other senior staff and the Chairman of the board talk about some of the pressures they face.

A classic example is my visit to the Noarlunga Hospital where I met with board members and senior staff (including the CEO) who highlighted the problems occurring in their accident and emergency department as a result of the shortage of GPs in the local area after hours. As I stated earlier, we are trying to ameliorate that effect. These are just examples. Once a month, CEOs meet with Christine Charles and other key officers of the department.

We are also trying to improve financial recording and reporting procedures. Personally, I am keen to develop some fairly sophisticated procedures which will keep the Department of Human Services fully informed of the number of patients in hospitals and the number of procedures being conducted on, at least, a weekly basis (perhaps, ultimately, on a daily basis) and then to have the cost of running those hospitals monitored against those activity levels.

As I said, we have already started to work with a number of hospitals to improve their financial reporting and accounting procedures and to ensure that they use what are regarded as the best management and financial accounting practices. The Royal Adelaide Hospital has had considerable experience in this area, because it uses benchmark figures obtained against most major hospitals in Australia. I think much can be learnt from the work that has been done at the Royal Adelaide Hospital over a number of years to enable us to look at applying those same procedures to other major hospitals in the metropolitan area.

Ms STEVENS: I refer to page 5.34 of the Portfolio Statements, Volume 1—a table which shows the percentage of patients attending emergency departments across all major hospitals. Will the Minister provide details of the percentage of patients attending accident and emergency departments who were treated within an acceptable time frame for their category of urgency (as he has in this table) in respect of each of the hospitals in the metropolitan area: Flinders, Noarlunga, Royal Adelaide, Modbury, Queen Elizabeth, Lyell McEwen, and Women's and Children's?

The Hon. Dean Brown: I think it is fair to say that, regarding the first two categories, we are falling just outside the accepted Australian standard. The Federal Government sets acceptable standards, and we are more or less line ball with those—we are just a fraction outside those standards.

Mr Koutsantonis interjecting:

The Hon. Dean Brown: It is a fraction of a per cent. From memory, the requirement in respect of category 1 is that 93 per cent be dealt with within a certain period, and I think we might have achieved 92.5 per cent, or something like that. I will obtain those figures for the honourable member. I have already provided some figures on elective surgery. According to those figures, we are only just outside the standard. I do not think the member for Peake was here when I cited those figures earlier, but he will find them in *Hansard*.

Ms STEVENS: Just to be clear, I am asking for accident and emergency figures.

The Hon. Dean Brown: For each of the hospitals in the five categories of accident and emergency?

Ms STEVENS: That is right. I now refer to funding for drug rehabilitation programs. I am interested in the Minister's earlier comments in response to a question from the member for Waite. I understand that the Drug and Alcohol Services Council, which has an annual budget of about $13.5 million, has not yet received advice about its budget for this year. I wish to raise three matters in this regard in the context of an article in Saturday's *Advertiser* regarding comments by the Premier about the importance of dealing with drug treatment. The article by Miles Kemp and two other journalists states:

> Mr Olsen does not hold the same tough view for drug users, saying they should be rehabilitated.

According to this article, Mr Olsen stated:

> It's time we stopped talking and started acting on the issues of user rooms and treatment programs.

I understand that the Drug and Alcohol Services Council has a $600 000 overrun in its budget for needle exchange programs. I am informed that the council wrote to the Department of Human Services requesting that this $600 000 overrun be covered and that it receive an increase in its budget in terms of needle exchange to cover the increase in demand. My question is: will the Minister write off this $600 000 overrun and provide increased funding to cover the increased demand?

The Drug and Alcohol Services Council has identified the need for expanding and decentralising heroin treatment approaches in Adelaide—specifically, establishing a clinic for heroin treatment in the southern metropolitan area—and expanding services that are currently available in the northern area. Will the Minister follow the Premier's advice that it is time that we stopped talking and started acting in terms of drug treatment, and will he indicate his commitment by addressing the two matters that I have just raised?

The Hon. Dean Brown: The honourable member has raised a number of issues. I will refer to some of them. There has been an increase in the needle exchange program. The latest annual report shows a 50 or 60 per cent approximate increase in the needle exchange program, which was brought in specifically to reduce the likelihood of the transmission of HIV/AIDS from one injector to another. This is also important in terms of Hepatitis C to which I referred before lunch. There is an approximate $270 000 to $300 000 overrun in

terms of sterile needles and syringes due to this increase in demand.

The Federal Government has allocated some money to this area, and we are expecting an increase in allocation from that. We are not exactly sure as yet what the details are, because that is still being negotiated, but we may be getting about $600 000 per year out of the Federal Government program for the clean needle exchange. I want that information treated with some caution still, because those aspects of the Federal campaign are still being negotiated between Governments around Australia.

We as a State have put down a number of priority areas, one being the education area. I highlight the point that some people have seen fit to report the fact that there is no drug education in schools already. That is not correct at all. Life Education, which is specifically the body that delivers drug education within the primary and secondary school area, currently has coverage of about 40 per cent of the students across South Australia. We as a department and the Drug and Alcohol Services Council both contribute to that program. Discussions are taking place between the Minister of Education and me to look at broadening that program. I would like to see it extended to cover all primary and secondary students in South Australia.

The program is excellent. They have a series of trailers with exhibitions which they take around from school to school, and they have trained staff to deal with that. We have had a series of meetings already, and there are some ongoing meetings to work out how to try to raise additional funds. It is also tied very much into the curriculum provided by the Education Department, so many of those matters are outside my jurisdiction, except to say I am a very strong supporter, and have been for some time, of making sure that we have more effective drug education programs in schools, and to extend it from the 40 per cent of students we are currently covering to as close to 100 per cent as possible. One should already acknowledge the work being done by Life Education, including that at primary schools.

The second priority is the area that the Premier and, I think, the Attorney-General have already raised about drug courts, and I will not go into that matter, as it does not involve me at all. There is a component of that dealing with treatment, and we would be responsible for the treatment that might be ordered by the drug courts. What was the other issue that the honourable member raised?

Ms STEVENS: The need to expand and decentralise heroin treatment approaches within the metropolitan area, with a new clinic in the south and expanded services in the north.

The Hon. Dean Brown: Heroin treatment was the other issue. I have already talked about heroin treatment in some detail.

Ms STEVENS: I am talking about dollars for new centres and programs.

The Hon. Dean Brown: We have put $450 000 of new money into naltrexone trials, for instance.

Ms STEVENS: Split between the northern and southern suburbs.

The Hon. Dean Brown: Let me explain. I have put $450 000 into the naltrexone trials, through the Royal Adelaide Hospital. Those people could come from the north or the south, but we committed it to one hospital. We expect some extra money to come from the Federal Government for treatment, and let me run through the specific details of the programs. The State Government in 1999-2000 is putting $2.6 million of additional recurrent money into illicit drugs. This will be used to implement a total of 10 initiatives. Of these 10, four will be managed by the Department of Human Services, including expanding the Drug Assessment and Aid Panel, with $150 000 in 1999-2000, and an additional $140 000 in 2000-2001. So, in the second year of the trial, it is $290 000 extra money compared with the present position. The sum of $300 000 will be allocated in 1999-2000 to provide increased services to cater for those people who have undergone compulsory assessment through the Drug Assessment and Aid Panel, with a further $500 000 in 2000-2001.

Expanding specialist drug treatment services for voluntary clients, which is also another point raised by the honourable member, will receive an additional $120 000 in 1999-2000 and an extra $450 000 in 2000-2001. Expanding the prison methadone detoxification and counselling services, will receive an additional $280 000 in 1999-2000 and an extra $280 000 in 2000-2001. I mentioned earlier that we have committed $2.6 million of additional recurrent expenditure for this coming year, and on top of that, $2 million additional expenditure in 2000-2001; so that is a total of $4.6 million in the second year of the program. The total funding for the Department of Human Services through our initiatives is $850 000 in 1999-2000, and $1.37 million in 2000-2001. In addition, a further $532 000 is provided in the original bids but not yet allocated for areas like the needle exchange and syringe program. We expect some or all of that money to come out of the Federal Government's program.

A range of other services, which will be managed independently or by a number of agencies on a joint basis, include: intercepting the supply of drugs in prisons, which comes under Justice—$150 000 in the first year and $300 000 in the second year; exploring the feasibility of needle exchange in prisons—there is no funding for that: it is only being considered at this stage; the feasibility and trialling of a specialist drug court—$700 000 in the first year, with $1.53 million in the second year; distributing an information book to South Australian households—$100 000 in the coming year; establishing drug coordinators in schools—$400 000 in the first year and an additional $400 000 in the second year; and establishing police-led drug action teams under Police—$400 000 in the first year and $1 million extra in the second year. I think that that covers what the honourable member has raised in terms of extra money. It shows a significant commitment of extra money by this Government.

There was an inference in the question that we are not attempting to increase the range of services. I have already indicated that we are, and at the time the Federal Government brought down its drug package I highlighted that, if we were to look at trying to put the level of funding per capita in Australia for illicit drugs on a comparative basis with a country like Switzerland, there would have to be a very substantial increase in funding for treatment. My concern is that, of the 5 500 addicts, only about 2 000 of them are receiving treatment—not that all 5 500 want to receive treatment. The drugs court will help to deal with that issue, with perhaps more of them receiving treatment, but we need to make sure that the money is there, and that is why these additional allocations have been made. The honourable member should recognise and acknowledge that there has been a significant increase in funding, including in the treatment area.

Ms STEVENS: I now refer to the Ramsay Health Care private collocation at Flinders Medical Centre. What is the minimum service payment to Ramsay Health Care under the

agreement with Flinders Medical Centre; and does this mean that, even if Flinders Medical Centre does not purchase services to the value of the minimum payment, this amount remains due to Ramsay?

The Hon. Dean Brown: In the first year of the contract the payment is $5.2 million, and we will ensure that services are supplied for that payment.

Ms STEVENS: The Minister has just said that it was $5.2 million.

The Hon. Dean Brown: I do not know whether the member knows this, but the original service agreement was changed and now we require the services to be delivered to be a mix of cardiac services and day surgery services, and that is to come up to $5.2 million.

Ms STEVENS: Is the Minister saying that $5.2 million was paid to it in 1998-99?

The Hon. Dean Brown: The $5.2 million is in the first full contract year.

Ms STEVENS: Which was?

The Hon. Dean Brown: It started in March.

Ms STEVENS: Was $5.2 million paid in 1998-99?

The Hon. Dean Brown: No; the member is not listening. I just said that $5.2 million had to be paid in the first full contract year, that is, between March 1999 and March 2000.

Ms STEVENS: We are still in the first full year of the contract.

The Hon. Dean Brown: Yes; I said, 'The first full contract year.'

Mrs MAYWALD: Page 5.15 of the Portfolio Statements relates to the promotion and protection of health and well-being. Specific reference is made to the provision of health screening services for breast cancer. Will the Minister give details of coverage and services and whether there are any plans to expand, particularly in regional areas?

The Hon. Dean Brown: First, let me compliment the breast screening program in South Australia. It is a very good service. Over 63 per cent of women aged 50 to 69 years of age participated in that screening program over a 27 month period. We aim to lift that from 63 per cent to 70 per cent of women in that age group. In the 1997-98 financial year, 58 341 mammograms were provided compared with 50 798 in 1996-97. So there was an increase. The target for this current year (1998-99) is for 62 000 screenings. The member can see that there has been a substantial increase. Two years ago it was 50 700 and now it is 62 000, so there has been an increase of over 11 000 in that period. They are currently screening to capacity. A capital works expansion of $1 million has been approved to cater for the expected increase in participation.

The Marion Clinic has been renovated successfully and expanded to increase screening capacity to 120 women per day. From the beginning of May, the clinic has been providing 80 screenings a day with a gradual increase in capacity occurring through to 30 June 2000. Later in 1999, the metropolitan mammogram bus will be commissioned to cater for those women who live in areas which make it a little harder to access existing services in the metropolitan area. In terms of country areas, I may need to take that part of the question on notice. We do have a series of caravans or buses that travel out to country areas. In fact they have just recently been in my area at Victor Harbor for a protracted period. However, I will get the details.

I am able to say that we have seven fixed screening clinics, six in the metropolitan area and one in the Riverland at the Berri Hospital. The member's electorate has the only fixed unit in the country. Rural and remote women for whom lack of transport can prevent participation and screening are well served by two mobile X-ray units which visit areas of the country every two years and which is the recommended interval for screening. The 3 per cent of women with screen detected abnormalities are recalled to the Wayville Assessment Clinic for further investigation by a multi-disciplinary team. I think that pretty well answers the member's question. There are some special issues in terms of Aboriginal lands, but I will not go into the details of that because I think that was outside the member's question.

Mrs MAYWALD: The same page in the Portfolio Statements also refers to cervical cancer. Will the Minister elaborate on what activities are being undertaken in this area, particularly in relation to reaching those women who are less well screened with an emphasis on regional areas and also women from a non-English speaking background.

The Hon. Dean Brown: The aim of the screening program with cervical cancer is to reduce the incidence and deaths from cervical cancer through early intervention. It covers all women from the age of about 18 through to 70. In fact, the Federal Government has been running an excellent television campaign. I have seen the advertisements several times in the past few weeks, and I think that that highlights the need for women in that age group to have regular testing. It is a very interesting model because it is the one that has given us the clearest picture of the value of these screening programs, and there has been a longer screening program for cervical cancer.

It is interesting that they are now able to say that every year at least six to seven women in South Australia are alive directly as a result of that program. In other words, there has been quite a dramatic drop-off in the incidence of death within five years of detection of the cancer as a result of the screening program. This is purely because of earlier intervention and more effective treatment as a result of that screening program. In many ways it is now the classic model. We have a lot of faith in screening programs, and this is why we should be out there putting more money into this, and we are doing that with breast cancer.

Breast cancer is further behind, but the department's latest statistics show the first signs of a higher survival rate for those with detected breast cancers, and again that is due to earlier detection, earlier intervention and more effective treatment as a result of it. Some classic models will emerge out of this.

The Commonwealth Government contributes to the funding of the program, particularly the advertising campaign, which comes under the National Public Health Outcomes Funding Agreement. The incidence of and deaths from cervical cancer are falling in South Australia. The screening participation rate in South Australia for the two year period to 1997-98 was 66 per cent of women between the ages of 20 and 69 or 70 years. Again, there is a very good participation rate. There has been a change in the participation rate by age groups, with screening increasing amongst older women. Recruitment activities focus on women who are under-screened, and include programs for women in some rural and remote areas, older women, women from lower socioeconomic areas and Aboriginal women. One group that is now being specifically targeted is women from non-English speaking backgrounds. So, this program has worked very well, and we have already seen the benefits of it within this State.

The Hon. G.A. INGERSON: Ensuring that our food is safe to eat is significantly important to all South Australians. Page 5.6 of the Portfolio Statements mentions the implementation of new food safety legislation. Will the Minister detail to the Committee how he believes this will improve food safety?

The Hon. Dean Brown: This is a huge issue. I will explain briefly; I will have time to give only a broad outline of what is currently occurring in that area. As a result of the Garibaldi case, South Australia took to the ministerial council the need to set up national uniform hygiene standards. Eventually Michael Armitage as the Minister got the agreement of the other States. They set up the food council, the Australian and New Zealand Food Authority is the agency, and the ministerial council sits over that. It has been developing new food hygiene standards, and we are also looking to develop uniform Acts. We believe that the new food hygiene standards can be introduced under our existing Act in South Australia. The draft hygiene standards are available and each State is currently working through them. Here in South Australia we have been working through those for the past couple of months and we are currently undergoing public consultation with them.

We have had a series of meetings with different groups such as the Restaurant and Caterers' Association, which meeting I attended. We have had meetings with Meals on Wheels, the Hotels Association and a range of other bodies such as that. Today we started the first of the public consultations, which anyone can attend, and I think today's meeting is at the South Adelaide Football Club. There are three meetings today: one at 10 a.m., one at 2 p.m. and another at 8 p.m. We are inviting local government to come along, although we have already had detailed discussions with the Local Government Association. There will be meetings in the northern suburbs, the centre of Adelaide and some country areas, particularly the South-East and Riverland areas. I have sent out details and notified members of Parliament of the particulars of those public meetings.

I should briefly explain what is in these food hygiene standards. There are three broad requirements, based on what we call 'hazards'. The first is that every organisation or company on a commercial basis must have a food plan, which will identify where the hazards are and how they will be minimised. The second is that they must suitably train their staff so that the staff understand the hazards, how to handle food and so on, and how to take appropriate action. The third is that they must have an audit process where, depending on whether they are high or low risk, they will be audited once or twice a year. That audit can be done by local government through the environmental health officers—and I expect most of them to be done in that way—or by a private food auditor.

There are some pretty fundamental issues here. The Ministers have had a series of meetings and not long ago we had a major telephone hook-up. We are trying to achieve national standards, but you can imagine how difficult that is in an area such as this. One area of contention is with charities and community organisations. The draft regulations that have been prepared provide, for instance, that any charity or community welfare organisation that has 12 or fewer functions a year—maybe trading tables or a sausage sizzle at the football club—is exempt from the food hygiene plans and the audit process but is required to be at least familiar with the general requirements for food hygiene. I take a strong stance in believing that charities and community organisations should be fully exempt, although they should still be aware of what is required of them.

Each year there are about 2 500 cases of food poisoning in South Australia, and it is interesting to look at where those cases are occurring. We have the obvious and publicly known cases such as the Nippy's case, whereby in the past year about 500 people were poisoned. However, many isolated cases and small batches of cases of food poisoning also occur. Representatives from the restaurant industry told me that they did not cause any food poisoning so they should be exempt from the hygiene standards. When I gave them the statistics about the number of food poisonings that occur in restaurants, they were quite surprised and alarmed, and they changed their stance somewhat. For instance, on the day the Nippy's case was announced publicly we closed down a restaurant because of salmonella poisoning. We do not announce these publicly if there is no point in terms of public safety. We try to identify the cases, make an assessment and then work with the restaurant or organisation to achieve much better standards of hygiene.

I have to take these hygiene standards to Cabinet before the next meeting, in the first week of August, and then we must try to achieve some level of uniformity across Australia. Whether that will be possible in the end is another matter. I think there will be some minor differences between the States but that we will get uniformity across Australia in the broad principles that I have talked about and the way they will operate.

A huge amount of work is being done. The food industry will get a shock as to the extent to which some of them, at least, will have to lift their standards. Generally, the big food manufacturers are good because they are very professional and they understand the risks, although, at the same time, that is where the big food poisoning cases will occur. Generally, they are very good. However, I do not think the transport industry, generally, has understood some of the risks involved. I know that food that is highly susceptible to contamination or food poisoning is still being transported to country areas, even to my own electorate, in non-refrigerated vans. Those days will be over. Some retail outlets do it very well. The staff wear gloves as they prepare sandwiches and they take off the gloves when they handle money. There are other cases where there is inadequate cleansing of hands and preparation for a high level of hygiene in those premises.

Another area that concerns me is the area of use-by dates. For example, a high quality product leaves a manufacturer with a use-by date stamped on it; it gets to the retail industry, perhaps a sandwich bar or a smallgoods shop; the pack is opened and suddenly the use-by date becomes irrelevant. That product could be served well past the use-by date. It would be most unfortunate if that sort of thing was occurring. They are the sorts of issues where there must be a significant tightening of standards by the food industry.

The Hon. G.A. INGERSON: I have a supplementary question. There is no question of the need; I do not think anyone questions that. There is a group called 'small to medium size businesses' that are involved with thousands of people who, up to this stage, have not had a great deal of training or probably given thought to potential hazards. How do you see their training and encouraging them without a totally bureaucratic approach, which would cause a massive log jam in the retail industry? I have been in the retail industry and I have seen behind the door and behind the curtain of many of those operations. There will need to be a massive training component. In making those comments, I am

not saying that we do not have to do it, but I can see the potentially huge bureaucratic exercise coming up which will make the final outcomes more difficult than you want.

The Hon. Dean Brown: It depends on the level of risk of that organisation and the type of food it handles. If it is in the low risk area, it has up to six years in which to comply. If it is in the high risk area, it has two years in which to comply. I have sat down with the Small Retailers Association, which covers many of the organisations, such as sandwich bars, coffee shops, and so on. I want to compliment them because they are very aware of the need to lift food hygiene standards, and they have been out there with their members promoting this. They understand what the new regulations are about and they are actively promoting food hygiene training. I think the program the association has in place is excellent.

I know they do not cover all outlets and, in some outlets, I urge people to get in there sooner rather than later. The sooner they understand what is required and start responding to it, the better it will be for their business. They need to understand that customers are putting a premium on hygiene. You have only to look at where people go and where you can use that as a significant marketing tool. They should be in there very early and making it quite an open fact that they are adopting the new food hygiene standards. They could grab a lot of the market share by doing that early in the piece.

One measure that I have floated at this stage is the possibility of applying for an exemption or exclusion for any organisation with an annual turnover of less than $15 000 per annum. They are not shops, because all shops would be well over that. It might be for people who do catering in a private home or at a board luncheon. Frankly, the last thing we want to do is to apply the full process—the plan, the audit and the training—to those people. They should be aware of the requirements for food hygiene, but I believe there needs to be a cut-off point to exclude those smaller organisations. Equally, I do not believe it should apply to charity cake stalls in country towns or the sausage sizzle at the local football club.

The Hon. G.A. INGERSON: I have a supplementary question. The Minister mentioned the need for business plans, and I accept that that is a principle we ought to adopt at a certain level. I use the example of occupational health and safety. The real issue is to ensure that people do not get injured at work and also to ensure that food is delivered in a healthy manner. Business plans for some of those smaller operations will be another exercise which they will have to carry out and which will prove to be useless. The real point is the training and the understanding. Is that what you are talking about in respect of separating out the small to medium size businesses?

The Hon. Dean Brown: The exclusion should be for the very small organisations that occasionally serve food. All other organisations including the corner delis which serve food and the smallgoods shops will need a food plan. Their associations will tend to prepare much of the information about food plans for them.

The Hon. G.A. Ingerson interjecting:

The Hon. Dean Brown: They will not be able to tear them up.

The Hon. G.A. Ingerson interjecting:

The Hon. Dean Brown: They will not be able to tear them up because, at least once a year, they must have those food plans audited.

The Hon. G.A. Ingerson interjecting:

The Hon. Dean Brown: Local government will have inspectors, and local government is gearing up on this. We have had some sessions with local government, and it is already starting to talk in the local areas about new food hygiene standards. I do not underestimate the extent to which every place will be caught. They will have to notify where they are and they will have to show that they have been audited.

The ACTING CHAIRMAN: I envisage that members of Parliament will be inundated when these inspectors go out, and the Minister's office will be inundated with irate members of Parliament who have had to deal with some fairly inflexible bureaucrats emulating Sir Humphrey. Can the Minister give an indication that commonsense will apply when dealing with these people on the ground, otherwise the system will not work?

The Hon. Dean Brown: First, many of these places are already inspected at least once or twice a year by local councils. It is not entirely new. I forget the exact figure, but we have done the audit on it. About 8 000 inspections are done every year by environmental health officers of councils. There is a two year period in which people can learn what is required and adjust to it. For those who take some regard for hygiene, I do not think the change will be all that great because most of them are already being audited once a year by local councils. This will be a slightly more formal process. I do not think that this will cause a huge problem—perhaps only in places where, clearly, food hygiene standards are appalling and they do not wish to take any action.

There are about 10 000 food premises in South Australia. In 1997-98, 7 500 of these premises were inspected at least once. So, it is already taking place: that is already being done by the local government officers. There are 142 authorised officers under the Food Act, 114 of whom are also responsible for administration of other legislation. So, a fairly significant effort is already taking place. This will formalise it a little more. However, there may be some individual premises that in the past have not been willing to apply food hygiene with any rigorous effort. In the future, they might have to.

Mr KOUTSANTONIS: I refer to the dental health care service. How many of the 400 000 eligible dental care card holders are currently on the waiting list for routine dental treatment? In 1998-99 how many routine procedures were carried out for non-emergency dental treatment?

The Hon. Dean Brown: I gave the figures yesterday. We believe that about 400 000 people could be eligible for free public dental services in South Australia (excluding those under the primary school dental service). That is a very high figure: potentially, it is about 40 per cent of the population. At the end of May 1999, the number of people on the waiting list was 87 350. This is an increase of about 7 400 over the number at the same time last year. The dental service provides about 75 000 services. In terms of how many of those 400 000 are on the waiting list, the waiting list is 87 350. We treat about 75 000 people each year.

Mr KOUTSANTONIS: Are they the ones who receive routine dental treatment?

The Hon. Dean Brown: Yes. Of the 75 000, about 80 per cent are emergency services and about 20 per cent are routine services.

Mr KOUTSANTONIS: Regarding the 400 000 people eligible for dental care, is there a dollar amount that the dental service spends on those people? What was that figure in 1998-99 and in 1993-94?

The Hon. Dean Brown: First, there is not a specific dollar amount per patient: it depends on the nature of the treatment. For instance, in country areas, where there are no dental clinics, treatment is provided by private dentists. In those areas the private dentist is paid a fee and a 15 per cent co-payment is required of the patient at the discretion of the dentist. If the dentist knows that someone is on a very low income and that there would be a real difficulty in paying, they would drop that payment. Recently, I met with some private dentists who said that they do not bother with the co-payment, but others do.

Mr KOUTSANTONIS: In terms of your budget, you do not allocate for the 400 000 people a set figure to be spent on each one if required. That is not how you work out your budget every year?

The Hon. Dean Brown: No, because it is like people in the community in terms of general health care. We do not have a specific budget line for you in terms of the dollars we will spend on your health this year. Some people are high users of the system and others are very low users.

Mr KOUTSANTONIS: Minister, I asked you a question in Question Time recently about whether some dentists in public dental hospitals were pulling teeth rather than doing follow-up treatment on patients. Have you been advised by anyone in your department that this is taking place?

The Hon. Dean Brown: The honourable member may recall that I asked him to bring forward any evidence, and he has not—

Mr KOUTSANTONIS: Do you have any information about that?

The Hon. Dean Brown: I asked you at the time of answering that question to bring forward any evidence, and you have not yet brought forward any evidence.

Mr KOUTSANTONIS: So, you have not been advised by your department at all that this is happening?

The Hon. Dean Brown: I have asked you for the evidence.

Mr KOUTSANTONIS: I am asking you now: have you been advised by your department ever, at any time, that dentists are pulling teeth rather than following up with treatment?

The Hon. Dean Brown: I know of one particular case of an elderly gentleman who wrote to me and who indicated that, because he could not access dental service treatment, he had had to have a tooth pulled out. That was his assessment: it might have been that the tooth had to be pulled at any rate. And there are some cases—

Mr KOUTSANTONIS: That was a constituent who wrote to you: it was not someone in the department telling you that this was taking place. No-one in your department has informed you that this is taking place. Is that what you are saying?

The Hon. Dean Brown: No; the department has indicated the level of need. The honourable member may not be aware that a major review is under way. I met with the group doing that major review and asked it to do more work because, first, I believe that the need among some of the 400 000 and their ability to pay varies significantly. I want to make sure that the dental services we are providing target those people with the greatest need. For instance, I want to look at someone who is on a very small part pension and whose need is perhaps less than that of someone who is on a full pension and for whom more urgent and severe dental work needs to be carried out. I have asked the group to try to work out what should be the criteria in the same way that we have done, very successfully, with the Housing Trust. The vast majority of people have accepted it with housing. So, it is those with the greatest need who are dealt with first.

Mr KOUTSANTONIS: I have a supplementary question: Minister, I do not doubt your commitment to the people you serve, but have you been informed by your department directly that this procedure is occurring because of the waiting list and because of the backlog in dental hospitals in that dentists are pulling teeth rather than doing follow-up treatment, which would save teeth? Have you been informed in any way by the department that this is taking place as a routine practice?

The Hon. Dean Brown: The honourable member will find that I have actually used that expression already in some speeches publicly. I am not quite sure what point the honourable member is making. I have already said that there are some cases where people are having teeth extracted and they believe that, if they had received earlier treatment, they might have been able to avoid that.

Mr KOUTSANTONIS: I am not asking whether the patients believe their teeth could have been saved: I am asking whether—

The ACTING CHAIRMAN: Order! It is entirely up to the Minister how he chooses to answer the question.

Mr KOUTSANTONIS: I do not doubt that, Sir.

The ACTING CHAIRMAN: This is not a cross-examination.

Mr Koutsantonis interjecting:

The ACTING CHAIRMAN: Please calm down.

Mr KOUTSANTONIS: I do not doubt that some patients believe that they have had teeth pulled which could have been saved, but patients are not experts in the field of dentistry. I am asking the Minister whether he has been informed by the department that dentists believe they are pulling out teeth which in their opinion could be saved because they cannot perform follow-up treatment. I am not asking whether the patients believe these teeth can be saved.

The Hon. Dean Brown: One dentist recently raised this matter with me. I do not think it would be fair to say that he was referring to extracting teeth, although the removal of one tooth may have been involved. This dentist saw me recently about a person who had to have a tooth removed. The question was whether the X-ray which had been taken earlier by the School Dental Service had identified the cavity and whether other treatment should have been undertaken.

I know this dentist very well—I have spoken to him twice about this issue and I have obtained copies of the X-rays involved. So, this matter was not brushed aside; it was looked at in considerable detail. The dentist was unsure because the earlier X-rays, perhaps surprisingly, did not clearly show the cavity. This dentist, whom I know, says that, based on the X-rays that were produced, it could not be argued that the service was inadequate.

I suspect that the person who approached me might be the same person who approached the honourable member about the School Dental Service. A parent wrote to me and the dentist came to see me, and I have taken up this matter with the dentist. It is difficult to know exactly what the situation was six or 12 months ago. I have asked the review to examine, in particular, the quality of health care offered by the School Dental Service.

I think that two dentists have drawn to my attention their view that the School Dental Service is missing the diagnosis of a number of caries in teeth and that that is partly due to the fact that, despite fluoridation, young children are sitting at

computers with a bottle of Coca Cola and taking a sip every 15 or 20 minutes, that Coca Cola has a high sugar content, and that this is causing some unique problems with teeth. If the honourable member is doing that, I urge him to change his habits, because the dentist will tell him that it is a very bad practice.

The honourable member asked whether this was being done on a routine basis. There is no evidence of that. One case has been referred to me, and I have followed that case through even to the extent of obtaining a copy of the School Dental Service X-rays and referring them to the dentist involved.

Mr KOUTSANTONIS: I gather that the Minister is saying that this is not a routine practice in public dental hospitals but that there might be one or two cases of where this has happened, that generally it is not the dentist who believes this is happening but the patients who believe the teeth could have been saved. From what the Minister has said, no departmental officer or ministerial adviser has informed him or his department that this is a routine practice within South Australian public dental hospitals.

The Hon. Dean Brown: Dr van Deth, the Chairman of the Public Dental Service Review, is the appropriate person to consult in this matter. He says that there are a number of cases where a choice must be made between conservative treatment or the extraction of a tooth. In each of those cases, individual professional judgment must be applied.

Mr KOUTSANTONIS: Is the Minister saying that the department is aware that some dentists are making choices to pull out teeth simply on a professional basis and not on a resource basis, that they do not pull out teeth simply because the patient will not come back for follow-up treatment but because, in their professional opinion as doctors, it is the right thing to do?

The Hon. Dean Brown: Their professional view is that it is better to extract the tooth than to have continued conservative treatment.

Mr KOUTSANTONIS: Is that based on a medical decision and not a monetary decision?

The Hon. Dean Brown: It is based on a dental decision. As I have said, the two dentists who came to see me wanted to know whether the School Dental Service was picking up all the caries that it should and whether, in some cases, caries were being passed over. Most of these cases involve young children, so they are primary and not secondary teeth: therefore, the circumstances are somewhat different. If the honourable member can produce the evidence which he says he has, which he promised to produce and for which I have asked, we might be able to progress this matter further without wasting the time of the Committee. I am still waiting for the honourable member—

Mr Koutsantonis interjecting:

The Hon. Dean Brown: If the honourable member is going to make statements like that, he should produce the evidence. I do not think it is fair that the honourable member should make claims—

Members interjecting:

The ACTING CHAIRMAN: Order!

The Hon. Dean Brown: In the House of Assembly, the honourable member made certain claims—

Members interjecting:

The ACTING CHAIRMAN: Order! The Minister is responding. I do not want to hear three or four questions at one time. If this continues, the Chair will get difficult.

The Hon. Dean Brown: I invite the honourable member to produce the evidence. If there is a matter that needs investigation, I will follow it up. When evidence has been produced, I have thoroughly and diligently investigated the matter even to the point of asking the dentist to see me and to go through the X-rays.

Mr KOUTSANTONIS: Is the Minister saying that this is not routine practice and that, although he has not been informed by the department that this is happening, if I can show him the evidence, he will do what he can to correct the situation?

The ACTING CHAIRMAN: Order! Continued repetition—

Mr Koutsantonis interjecting:

The ACTING CHAIRMAN: Order! The Chair will make whatever comment it thinks is appropriate. Continued repetition is not only out of order but unnecessary.

The Hon. G.A. INGERSON: I refer to page 5.6 of the Portfolio Statements—the statement about food safety. Will the Minister provide details of some of the outbreak investigations which have been carried out by the department?

The Hon. Dean Brown: In terms of specific disease outbreaks, about 2 500 cases of food poisoning are investigated per year. We cannot always trace the cause of these outbreaks. In 1998, 74 disease outbreaks were investigated, 32 of which resulted from the notification of sporadic meningococcal infection and 25 were food-borne disease investigations. In 1999, there were 24 disease outbreak investigations, of which seven (33 per cent) resulted from the notification of sporadic meningococcal infection and 12 were food-borne disease investigations.

The Hon. G.A. INGERSON: The media have run a number of articles recently about using genetic technology in food production. What action has the department taken to ensure that foods produced using this genetic technology method are safe to eat?

The Hon. Dean Brown: This has been a huge area of public interest in the last six months. You only have to look at some of the articles that have come out of Britain, for instance, to know this has been one of the biggest public issues in the English media. It occurred, of course, because of the genetically modified potatoes incident there. It is now a big issue throughout most of Europe. I think I am right in saying that 20 of the biggest supermarket chains in Europe have taken genetically modified food off the shelves.

I received a letter the other day from one of the major food manufacturers in Australia indicating that they will no longer put any genetically modified food on the supermarket shelves. I talked recently to one of the largest food manufacturers here in South Australia who indicated to me that he would only use materials in his food that were not genetically modified. I think we are about to see consumer concern here in South Australia that we have seen in other countries, at least in Europe and Japan. In America, there is not the same level of consumer concern.

The first thing that needs to be recognised is the great consumer interest in whether or not food is genetically modified. A recent television program highlighted some of those concerns. There are two issues involved. First, is genetically modified food safe? All the evidence is that it is safe. We are putting in place around the world better procedures for approval of any genetic modification that occurs, and that has to be signed off and shown to be safe. Here in Australia there was a requirement that, as of a month or so ago, all companies bringing in food ingredients that may

have been genetically modified had to have their products registered with ANZFA, the food authority in Canberra, and they had up to 12 months in which to then get official approval for that certification. In registering it, they have to show they have already had the product approved elsewhere around the world and that it is shown to be safe technology. Anyone with a brand new product that had not been classified as safe elsewhere would not be allowed to bring in their product or sell it in Australia.

The Ministerial Council decided before Christmas that in fact there should be mandatory labelling of all foods. Where it is known that a food contains genetically modified material, it should say that this food contains genetically modified material. Where it is known that it does not, it should quite freely say it is free from genetically modified material, and where there is some uncertainty, because it contains soya bean flour that might have come from the USA and you do not know whether or not it does contain such material, it should indicate that this food may contain genetically modified material. At this stage, the food authority has put that down as a broad principle, but more work needs to be done.

What are you referring to if you extract oil from a plant and there is no genetic or protein material in that oil, even though it has come from a genetically modified plant—should it be regarded as genetically modified material? Those side issues are still being worked through. This issue has to be further considered by the food council in the first week of August.

The member for Peake raised a series of questions about extraction of teeth. He asked specifically whether I was aware of, or did I have information about, inappropriate clinical practices of extracting teeth rather than treating the tooth. I asked him to produce the evidence. I have now asked the departmental officers involved whether they know of any evidence. There is still no evidence of routine inappropriate clinical dental practice for the extraction of teeth and whether in fact those teeth should be treated rather than extracted. That is a clinical issue.

However, as shown up by the information provided by SADS (South Australian Dental Service), there is an increase in the instance of dental extraction. That is a different matter from inappropriate practice by dentists. The honourable member should understand the difference. He should also be very careful in not making an automatic assumption, because the two may not be directly linked. It may be that other factors are causing an increase in the incidence of teeth extraction, such as the ageing of the population.

So, whilst that information is being looked at by the dental review in terms of the causes of the increase in the incidence of dental extraction, I again come back to the honourable member and in fact issue a challenge: if he has any evidence of inappropriate clinical practice by dentists who are extracting teeth when in fact those teeth should not be extracted, I would urge him to give me that evidence immediately. I have asked him to do that previously. He has not done so, and I highlight the point that I think it will be a negligence on his part if he continues to make the accusation without producing the evidence for me. What I want to do is see the evidence of inappropriate clinical practice rather than some broad assumption of an increase in the incidence of teeth extraction.

Membership:

Ms Bedford substituted for Mr Koutsantonis.

Mr SCALZI: My question relates to the State tobacco strategy. Research has shown that smoking causes serious and life threatening diseases which, in turn, place a preventable burden on the public hospital system and public funds. Page 5.8 of the Portfolio Statements mentions the implementation of the State tobacco strategy to reduce the prevalence of smoking. Will the Minister explain what is involved in this strategy and how it will contribute to the decreasing number of people who smoke in South Australia?

The Hon. Dean Brown: I appreciate the member raising this because he is one member who has taken a very strong stance against smoking, particularly in school children, and I appreciate the stance he has taken as a former teacher. I share that passion with him. In fact, I am somewhat surprised that the member for Elizabeth has not raised this issue because—

Ms Stevens interjecting:

The Hon. Dean Brown: I said, 'Raise it in the Estimates Committee and I will go through the detail.' Here we are in the Estimates Committee and it has not been raised. First, let me make it clear that I gave a commitment in a ministerial statement to the House last year that we would put $3.9 million into an anti-tobacco strategy. In the 1999-2000 budget $3.9 million has been allocated for that strategy. I know that destroys a good story for the member for Elizabeth who keeps trying to suggest otherwise, but they are the facts.

Ms Stevens interjecting:

The Hon. Dean Brown: No; I saw one of them yesterday and they complimented me on the fact that we had stuck by our promise on which I put enormous credence. I promised to give a broad breakdown of those programs and therefore I appreciate the member's question because it gives me the opportunity to do that. The South Australian smoking and health project, which includes the Quit campaign and the Quit line, receives $1.42 million; research and evaluation, $450 000; Tobacco Control Unit and Task Force, $323 000; the small grants, anti-tobacco grants, $200 000; the legislative surveillance—smoke free dining and also the sale of cigarettes to minors—$97 000; smoke free dining, which includes the assessment of appeals and so on, $65 000; sales of cigarettes to minors project, $15 000; and the point of sale advertising project, $10 000. That comes to $2.302 million.

A remaining allocation of $1.598 million is yet to be recommended by the ministerial task force. If the honourable member adds up all those figures, it comes to $3.9 million, which I promised in the ministerial statement last year.

Ms STEVENS: But you have not allocated that proportion, over $1 million.

The Hon. Dean Brown: There is $1.598 million, which I just said is money yet to be allocated by the task force. That is not unusual. The financial year has not yet begun and it wants to keep some money aside to allocate to projects during the year. Put all that together and you have $3.9 million, which is what I promised previously, and the task force will continue to meet and carry out its strategy. I assure the member that we are maintaining our strong stance against tobacco smoking in the community, but I am still particularly perturbed by the high and increasing incidence of smoking amongst young people, especially the 12 to 17, 18 year old age group.

Mr SCALZI: I refer again to page 5.8 of the Portfolio Statements and the State tobacco strategy. Will the Minister indicate what initiatives have been undertaken and what is proposed to ascertain the understanding, compliance and impact of smoke free dining legislation?

The Hon. Dean Brown: We were the first State to adopt smoke free dining, and that was introduced on 4 January this year. I think it is fair to say that it has been very widely accepted and appreciated. I still receive letters from the public saying how much they appreciate the fact that it has been introduced, and particularly from asthmatics who write to me saying that, for the first time, they now feel safe to dine out because they know they will be able to dine in a smoke free area. I do receive a small number of letters from people complaining about apparent breaches of the legislation, and we follow those through. Recently, we have received a relatively small number of complaints, but it is just the odd one here and there.

First, we amended the legislation, as the member knows. There have been a small number of appeals from licensed premises, and I understand that all those appeals have now been worked through to the satisfaction of both parties; that is, the department and the premises that lodged the appeal. The number of appeals has not been great—I think it involves between nine and 12 licensed premises. A number of applications for exemptions in the licensed area are yet to be processed. There were about 220 or something like that—I am not sure of the exact number. There is a significant number in the non-licensed area. We have amended the Act, as the member knows, so some of those applications for exemption are still being received and there may be a certain number of appeals.

I think some of those appeals are starting to come through as well, but generally the whole thing has been a great success. I have the latest figures which are: in licensed areas, 256 applications for exemptions; 113 of those have been decided; 94 of them have been granted a conditional approval or advice that the exemption was not required; and 18 requests for review of these decisions have been received and eight have been finalised. About 28 applications have now been received from unlicensed premises. None of those has been finalised. After an application for exemption has been received and during the period whilst they are being assessed, they are able to continue to operate as if they have the exemption.

Mr SCALZI: The issue of tobacco sales to minors is very dear to me. Will the Minister elaborate on how it is proposed to tackle the continuing problem of the sale of tobacco products to children?

The Hon. Dean Brown: The figures in 1996 showed that 15 per cent of 12 to 15 year olds were smoking and that 29 per cent of 16 to 17 year olds in South Australia were smoking or had smoked a tobacco product on a regular basis. Clearly, the incidence of tobacco smoking amongst teenagers is far too high. I was amazed when I first launched this campaign several weeks ago that the *Advertiser* sent a minor to try to buy cigarettes from 10 retail outlets, and nine of the 10 sold the minor (the person under the legal age) cigarettes without even questioning their age, which highlights the problem. I was somewhat surprised that in its editorial the newspaper then said that we should not be taking any appropriate action to rectify this.

I personally believe that, where a breach of the law occurs to that extent, there is an obligation on me as Minister to make sure it is effectively policed. We are carrying out an education program with retail outlets initially, and we are doing this with both the Retail Traders Association and the Small Retailers Association. They have agreed to cooperate to warn retailers to make sure they are aware of the law and to help them set up protocols so they can make a genuine attempt by simply asking the person their age. That program will be run over the next six or so months. Then, we will be asking young people to come along and work for us on a volunteer basis where they go out and try to buy cigarettes, and they will be under adult supervision. We will try to identify those retailers who are breaking the law, and they will be warned once but certainly not a second time.

The Ministerial Council on Drugs has recently set down a new national framework to be looked at by State Governments. This particularly targets the sale of cigarettes to minors and deals with issues such as vending machines and a range of other initiatives. Here in South Australia we have not yet made decisions about those initiatives within the framework, but they are certainly on a suggestion list of actions that should be taken by each of the State Governments. I stress that the sale of cigarettes to minors and the availability of vending machines are two of the key issues in that framework to be taken up by State Governments.

Ms STEVENS: I understand that, when the procurement reform strategy was implemented in July 1998, it was described as saving $72 million per year. The specific target of 3 per cent savings after a full two years of implementation is shown for DAIS in Budget Paper 4, Volume 2, section 7.9. We are aware that health services have been told that savings made by the Department of Human Services as part of the Government's procurement reform strategy will not be retained by individual health services but have been factored into the forward estimates for the department. As the strategy was implemented in July 1998, what savings have been achieved to date and how many contracts have been completed so far by the department's strategic procurement unit or State Supply on its behalf, and for what classes of products and capital items?

The Hon. Dean Brown: Let my clarify to the Committee that the honourable member made a statement that the procurement reform strategy which was launched in 1997 aimed to make savings of $72 million. The inference might have been that this related to the Department of Human Services: it did not. The statement that the Minister made related to the whole of Government, not to the Department of Human Services. I know, because I happened to make the statement. At the time I happened to be not the Minister for Human Services but the Minister for the equivalent of Administrative and Information Services, and I was the Minister responsible for setting up the reform strategy. Considerable work has been done in the department. The honourable member has asked a series of very specific questions and I will have to take them on notice and get the information for her.

Ms STEVENS: I have some other questions in relation to the same topic. I am happy for the Minister to take them on notice. What will happen to health service budgets should the savings target I asked about not be achieved?

The Hon. Dean Brown: Which savings target?

Ms STEVENS: My first question was: what savings have been achieved to date? I was asking about the specific target of 3 per cent savings after a full two years of implementation as shown for the DAIS budget. Is the information about the fate of any savings correct, that is, that they will not be retained by individual health services? If so, what incentive do individual health services have to actively identify and implement better procurement practices if all the savings are retained by the department? Finally, is the Minister satisfied that a 3 per cent savings target is adequate, and how does this

compare with savings achieved by agents in the public and private sectors when procuring these classes of products?

The Hon. Dean Brown: I will certainly have to take some of those questions on notice. In respect of where the savings go, I think the honourable member asked why none of the individual health units will be able to retain any of the earnings. That is not correct at all: it is a matter of sharing those savings partly with the department and partly with the individual units. It may be that the share will change with the nature of the individual purchase. For instance, if hospitals contract out some services and buy in some services, in large part they are able to retain the benefit. In other cases they may be more centralised purchases, in which case the department might share in the majority of the savings.

Ms STEVENS: Will that be on an individual case by case basis or is it covered by a policy or schedule?

The Hon. Dean Brown: It will change greatly as part of the whole budget process. It will change according to what item you are looking at, as part of the ongoing financial management of the department and the individual health units. So, one cannot come to any overall assumption that it will be one or the other: it will vary. For instance, if we were buying larger items of equipment such as angiogram suites and equipment and they were coming out of the capital budget, I would expect any savings that were achieved largely to benefit the department, because that expenditure was on a specific basis. I can indicate that the efficiencies that we are attempting to factor into three areas—procurement, information technology and competitive tendering—amount to $5.1 million in 1999-2000 (the coming year) and $8 million in the year 2000-1. So, they are the figures for the next two years.

Ms STEVENS: My next question relates to the Department of Human Services itself. How many executive staff were unattached as at 1 June 1999 and what is the total amount of their salary packages?

The Hon. Dean Brown: We will take that question on notice to get that detail for the honourable member. I do not think there are any obvious areas of concern, but we will get the individual data.

Ms STEVENS: The Opposition has been briefed by IT industry sources who have expressed strong reservations about the way in which the Department of Human Services is managing the plan to ensure all systems are Y2K compliant.

The Hon. Dean Brown: Could the member clarify that? Who is questioning it?

Ms STEVENS: Some industry sources: I am not prepared to reveal who they are. Suffice to say, there are some concerns.

The Hon. G.A. Ingerson interjecting:

The Hon. Dean Brown: Yes, unsubstantiated allegations.

Ms STEVENS: I will use the Queen Elizabeth Hospital as an example. What level of compliance is required at the Queen Elizabeth Hospital and which systems have been identified as critical to be level three compliant? For example, are patient monitoring systems, refrigeration, airconditioning, building security and patient record systems regarded as critical?

The Hon. Dean Brown: First, in terms of Y2K compliance, we have put considerable effort and resources into this area. By late last year, many assessments had been done, areas of risk had been identified and action programs had been put in place. I went to Cabinet and specifically asked that I be given the resources to carry out that compliance.

I am not sure whether the appropriate Minister has been before the Estimates yet—and he might be the appropriate Minister to ask a general question about health—but he has been very complimentary. Every month Cabinet gets a detailed report, and I get a detailed report which I take back to the department and which covers the human services portfolio, including the health units. We have allocated $35 million of expenditure in this area. In November 1998, Cabinet approved a special allocation of $21 million for capital for compliance, covering areas such as security systems, corporate computer systems and biomedical engineering equipment.

The department has made significant progress, and in his monthly reports to Cabinet the Minister has complimented the Department of Human Services, even though it had the biggest task of all, on the huge headway it has made in that process. As a result of that, it has changed the level of perceived risk and reduced the level of perceived risk in respect of independence assessment. The department has made significant progress in meeting its obligations to manage risks presented by the problem and is well placed to complete all its contingency planning work for critical items by 30 June 1999.

The department is working with key private sector health providers with a view to raising awareness and to assist in remediation and contingency planning efforts. A seminar was held for the private sector in late May 1999 so that support arrangements could be discussed and delivered. Mainframe conversion and testing projects for the housing sector are progressing, and completion is expected by the end of June 1999, with the main focus on compliance testing. Compliance testing of the housing sector's mainframe system infrastructure found no significant problems.

The testing of all biomedical equipment in the Royal Adelaide Hospital and the Women's and Children's Hospital has been completed, and the extent of problems, as highlighted in the media, has not eventuated. Less than 1 per cent of the systems have failed, and I highlight that in respect of a high profile article that appeared in the *Financial Review* less than 12 months, perhaps nine months ago, which suggested that up to 30 per cent of all medical equipment would fail. As I said, testing has suggested that less than 1 per cent will fail.

Implementation of patient information systems has now been completed at the Lyell McEwen Health Service, the Noarlunga Health Service and the Queen Elizabeth Hospital, and it will be completed at the Women's and Children's Hospital and the Repatriation General Hospital in 1999. Specifically, in terms of the QEH, the patient information system has been completed. Implementation of final information systems has been completed at the Repatriation General Hospital, the Queen Elizabeth Hospital, the Women's and Children's Hospital, the IMVS and the Child and Youth Health Service. It has been commenced at the Noarlunga Health Service, which is the only location where it has not been completed.

The statewide licence and software maintenance agreement has been introduced. Consolidation and commonality of hardware reference files and reporting tools have been introduced allowing for meaningful comparative studies and an overall reduction in cost, and preparations are under way to upgrade the Flinders Medical Centre system to achieve year 2000 compliance.

There are some key areas, one in particular of which I am aware, where it needs the procurement of specialist medical equipment from overseas because, at fairly late notice, the

manufacturers withdrew any further acceptance of liability for this equipment, including the year 2000 problem. There are still some key areas where we are taking action as quickly as possible, but we are aware of the problem. We are aware that new equipment must be purchased, and we are trying to speed up that process as quickly as possible to get the equipment on board.

We have had difficulty getting answers from the manufacturers of equipment. We sent out 11 000 letters to manufacturers of equipment asking them to give us a written assurance that the equipment is compliant. We have had an exceptionally low level of response to those letters. Clearly, in the majority of cases manufacturers will not accept any liability and are not even willing to send back a letter saying that they will not provide any answers. Of course, the other problem is that some manufacturers are not sure which chips are in which pieces of equipment because they used various manufacturers of computer chips and they vary from one computer to the next. That is why we have had to test each piece of equipment as thoroughly as we can.

If the honourable member has any information at all, without naming her source, I would ask her to see me, but I ask her to be specific and not just make a general accusation. If the honourable member has any specific information, I would appreciate it and would ask her to bring it along. It is an important issue. We have six months to go, and it is important that it is done thoroughly. I think we have a good team. We also have a good team working on the contingency plans. In other words, the fault may not lie with us but with an outside source, such as an electricity generator or something like that. Therefore, we have contingency plans. If the power goes off in a number of hospitals, we will be able to bring on emergency power and maintain the services as quickly as possible. In fact, I was at the Women's and Children's Hospital several weeks ago where it was pointed out that they had received some excellent training when someone from outside the hospital had thrown the entire power supply to the hospital. They said that it was good practice and training for them for the year 2000.

Membership:

Mr Hamilton-Smith substituted for Mr Scalzi.

Additional Departmental Advisers:

Mr I. Proctor, General Manager, Family and Youth Services.

Mr G. Fox, Manager, Magill Training Centre.

Mr K. Teo, Manager, Operational Policy and Planning.

The ACTING CHAIRMAN (Mr Hamilton-Smith): We will now deal with Family and Youth Services.

Ms STEVENS: Minister, this morning you said that there would be a cut of $1.449 million to FAYS. How will that cut be achieved?

The Hon. Dean Brown: The figure I quoted earlier was $1.449 million. First, that is a saving on forward estimates that has to be achieved; in fact, for the full year the department is below its expected expenditure. Therefore, it is a saving of $1.449 million on the forward estimates but, in terms of comparing this year with next year, there will not need to be anywhere near that sort of saving achieved, because this year's expenditure has not been as great as anticipated in the forward estimates. There are a number of different areas. For instance, regarding children's payments, it was thought that there would be an overrun, but it has come in lower. At any rate, they tend to vary from time to time; it is hard to predict. Therefore, the level of potential overrun in that area seems to be less.

In terms of core staff, it would appear that the staffing level is about right to be able to go into the new year and meet the target. It is not anticipated that there would need to be any significant changes in staffing levels for the year. There was an anticipated overrun in concessions, but we get concessions fully paid by Treasury; in other words, we do an estimate of what the concessions will be, we get paid on that estimate and, if there are more pensioners who have applied for concessions, we get more money. That is one area where there was some pressure, but it would appear that we will be compensated for that at any rate. So, that saving of $1.449 million across the FAYS budget would appear to have little impact compared with what was spent this year.

Ms STEVENS: Can the Minister be any more specific than that?

The Hon. Dean Brown: What has been allocated in the coming year's budget to fund the base complement of staff, salaries and activities is there.

Ms STEVENS: The same as for the previous year?

The Hon. Dean Brown: No. Compared with what we spent this year, we have the core funding to be able to spend a similar amount with adjustments to salaries and everything else. Although it was anticipated, based on forward estimates, that a saving of $1.449 million would have to be made, because of the level of activity that has occurred this year it appears that very little change will have to be made. So, any savings will be much lower; in fact, the saving may be fairly small. The honourable member must appreciate that the savings that I listed earlier were based on forward estimates. If an agency or part of an agency comes in at below expenditure, no savings will have to be made.

Ms STEVENS: My second question relates to child protection. The Productivity Commission's 1999 Report on Government Services (Volume 2) refers to child protection effectiveness indicators. In 1997-98, in South Australia almost 30 per cent of children who had been found to have suffered child abuse and neglect, the case having been closed following an investigation, were subsequently renotified, re-investigated and found to have been re-abused. Will the Minister say what action he is taking to ensure that children do not suffer repeated incidents of abuse?

The Hon. Dean Brown: Productivity Commission figures for the year 1998-99 indicate that about 400 children were confirmed as having been re-abused or neglected within 12 months of the initial confirmation. If the honourable member looks at the appropriate page in the budget document, the figure of 400 is indicated under 'Quality'. It is suggested that there will be about 350 cases in the coming year. I will ask Mr Ramsey to explain the reason for that reduced figure.

Mr Ramsey: Clearly, this is difficult to predict. We have stated a slightly lower number this year on the basis that the child protection reform strategy that we are following is bringing with it more effectiveness in terms of the way in which we go about our work. We are optimistic that through this strategy we can produce a lower result, but we emphasise that this figure is in no way intended to be a prediction.

Ms STEVENS: The Productivity Commission's report states that in 1997-98 30 per cent of children were found to have been re-abused. I think that is astounding—it is damning to think that this is happening. Supposedly there has been some intervention, but it has happened again in 30 per cent

of cases. What is the department doing about this? I do not think that it is good enough to say, 'We can't do anything about it.'

The Hon. Dean Brown: We have the 1998-99 figure. I believe that the honourable member has the 1997-98 figure.

Ms STEVENS: The Minister said that there were 400 cases in 1998-99.

The Hon. Dean Brown: That is correct. We are working on the basis of 350 next year. At the beginning of this financial year, I announced that we would allocate an extra $1 million to increase services for children who have been abused or neglected. I said that that funding would provide 14 new positions to provide clinical assessment and treatment for these children, that demand for these services was increasing at an average rate of about 5.8 per cent per annum, and that these new positions would allow a more prompt and consistent approach to be adopted.

I went on to say that nothing was more important than keeping our children safe and that this extra funding would help us to do that. Five of these positions are located at the Women's and Children's Hospital, two at the Flinders Medical Centre, five at the Northern Child and Adolescent Mental Health Service (including positions in the country), and two at the Southern CAMHS.

As well as helping to meet the increased demand, this new funding will enable the instigation of a number of new initiatives including: a service for the management of young children who display inappropriate sexual behaviour; a therapeutic early intervention program for families where child abuse and neglect have already been identified and where the aim is to reduce the incidence of further abuse (the point to which the honourable member refers); a program for low birth rate infants identified at high risk of abuse and neglect; and a State system for reviewing the deaths of children in South Australia in order to reduce the number of preventable deaths.

Ms STEVENS: I suspect that the $1 million you are referring to was not just to deal with the children who have suffered repeated abuse. That would have been generally to address the increasing levels of child abuse in our community. I still say that I am shocked that we have 400 children who, after your department's intervention and supposed dealing with the issue of child protection, were re-abused, and you say that you have a target of 350. Is that good enough?

Mr Proctor: I think I have already made the point that we are not in any way attempting to predict an outcome. Obviously, the lower that number is, the better: that is self-evident. Further to what the Minister has said, with regard to the efforts the Government is making to deal with the issue, which is critical for us, we are now fully into the use of $700 000 additional money put in the previous year by the Government to establish our central intake team and our central abuse report line. That is now becoming much more effective. We know from our statistics that we have much higher levels of reporting.

In this present financial year, through adjustments within the budget based on pressures in the system being higher in some district centres than others, we have managed to reallocate resources across the system of the order of $300 000 for salaries to the busiest centres. That has gone into dealing with the issue raised by the honourable member. I come back to the point I made about the reform methodology enabling us to better target our efforts. Clearly, a critical target will be that of avoiding re-abuse. We understand the risks and how to manage them better than we did before. In summary, we can only aim to work away at reducing that figure.

Ms STEVENS: Can the Minister advise how many child abuse or neglect reports are not investigated because there are insufficient staffing resources in Family and Youth Services? I understand that these cases are labelled RPIs (resources prevent investigation). I also understand, for example, that the Gawler Family and Youth Services office has taken no action on more than half of the reports on children in its area. I understand that Elizabeth has a high rate, about 20 per cent, and Noarlunga is a little below that of Elizabeth. I would like the Minister to provide the exact numbers of RPIs that exist throughout his department in all offices.

The Hon. Dean Brown: We will obviously need to obtain that information. We do not have that information here, but I will ask Mr Proctor to comment briefly on what is occurring. In broad terms, the number of reports is increasing with respect to abuse and neglect. We think one reason for that is that the community is much more aware of this and much more willing to talk about it and report it than it was a few years ago. Whilst there is a significant increase in the number of reports, the number of proven cases is in fact increasing at a fairly slow rate by comparison. In other words, the number of cases reported now are marginal cases that eventually do not prove to be accurate or to have enough substance to follow through.

Ms STEVENS: What is a marginal case?

The Hon. Dean Brown: I will ask Mr Proctor to deal with that in more detail.

Mr Proctor: The Minister made the point that notifications have gone up at a much faster rate than confirmations of abuse: that is relatively stable. As an example of the issue of notifications, we noticed last year that, with the arrival of the central abuse report line, there was an increase of something of the order of six times the reporting in the country as opposed to the city which we would suggest is nothing other than a reflection on the availability of the central abuse report line, that being, therefore, an easier thing to do.

In terms of confirmations of abuse and neglect, we have made the point that compared with the number of notifications there has been an almost negligible increase in numbers. As to the responses we have been making, it is the case that all tier 1 cases—those where children are in imminent danger, the ones at the highest risk—were investigated and action taken. That is true in over 80 per cent of tier 2 cases, and tier 3 cases—

Ms STEVENS: The same as last year, 20 per cent—

The ACTING CHAIRMAN (Mr Gunn): Order! Allow the adviser to finish the answer.

Mr Proctor: The way the question was put suggested that last year we were missing 25 per cent of tier 1, from memory. The point I am making now—and it was probably true last year in any event—is that all tier 1s are attended in accordance with the methodology; they are attended within 24 hours. With respect to tier 2, we get to 80 per cent, and they are those of lower risk. Beyond the 80 per cent, there are other cases where, for example, a worker will go to an address and there is no-one at that address and that is really the end of the trail. That is bundled up in the difference between the 80 per cent and 100 per cent.

What we are talking about, using the terminology 'resources preventing investigation', are those cases where—after considerable discussion within each district centre,

between district centres and between district centres and the central intake team, a judgment is made as to the availability of resources to follow up each and everyone of these right across the system—it is inevitable that in the end some cases cannot be attended immediately. However, because of the way we go about our work, they are those of lower risk.

Across the system, there are one or two centres where there are matters of concern and these are brought to our attention at the centre through the kinds of statistics we collect, and we have acted immediately in those cases where centres look to be under considerable pressure to assist in alleviating those particular pressure points. Generally across the system their resource preventing investigation numbers are relatively low.

The Hon. G.A. INGERSON: Page 5.7 of the Portfolio Statements refers to improving service delivery for Aboriginal communities through better coordination of planning, funding and future service delivery. What is the department doing about the needs of those people, most particularly those in the inner city?

The Hon. Dean Brown: This is an issue I have talked about a little in the House, and you may recall an answer to a question several weeks ago. Services to the Aboriginal people, particularly in the inner city areas, are a key priority of the Government. To support that, we have a number of initiatives, and let me run through some of those. We are providing: $600 000 for a new boarding house facility to provide accommodation for 15 to 20 women; $1.8 million for the redevelopment of the St Vincent de Paul night shelter to provide state of the art facilities; and increased funding of $42 000 for Hutt Street. We are also providing $20 000 for Westcare day centres, where homeless people go to have a meal, perhaps have a shower and have health matters attended to, and where meals are now available seven days a week. Previously, meals were provided on only five days a week at these centres; so we have put extra money into that area.

There is funding for the Burdekin Clinic to ensure that its clinical and outreach programs continue to be an important access point for vulnerable people to general practice and primary health care. There is funding for an Aboriginal outreach support team to work with people in the parks and squares. There is an amalgamation of that team with the City Homeless Assessment and Support Team, which has also received increased funding. There is Commonwealth funding for four Aboriginal outreach and support workers at the Sobering Up Unit through the drugs strategy to improve the transition of Aboriginal people into rehabilitation programs.

The member can see that a fairly comprehensive list of programs has been put in place specifically to target homeless Aboriginal people in the city area. Those people invariably have a number of complex problems. It may be lack of accommodation or a health problem, but invariably it is lack of money to buy food and things such as that as well. Whatever one does in that area needs to be a fairly comprehensive service. There is no simple solution. I think that people do not appreciate how much is being done to tackle these problems. Some problems will always arise, but a very comprehensive program is now being put in place to tackle the issues as broadly as possible. I was surprised to find that something like 28 different programs are funded by the State Government in the City of Adelaide for homeless people.

The Hon. G.A. INGERSON: I think it is fair to say that very few people know that, so it would be good to see a release put out into the community to tell them what is going on.

The Hon. Dean Brown: I have provided information publicly. It is hardly high profile material, though: the media do not find a great deal of interest in it.

The Hon. G.A. INGERSON: In relation to the new Supported Accommodation Assistance Program agreement, I understand that recently some development has occurred with the Commonwealth. Will the Minister advise the Committee of the progress in the negotiation of this program?

The Hon. Dean Brown: SAAP (Supported Accommodation Assistance Program) is the agreement about which we are talking. It is a joint effort between the Commonwealth and State Governments. The Commonwealth provides most of the funding, although there is some joint funding. We normally have to get the Commonwealth Government's approval for signing off on the program, although we do the assessment and make the application to the Federal Government. The current agreement expires in December 1999. In April, the Commonwealth and State Community Services Ministers agreed that SAAP was a vital and successful program and that it has responded well to the needs of homeless people in the community.

They have agreed that SAAP should be built on with ongoing in principle support. It is strengthening its focus on the client. It is enhancing the program's performance. It is ensuring that there is a link between the SAAP programs and other programs administered in this area as well and it is ensuring that there is, if you like, a partnership between those who provide the services in the community. The amount of money we put into SAAP is quite considerable. I am encouraged by the high level of extra money that goes into these programs each year.

The Commonwealth 1999-2000 budget included $140 million nationally for SAAP compared with $134 million for the previous financial year. So, it is a $6 million increase on the previous year. That is partly due to $45 million of extra funding over a five year period for industrial award increases in some States. The Commonwealth budget included $13.5 million for South Australia in 1999-2000, which was similar to the allocation for the previous year. From that the member can see that we receive about 10 per cent of the national money, which is higher than our normal share on a per capita basis. The Commonwealth funds make up 60 per cent of the total program, and the State funds make up about 40 per cent. If the member puts that together and takes $13.5 million for South Australia in 1999-2000 (that is 60 per cent of the funding), he will find that the total funding will be about $22.5 million for this coming year. We are putting a lot of money into that SAAP program.

In addition to that, there has also been some one off funding under CAP. CAP provides the capital funding and SAAP provides the recurrent funding. In other words, CAP funding is used to build the houses, furnish the houses and things such as that, and then the SAAP funding provides the support within those houses.

The Hon. G.A. INGERSON: Unfortunately, domestic violence is all too common, as the Minister would be aware. I understand that people escaping domestic violence are high users of the Supported Accommodation Assistance Program. Could the Minister advise the Committee on other programs that are being set up by the department and how they are being implemented to help those people suffering from domestic violence?

The Hon. Dean Brown: We have, if you like, a joint agreement between the Commonwealth and the State for a

range of programs for domestic violence, and there was an initial allocation of $200 000 to projects which have now been completed. What has come out of those programs is an accredited competency standard for workers in the area of domestic violence; a resource kit for use with Aboriginal children; 13 community service announcements about domestic violence which specifically target women; a project report detailing the benefits of peer education, especially amongst young men who are invariably the perpetrators of the domestic violence; and community resource material. Materials have now been distributed to 35 locally based domestic violence action groups working in various communities, and there is research into the needs of people experiencing domestic violence.

We are addressing domestic violence in some key areas such as mental health and family violence within selected Aboriginal communities. In fact, there was a very good program on I think it was *Business Sunday* or the Sunday program on Channel 9 that specifically looked at domestic violence in Aboriginal communities around Australia. It is a huge issue. I know we see in the hospitals some of the consequences of domestic violence, particularly in respect of the Aboriginal communities. The level of violence in those communities is many times that of the rest of the community.

It is a very difficult issue with which to deal. For example, when I asked one particular person whom I saw at the Queen Elizabeth Hospital and who was from the Anangu Pitjantjatjara lands what had happened she said, 'I got very excited and hit myself violently with a brick too many times.' She had a face that looked like a football. It was extremely severe to say the least. It was appalling. In other words, we cannot even put this down as domestic violence because they will not report it as such. There are some real issues to come to grips with, especially within Aboriginal communities. We are allocating about $200 000 to $280 000 each year to come up with a range of programs.

We had a ministerial forum, and a ministerial group, comprising four Ministers, looks at this. I am a member, as are the Attorney-General, the Minister for the Status of Women and the Minister for Police. I am sure that, having been Minister for Police, the honourable member is aware of the ministerial group. We decided to hold a forum on the prevention of domestic violence; I went to that forum and participated in the closing sessions. We have 35 different locally based domestic violence action groups and as Ministers we saw details of two specific programs in the southern suburbs aimed at young men in particular who tend to be violent amongst each other and in any relationship they get into. It may be that they are still in their normal family relationship so it is against their parents or siblings, or it may be in their relationship with a partner. We are trying to educate those people, at the age at which that aggression starts, to understand, recognise and control that aggression and to seek help when they need it.

Ms STEVENS: The Productivity Commission report on Government services 1999 indicates a 15.4 per cent increase in child protection notifications in South Australia for 1997-98, and the Minister can probably give more up to date figures for next year. However, the report states that the number of individual children notified per 1 000 children aged nought to 16 is 22.5 for all children, yet 81.5 per 1 000 for indigenous children—four times as high. Will the Minister advise what action he is taking in relation to child protection, prevention and support for indigenous children and their families?

The Hon. Dean Brown: Mr Proctor will give the details of some of those programs.

Mr Proctor: All the additional resources we talked about earlier as having gone into the system are addressing the child abuse needs of all the children, but specifically within the system there exists a central Aboriginal team called Yaitya Tirramangkotti, which receives notifications on Aboriginal children and provides advice on how best to intervene for Aboriginal families and children so that family and kinship structures are recognised and respected. So, we are trying to be sensitive to the needs of Aboriginal children and their families in the way we go about that part of our business.

Ms STEVENS: Is that all?

Mr Proctor: No; various programs are available to provide support for the Aboriginal community and assistance to families in the community. They are all designed to support families to avoid the issue of child protection becoming part of the picture.

Ms STEVENS: The information I have is that the notification rate is four times that of other children. What specific programs exist? What specific dollars do you attach to those programs which would give us some confidence that you are actually dealing with the issue?

The ACTING CHAIRMAN: The honourable member can be critical of the Minister but she cannot make criticism of the people assisting and advising the Minister.

Ms STEVENS: I am asking a question.

The ACTING CHAIRMAN: The honourable member may ask a question but it is the manner at issue. The Chair wants to be reasonable and tolerant. Criticism can be made of the Minister and the Government but not of the people assisting the Minister.

The Hon. Dean Brown: I think the honourable member is ignoring what is being talked about in terms of the broad range of services available. She has asked what specifically is being done for the Aboriginal communities, and Ms Charles will answer that.

Ms Charles: As a portfolio we well recognise that on any indicators Aboriginal people tend to be in a much more disadvantaged position than are most other members of the community. With this in mind and with very strong support from the Minister, we have formed an Aboriginal Services Division that brings together at the top level of the portfolio the responsibilities around policy and working with the Aboriginal community on health, housing and community services. So, the FAYS response is part of an overall approach of working with the Aboriginal community.

The health planning that has gone into quite significant consultations right across the State to develop regional health plans takes a holistic view of health, looking at mental health in families, violence within communities and families, and family support structures. It links into mainstream services, as well as our crisis and acute responses around child protection and family violence.

I would not for a minute pretend that we have any magic or easy answer, but I can say that we have genuinely put a very high priority on this area across the portfolio. We require that all service agreements for all services not only in crisis and welfare response but also across the health and housing services take into account the needs of Aboriginal people as one of the highest need client groups. To that end, reporting frameworks are being brought together to try to look at the total experience for Aboriginal children, particularly as victims in child protection but also as affected by the high level of family breakdown in this community and the inter-

community and intra-community violence that exists. So, that also needs to pick up our drug strategies as well as mental health and the broader education strategies.

We are also aware that the over representation of Aboriginal young people within the justice system itself is another component of that jigsaw puzzle. I do not think that in a year's time I will be able to sit here and advise the Minister that we have solved the problem, but I can say that resources are being directed seriously into this area. Because we have taken a high profile, we are also being more successful in attracting Commonwealth funding, and Aboriginal services and Aboriginal health in the broader sense is an area where more Commonwealth funding is likely to be available. At the end of last financial year we received additional funding because of the new arrangement. Working closely with Health and Aged Care and Family and Community Services federally, who are very interested in some integrated programs for Aboriginal families and children, we expect to be able to put some further initiatives on the ground. As Ian Proctor has already reported, we have specialist teams working within Family and Youth Services to pick up on Aboriginal children.

We have some more detail about how we are dealing with Aboriginal young people in the system. We have the Metropolitan Aboriginal Youth Team, which is a team of Aboriginal workers who are working specifically with Aboriginal young people and who are trying to focus on early intervention. We have just put continued funding into the outreach team working with the Adelaide City Council in dealing with vulnerable adults and young people in the city, and that has an Aboriginal focus. A range of programs is being delivered by the Metropolitan Aboriginal Youth Team, including bail supports, family placements and alternatives to custodial remand for young Aboriginal people. That is as much as I can say in support of the information we have already given. Certainly, we would be happy to provide additional material on the current activities of the Aboriginal Services Division, which cover the spectrum.

The Hon. Dean Brown: There is no doubt that Aboriginal children are over represented in the alternative care area. The figures show that on 30 June last year approximately 1.8 per cent of the children in alternative care were Aboriginal. That figure of 18 per 1 000 is below what it was before, which was 23 per thousand.

Ms STEVENS: Is that alternative care or protection? I was talking about child protection.

The Hon. Dean Brown: I was talking about alternative care. If there is a child protection issue, the child then goes off to alternative care, so we are acknowledging that there is a high level of children in alternative care as a result of abuse or neglect within the Aboriginal communities.

So, I am saying that there has been a drop from 23 per 1 000 in the previous year to 18 per 1 000, but one of the problems has been the shortage of Aboriginal foster parents. Therefore, in the large majority of cases it is necessary to place Aboriginal children with non-Aboriginal families, and that has been a real issue of contention. I have met with some of the parents involved in some of those cases. The Government is trying to increase the pool of Aboriginal foster parents so that they are within a similar culture as Aboriginal children. But, it is a major issue and, frankly, because of the high break-down rates and the high level of violence within those Aboriginal communities, it is simply an area that we have to continue to work at. But, that is acknowledged. I think the honourable member should not suggest that we do not understand the problem and that we are not trying to put resources into it.

Ms BEDFORD: Can the Minister advise what steps have been taken to implement the recommendations of the Social Development Committee that research on gambling conducted in Australia be coordinated and collated to avoid unnecessary duplication and to assist in facilitating other research programs, in particular those relating specifically to South Australian conditions? Has the Government undertaken any research on the cost to the community for each problem gambler?

The Hon. Dean Brown: I think the honourable member has indicated she is talking about the recommendations of the Social Development Committee's report on gambling. Let me start by expressing some concern about what I see as further escalation in the use of poker machines within the community. First, something came out nationally yesterday which indicated that Australia has a higher level of per capita gambling than any other nation in the world. That concerns me. I think I am right in saying that the figure is perhaps something like twice as high in Australia per capita compared with other developed countries. Gambling losses in South Australia have soared to $669 million a year, the equivalent of almost $600 for every adult in the State. It is a 66 per cent increase in three years and, clearly, a lot of that can be attributed to poker machines.

It is something about which I feel strongly. I am concerned at the projected income this year for the State from poker machines which, again, further reflects that escalation. I think the figure this year in the budget—and this is off the top of my head—is $201 million. Two years ago it was $159 million. We have had over a $40 million increase in just two years in South Australia in terms of projected tax to the State from poker machines.

I can recall when poker machines were first introduced—and I want to say from the outset that I was not a member of this Parliament when that crucial vote was taken on poker machines. Some people are trying to blame the Brown Government for the introduction of poker machines: I was not even in the Parliament when that vote was taken. Frankly, if I had been here I would have voted against them. I have always taken a strong stance against poker machines. I went to university interstate in New South Wales. At Armidale, I saw the direct impact of poker machines on the community. All that I have argued about the impact of poker machines has come to fruition in South Australia. I am not a supporter of them at all. The introduction of them highlights the problem we have.

I am also concerned at the further escalation which is occurring in this year's budget in terms of projection. As I said, a few years ago we thought the Government tax take would level off at about $150 million a year. It is now estimated to be over $200 million for this coming year—and growing. In other words, a new spurt appears to be occurring.

My department is having to pick up a lot of the social consequences that result from the abuse of poker machines. Many people in the community can use a poker machine and use it in moderation, but there are some who find that they have a habit and that they cannot control that habit. As a result, there is a severe impact on other members of the family. If you talk to some of the welfare organisations within our community, they continue to be concerned—in fact, alarmed—about the growing incidence of the social impact on children who do not have lunch money, who do not have money to buy decent clothes for school, and who do not have

money to do all the other things that we assume a child should have. It must be excruciating for those children to go to bed at night without a decent meal, feeling absolutely hungry, simply because someone in their family has a poker machine habit that they cannot control and has spent the money on poker machines and wasted the money on poker machines rather than looking after the children. I am scathing, frankly, of people who put their children in such a predicament.

We have programs under the Break Even area. We have two reports before Government at present, including the Social Development Committee report which is currently being assessed by Government. The review of the Break Even Service, the Gamblers' Rehabilitation Fund, is in my area of responsibility and I am working through those issues. The review of the Social Development Committee report is the responsibility of the Treasurer. I have made a submission to the Treasurer expressing my views on a number of the recommendations. They are yet to be considered by Government, but they are being collated by the Treasurer at present. All I can say is that I have taken the view that I believe more money ought to be put into the Break Even agencies.

The Hon. G.A. Ingerson interjecting:

The Hon. Dean Brown: I know the honourable member was one of those who argued that there should be a certain fixed percentage—and I support that. We have had no increase, despite that significant increase in the use of poker machines, from when we were getting $1.5 million a year, when the use of the poker machines was $150 million or $145 million a year. It is now up over $200 million a year and there has been no increase in funding for the Break Even agencies. Equally, there has been no increase in the community benefit. This Parliament put through legislation, which I initiated when I was Premier, that $25 million should be put into a range of community projects. Some of that went to education, some to health, some to other areas; and $3 million of it went to Community Benefit SA.

Although there has been a substantial increase to both the Government and the industry from poker machine revenue, there has been no increase in moneys to the Break Even agencies, the Gamblers' Rehabilitation Fund or the community projects. I have a strong view on a number of matters raised by the Social Development Committee. However, those matters are yet to be resolved.

Ms BEDFORD: I have a supplementary question: in the light of all that, why does the Minister think there has been no increase to the funding for the Break Even services?

The Hon. Dean Brown: Because it is on a voluntary basis—and I acknowledge this—through the Hotels Association in that $1.5 million a year is provided for Break Even services; therefore, it is not a percentage of the funds collected. My personal view is that it should be a percentage of the funds collected. The need is increasing, but the allocation of funds to that area is not increasing. We have established a telephone hotline. We anticipated that there would be about 210 calls a month to that telephone hotline which operated on a trial basis and which was funded under the Gamblers' Rehabilitation Fund. We had 333 telephone calls during March this year. Over the past few years there has been an increase in demand for services provided by Family and Youth Services. There has been a 20 per cent increase in demand for emergency financial assistance. Again, that directly reflects the impact of poker machines.

The Gamblers' Rehabilitation Fund evaluation highlighted that the nature of gambling is changing rapidly with the advent of the Internet and also pay-TV gambling, which has the potential to have a dramatic, further increase in terms of an adverse impact on the community and to encourage even more gambling within the Australian community. Currently, the Gamblers' Rehabilitation Fund holds $1.5 million. However, gambling problems are not restricted just to poker machines. I think it is time to look seriously at other areas of gambling and whether they should contribute to a rehabilitation fund as well.

Ms BEDFORD: I have a further supplementary question: that is one recommendation in the SDC report and, as you say, it is still under consideration. Why can the Government not put some of its own money into this fund? We have talked about the contribution of the AHA. Why can the Government, as it used to, not put some money into it? Is that not possible?

The Hon. Dean Brown: That is a point I will take on notice. I will draw it to the attention of my colleagues.

Mr HAMILTON-SMITH: I refer to families in poverty and to what this budget is doing to help them. I note that data is often published by agencies such as the Australian Bureau of Statistics and the Australian Institute of Health and Welfare that highlight the increasing number of families living in relative poverty. At page 5.7 of the Portfolio Statements there is reference to reducing the rate of families falling into the low income bracket. There is some confusion in the community about what is 'poverty' and what is 'living in a low income environment'. Could the Minister explain what strategies have been developed within the department which are funded in this budget to support low income families?

The Hon. Dean Brown: First, we should be aware—and I am using my memory here—that 42 per cent of the South Australian population lives on an income of 60 per cent of average weekly earnings. I am not sure of the exact time frame, but that has increased from about 23 per cent. We are now talking about 40 per cent of the population being in this category of lower income—60 per cent of average weekly earnings or less. My recollection is that that 60 per cent figure represents about $17 500 or $18 000 a year. We offer a range of incentives and programs in this respect. There are the housing programs conducted by the Housing Trust, and so on, and we have tried to make sure that we target the housing needs more specifically. I have talked in the Parliament about the whole range of initiatives in that area. There are concession programs for electricity, water, sewerage and council rates. The demand on our concessions is increasing each year, simply through more and more people being eligible for existing concessions. Of course, with the new emergency services legislation we are offering concessions as well.

We have a range of anti-poverty programs, and they include such things such as financial counselling and support, project development, funeral assistance, concessions—and we are putting about $68 million or $69 million into concessions before the emergency services concession is included—and low income support programs. Of course, a number of them are provided through FAYS. There is financial counselling for families where they sit down, work through their budgets and look at what money they have and how they can target important expenditure. There are target groups who are at risk and people who work with those groups. There is enormous support in the community via non-government agencies.

I referred earlier today to the fact that we put out about $145 million through non-government agencies in the FAYS area generally, and much of that help goes to low income

families. In some special areas such as Aboriginal areas and non-English speaking background areas, we have special support for individuals and families on low incomes. It is an area where you could keep talking about a whole range of different initiatives, but they are the types of services generally that we are delivering to those families. I mentioned earlier—and this is something that the Parliament and Governments have to come to grips with—the growing gap between the haves and the have-nots in the community and the increasing number of people in that low income group.

Ms BEDFORD: What steps have been taken in Cabinet to convene the subcommittee recommended by the SDC—and this goes back to August last year—of all Ministers with portfolio involvement in gambling activities to ensure that there is a proper balance between revenue raising functions, licensing and community welfare responsibilities?

The Hon. Dean Brown: I appreciate that the honourable member has not been in government, but you cannot talk publicly about what goes on in Cabinet, which is exactly what the honourable member has asked.

Ms BEDFORD: Just a hint will do.

The Hon. Dean Brown: No. The honourable member specifically asked what was being done within Cabinet on this issue. I am not in a position to do that. I can indicate that Ministers, including my agency and me, have put in submissions in terms of what we think should be the response in relation to the Social Development Committee's recommendation.

Ms BEDFORD: When might we see some action? This is nearly a year old.

The Hon. Dean Brown: I cannot put a time frame on it; I am not responsible for the response.

Ms BEDFORD: We know that we have your support on it, so I suppose that is good.

The Hon. Dean Brown: The answer to that last question is 'Yes.'

Mr HAMILTON-SMITH: As the subject of poker machines and revenue gain has been raised, what does this budget propose in respect of the Charitable and Social Welfare Fund, which was established under the Gaming Machines Act to distribute funds to incorporated non-government community organisations? I note on page 5.53 of the Portfolio Statements the provision of $3 million to the department for distribution by this fund. Will the Minister provide details on how these funds will be allocated?

The Hon. Dean Brown: The Parliament passed legislation requiring $3 million to be allocated each year to this fund. A separate independent board was set up to assess projects and allocate the funds. I recently met with the board and discussed a number of issues, one of which involved the fact that a huge number of applications are received but only two allocations of just below $1.5 million are made each year. Two funding rounds were conducted in 1998-99: round 6 in November 1998 and round 7 in November 1999. A total of 929 applications were received requesting $16.45 million. So, requests were made for $16 million, but there was only $3 million to hand out. It has become a bit of a lottery in itself in terms of the money available to go around.

The number of requests has increased from 724 applications for $12 million in the previous year. That is a fairly significant increase: a 28 per cent increase in the number of applications and a 36 per cent increase in requests for funds. One-off projects numbering 289 were funded at a total of $2.89 million (the remainder of the money was used for administration); $1.27 million (44 per cent) for metropolitan projects; $887 000 (31 per cent) for statewide projects; and $724 000 (25 per cent) for rural projects.

Specific assistance was provided in the following high need areas: 44 projects to assist people with disabilities ($552 000); 29 projects to assist ethnic communities ($253 000); 24 projects to Aboriginal people ($360 000); and 22 projects to assist organisations to develop new fundraising strategies to increase their annual revenue ($423 000).

Two areas of funding are involved. The maximum for normal grants until now has been $25 000. I think it is worthwhile informing the Committee that my approval has been sought to put a ceiling of $30 000 on those grants. There are also the $75 000 grants specifically for organisations which may have missed out on money from fundraising efforts because of poker machines. This is an interim way of helping them to establish a new means of raising money. These funds are highly treasured, and all this goes under the name of Community Benefits SA.

Ms BEDFORD: I refer to the Gamblers' Rehabilitation Fund. Has the current allocation of funds been spent, including the backlog of previously allocated moneys; and, if so, in what way?

The Hon. Dean Brown: Total anticipated expenditure for 1998-99 is $1.75 million. That is more than the amount of revenue received for the year. There is $1.306 million for ongoing services, $441 000 for one-off initiatives, and $1.38 million of accumulated funds was committed to a two year plan announced in December 1999. I will supply the honourable member with the remainder of this information.

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

Membership:

Ms Thompson substituted for Ms Bedford.

Mr Conlon substituted for Ms Stevens.

Additional Departmental Advisers:

Mr P. Smith, Acting General Manager, South Australian Housing Trust.

Mr P. Jackson, Director, Asset Services, Department of Human Services.

Mr CONLON: I note the almost weekly letters to you from residents of the Stowe Court Housing Trust tenancy. You seem never to solve their problems. What is the reason for your abject failure to sort out the problems of the people at Stowe Court? I got another letter today and I assume that you still have not fixed up their problems. Why is that?

The Hon. Dean Brown: I have been to Stowe Court. The member for Waite took me there and we had an interesting time when we had morning tea there one Sunday morning in the rain with a group of residents. I am impressed with that facility, which has superb gardens. There are one or two issues involving some of the tenants in those houses, but they were delighted that we have now introduced the six month probationary tenancy. They were also delighted that we had reintroduced home visits. Here was a group of well established Housing Trust tenants; they tended to be long-term tenants, many of them single aged women who had retired and wanted to ensure that the security of that area is maintained.

They were concerned about how in the past some tenants who had been brought in were unsuitable to go into that area. We worked hard to make sure that that does not occur. They were particularly pleased because, if a tenant comes in and

is clearly unsuitable for the environment and causes problems to neighbours, under the six month probation tenancy action can be taken: a person can be appropriately warned and, if need be, found accommodation elsewhere. They were pretty pleased about that. If the honourable member has specific issues that he wants to raise, perhaps he should raise them and be specific.

Mr CONLON: I am sure you know what the issues are. I just wondered why it has been so hard for you to please people down there.

The Hon. Dean Brown: What specific issue are you talking about?

Mr CONLON: I have a copy of a letter sent to you complaining yet again about a whole range of things such as gardening, tenants and the operation of the six month probationary period. I am sure you have the same lengthy letter as the one I received.

The Hon. Dean Brown: From one particular tenant?

Mr CONLON: Yes, from one particular tenant.

The Hon. Dean Brown: Some tenants like to write to me on a regular basis and they invariably raise the same issues each time they write. That is okay: different people have different characteristics. I am delighted that they feel they can relate to me so closely that they can send me frequent letters to tell me some of the issues that concern them.

Mr CONLON: They seem to relate to everyone in a rather forthright and blunt fashion. Back in February 1998 the Minister gave an answer in Parliament about things that could be done in the Housing Trust if ETSA were sold. One of those things, I understand, was that you can substantially upgrade 90 houses a day.

The Hon. Dean Brown: The honourable member has used a very general phrase there. Will he read the specific answer that I gave?

Mr CONLON: In terms of housing, the Minister said that he could provide 15 new houses for the Aboriginal community every day with the $2 million, that he could provide 20 new public houses for those on Housing Trust waiting lists, or that he could substantially upgrade 90 houses a day down in The Parks community. I am not suggesting that now that the Government has sold ETSA the Minister will upgrade 90 houses a day.

The Hon. Dean Brown: What was my opening remark? My opening remark was: if we spend $2 million a day on interest, what could you do with $2 million of interest? That was a very specific answer I gave.

Mr CONLON: I would like to say that I can find that here, but I cannot; I can only find the answer. I will read out the entire answer if the Minister likes, but that is not what he says. The Minister mentions interest payments there, but these are his words. I have not suggested that this is what the Minister should do if he sold ETSA: I am suggesting that this is what he told Parliament he could do. I do not think that the Minister has been pointing at any particular person, but in recent days he has had criticisms of the integrity of politicians who are not prepared to tell the truth, so I assume that he would like to do at least some of those things he outlined; not 90 houses a day being upgraded but that $23 million will go into renovation of Housing Trust stock. How many houses will that renovate?

The Hon. Dean Brown: The honourable member has, quite deliberately I think, missed the point that I made in that answer. I can recall that answer very well. I said that we had a debt and we pay approximately $2 million a day on that debt, and that if we did not have to pay $2 million a day on that debt these are the things we could do.

Mr CONLON: If we are going to retire the debt, when will the Minister do these things?

The Hon. Dean Brown: There is a difference between what the honourable member is saying and what I am saying. I talked about a general debt and said that we spend $2 million a day on that general debt, and then I described some of the things we could do with $2 million a day. I did not say at any stage that by selling ETSA we would have $2 million a day available. I did not say that at any stage.

Mr CONLON: Perhaps the Minister could tell us what is the Housing Trust dividend out of the ETSA sale. We are not going to get the $2 million, and I accept that. We did not accept at the time that all you people could spend the same $2 million every day. What is the Housing Trust dividend from the ETSA lease? What extra do we expect from the sale now that the thing that is going to save us all has occurred?

The Hon. Dean Brown: The benefit to the budget from the ETSA sale is a matter for the Treasurer, and he has already talked about that before the Estimates Committees. As the honourable member and everyone else knows, an allocation has been made to housing, and we are dealing in this budget with that allocation. There is also the money under the Commonwealth-State Housing Agreement, and that is the other significant area of funding in the housing area; in fact, it is the biggest area of all.

Mr CONLON: I note that the budget papers, I think at page 5.20, give a target for reduction in the number of properties this year as 1 000, with 150 homes to be built. I also note the Minister's comments in recent days, which I welcome, concerning the widening gap between the 'haves' and 'have-nots'. How will the reduction in Housing Trust stock, an overall reduction of 850 next year, help to address the widening gap between the 'haves' and 'have-nots'?

The Hon. Dean Brown: We have an allocation of money from the Federal Government. I remind the honourable member that it was his Federal Labor Government in 1989 that decided no longer to index allocations of funds under the Commonwealth-State Housing Agreement. As a result of that, there has been an effective 42 per cent reduction in real terms in funds under the Commonwealth-State Housing Agreement.

If you have a declining amount of money coming in under that agreement, clearly you cannot maintain all the housing stock that you have, the new build program and the renovation program, particularly when a significant number of your houses are over 30 years of age. The Housing Trust has a program where it is trying to encourage those who can afford it to buy their own home and, through buying their own home, therefore no longer to be a Housing Trust tenant but in fact be fully supportive of themselves. That is one reason for the reduction. Another reason for the reduction is that we are doing major urban renewal projects in a number of areas, such as The Parks, Salisbury North, Hillcrest and others—

Mr CONLON: You couldn't add Edwardstown to that list, could you? We could do with a bit of work down there.

The Hon. Dean Brown: Mitchell Park did receive a very substantial amount. Is that outside the member's electorate?

Mr Conlon interjecting:

The Hon. Dean Brown: I see. Heaven help us, then, if you are Minister, if you had to allocate it to specific electorates!

Mr Conlon interjecting:

The Hon. Dean Brown: I see. But there are programs in country areas such as Port Pirie and Port Lincoln as well. As part of those urban renewal projects, that also tends to bring about a reduction in the number of houses. We are out there with a new build program, trying to build houses which are more relevant to the needs of our tenants. Also, we are diverting an increasing amount of the Commonwealth-State Housing Agreement money across to community housing.

For instance, there will be about a 300 home increase in community housing this year. Community housing now has about 3 000 homes. So, if you take the community housing and add it to the Housing Trust homes in South Australia—at present we have about 57 000 Housing Trust homes, and by the end of this coming year we will have 3 000 community houses—we will be very close to 60 000 homes. In fact, over a number of years, there has not been much variation in the total number, but there has been a substantial rebuild or refurbishment program within the Housing Trust which has brought that about and, at the same time, fairly significant home ownership has been secured, and we have openly encouraged that. Some of that was done under the deposit 5 000 scheme where there was a specific program for Housing Trust tenants.

Mr CONLON: I would like to follow that up in a moment. The Minister actually has my sympathy in this regard. I think he is one of the few people on his side who actually do make noises about the contribution via the Federal Government to South Australia. I would say it has been a great disappointment that we have seen some fairly big surpluses in Canberra and not a lot going our way. Minister, why do you do your bit for South Australia—that is, make noises about what we are getting from the Commonwealth—when your Premier seems to be completely sanguine and always comes back from there (dare I say it) relaxed and comfortable about what he gets from Canberra? When can we expect the Premier to say a little more about the lack of support he is getting from the Federal Liberal Government?

The ACTING CHAIRMAN: Order! The Minister is responsible only for his area. A Minister cannot comment on other portfolios.

Mr Conlon interjecting:

The ACTING CHAIRMAN: It is a good try, but it is not relevant to the Minister.

The Hon. Dean Brown: Mr Chairman, I appreciate your ruling, and I will certainly adhere to it. I should point out to the honourable member who has just raised that point that it was his Government that did not index Commonwealth-State housing grants, and they ran for the longest period. In fact, the Premier of South Australia has given good support in the campaign against the Federal Government. Along with other Housing Ministers, earlier this year I raised concern about the real reduction in funding that would occur as a result of the GST. When we could not resolve it with the Commonwealth Minister for Housing, we asked the State Premiers and Leaders to take up that issue. They took it up at the Premiers' Conference, and they secured the money we had asked for, which was $269 million extra. We have had good support from the Premiers; they have given us complete support.

In the most recent case, there is an agreement between the Democrats and the Federal Government over the GST, and the extra 4 per cent that would be allocated to pensions—it is not a simple thing but let us simplify it for this case—as well as the extra amount that would be allocated to pensions to ensure that the level remained at 60 per cent of average weekly earnings would not become part of the additional rent charged. In other words, we would not be charging as rent 25 per cent of that 4 per cent. Hence, we would have been short of money. I raised this matter with Cabinet, and we encouraged the other Housing Ministers around Australia to raise it.

We have taken up the issue with the Federal Government and, with the support of the Premier and the Treasurer, we have now had allocated back to the States a specific tax, which is a stamp duty on the sale of unlisted shares. That money comes back to the States, and in South Australia it has been earmarked for compensation back into the housing portfolio for money we would have otherwise received from the increase in the pension on which we are not allowed to impose the additional 25 per cent. So, there is another example where there has been good support from the broader Government and the Premier back into the housing portfolio.

Mr CONLON: In regard to the reduction of public housing stock—and I touched on this question last year—when you were Premier the Audit Commission recommended a reduction in the proportion of public housing stock to the national average of 6 per cent from 11 per cent. There will be no continuing reductions. Is that the target for the reduction of public housing stock in South Australia?

The Hon. Dean Brown: No, it is not because, on those figures, you would be down to about 30 000 and that is not our target at all. If the member looks at the triennial review, they have done some modelling—and this is the part that concerns me. We need to ensure that we have enough resources to maintain our Housing Trust stock at a reasonable and acceptable level. They have highlighted that there are increasing financial problems as we move further out from where we are at present and we have this large block of housing which is getting older and older. Therefore, you need to be able to invest more into refurbishing the housing, and that creates a problem. Unless there is a significant shift in parameters on all the known parameters at present, particularly money coming under the Commonwealth-State Housing Agreement which is declining, clearly we have to be very aware of this difficulty into which we are heading with the 57 000 homes which are ageing and the maintenance costs for which are thus substantially greater.

The triennial review highlighted some of the ongoing funding problems we will have. We are conscious of that. Under the model that they used, they suggested a gradual reduction over 15 years (I think it was) to 43 000 homes.

Mr CONLON: I want to touch on that upgrading of stock, and I appreciate the difficulties the Minister has. Can the Minister tell us, in general terms, how many homes will be upgraded next year and, in particular, how they are selected? I will tell the Minister a story from my own electorate, which is the reason for my asking the question, although I must say that the Minister's office did fix this up, for which I am grateful. I wrote to the Minister about it and his office fixed it up. The woman lived at Morphettville in a row of Housing Trust homes which were exactly the same. She came home one day to find that the homes on either side were being renovated and hers was not. She inquired of the local people responsible why that was the case. They said that they had only enough money to do a certain number. She had not been home when they visited and the other people had been, so they were getting their homes renovated. How many will be renovated next year and on what basis is that decided? I just hope that it is on a better system than who happens to be home when the person calls.

The Hon. Dean Brown: The member has asked the question in terms of how many homes will be renovated. We expect to sell about 1 150 homes this year and we think that will raise about $42 million. We expect to purchase over 30 established homes at an estimated cost of $4.1 million. We expect to construct—that is to finish construction—150 new homes at an estimated cost of $12.9 million. We anticipate spending $4.9 million on the purchase of land for a future building program because the number of Housing Trust homes that will be built is on the increase now that we have virtually written off the high interest rate debt within the Housing Trust. We have done a very good job. I think we have reduced it from $375 million (which is what we as a Government inherited) to about $20 million, and in the next few months it will be eliminated completely.

Mr CONLON: The Minister is not saying that he has eliminated the 4 per cent debt, is he?

The Hon. Dean Brown: No, this is the high interest rate debt about which I am talking. It is relevant to know that, because of the actions that we have taken, instead of spending about $30 million a year on interest payments that $30 million can go into renovations, upgrades and the purchase of new homes. About 950 homes will be renovated this year at a cost of about $22.6 million, and we have redevelopment and urban regeneration projects going on in the areas I mentioned earlier—Elizabeth North, Hillcrest, Mitchell Park, The Parks, Lincoln South at Port Lincoln, Risdon Park at Port Pirie, Windsor Gardens and Salisbury. Those programs are costing us about $9.6 million in the year.

Mr CONLON: I ask the Minister to answer the second part of the question, given the story I have related, which I assure him is a true one. How do you select homes for upgrading? I hope it is done on a better basis than whoever happens to be fortunate enough to be home when the people call out.

Mr Smith: The basis for determining the priorities involves a range of asset management weightings plus ratings in terms of the range of social health indicators in particular areas, looking at targets around densities, and so on, and the various communities are prioritised in that way.

The Hon. Dean Brown: It may help if I add to that so that you have the full picture. Our forecast expenditure for maintenance programs is $59.26 million this year made up of the following: responsive maintenance, $25.38 million; vacancy and transfer maintenance (in other words, the house is vacant and new tenants are coming in—we expect about 7 000 of those this year), $15.52 million; program maintenance, $10.8 million; minor improvements (such as installation of exhaust fans, smoke alarms, external paving and other improvements), $3.54 million; and other (special facilities for disabled people, demolition of some homes, contamination if it occurs and issues like that), $4.02 million. Of course, there are other special programs we include in that, namely: the smoke alarm program, to which I have referred; security doors and locks on cottage flats—an initiative I took about 12 months ago (we are expecting to do about 60 per cent of cottage flats in the coming year); insulation in some houses; and certainly a new database, so that we have more information about the houses and the maintenance program.

Mr CONLON: I am grateful—it seems that I can have any information I like as long as it is not the information I ask for. How could it have occurred that a woman in a Housing Trust home—the same as the homes on either side of her—could see those homes on either side renovated while her home was not up for renovation, until a fuss was made? How could that have occurred in the system outlined by your associate, and how do we ensure that that does not occur in the upgrading of homes? It strikes me as being a touch absurd.

The Hon. Dean Brown: Until you give us the name of the woman or the location of the home, it is a little hard for us to answer the question. There are 57 000 homes out there.

Mr CONLON: She lives in Morphettville; we wrote to your office and you fixed it up because your office was embarrassed about it.

The Hon. Dean Brown: What is the problem if we fixed it up?

Mr CONLON: I want to know how it could have happened in the first place—that is the problem. I want to be assured that it will not happen again. I hope you have a system for upgrading houses and not one based on who happens to be lucky enough to be home.

The Hon. Dean Brown: If you like to give me the address we will look it up and see why it occurred. We have heard your version. I got the impression that she went shopping and came home and suddenly the other two places had been refurbished. We normally take more than a couple of hours to refurbish a home.

Mr CONLON: You can be facetious about it. It was not completed—she found that work had been commenced on the other side and, upon inquiry, she learnt that hers was not to be refurbished. The Minister can be facetious about it if he likes, but he should be embarrassed if a system of upgrading houses relies upon who happens to be home when the person calls around. It is not acceptable. It has been fixed now. Thankfully you have a much better Minister's office than most we deal with, but it should not have occurred in the first place. How will the Minister make sure that it does not happen again?

The Hon. Dean Brown: There are specific criteria, such as age, location, the needs of the tenant in the home, and the assessment of the condition of the home. Also, as the honourable member would know, some types of properties lend themselves more to effective refurbishment than others. I would urge the honourable member to look at some of the homes that have been refurbished. I looked at some at Salisbury North and was very impressed.

Mr CONLON: I lived in a Housing Trust home when I was young and I visit them regularly; I have 3 000 in my electorate. A lot of them need refurbishment, and in all fairness we should look at the Edwardstown area.

The Hon. G.A. INGERSON: I understand that the current Commonwealth-State Housing Agreement expires tomorrow. What is the status of the agreement, and how much money does the Government envisage will be provided to South Australian housing services?

The Hon. Dean Brown: The agreement finishes at the end of June, which is tomorrow. A couple of issues are still being finalised, although we have basically negotiated the agreement. The big outstanding issue was the $269 million compensation for the GST; we have yet to determine how that will be divided between the States, but we are working on that. Some minor issues must be resolved or cleaned up because of the change in the GST package, even in the past couple of weeks. They are looking at what further drafting changes have to be made there, but I would expect to be signing the new agreement in a matter of weeks. It is not as if there are major outstanding issues, apart from resolving how to divide up the $269 million.

The Hon. G.A. INGERSON: Over a period of time the Auditor-General's Report has indicated that the Housing Trust needs to monitor rental rebates more closely, in particular obtaining appropriate proof of income on a regular basis. What action has been taken to monitor these rental rebates to ensure that tenants receive the rebate they are entitled to?

The Hon. Dean Brown: The Auditor-General did make that recommendation and as a result we are doing that audit on a routine basis. Prior to March 1998 the trust tended to do a random audit of 10 per cent of the tenants on a six-monthly basis. In March the trust introduced a new requirement, which I asked it to do, which is that tenants who receive a rental rebate must provide proof of their gross household income at least once a year. This is carried out on a rolling program with approximately 4 000 tenants providing proof of income each month. To assist both the tenants and the trust, Centrelink provides tenants with a letter setting out incomes in a manner which meets the trust's needs prior to the trust writing to the tenant. The new process ensures that all tenants receive their correct entitlement. Where the trust identifies instances of overpaid benefits, a debt is raised, but that does not have to be paid in one instalment. Tenants can make arrangements to repay the debt; in fact, we deal with that in a very sensitive way indeed.

The results of the audit have been very interesting indeed. Approximately $5 million extra has been raised in rent, because a fairly large number—in fact, approximately 50 per cent of tenants—were receiving a rent rebate that was higher than it should have been, given the income they were receiving. As a result of that, we have $5 million that we can now spend on further refurbishment, building programs, upgrading properties, maintenance of properties and so on. That is a significant amount of money within the portfolio that will go back to benefit the tenants and to help house more people in Housing Trust homes.

The results from the first 12 months of the proof of income process showed that 34.6 per cent of the tenants had no change to their assessed rent, 12.6 per cent had their rents decreased and 52.8 per cent had their rents increased—therefore, they were understating their income. It should not be construed that they were deliberately understating their income; many people do not understand the system and did not realise what they had to include by way of income, and so on. Once they have filled out a form in which they have to state their income, they see that a mistake has been made. In some cases, it may be that they are receiving an overseas pension and that pension has been increased, some superannuation payment has been made, or something such as that. However, members will see that a fairly significant amount of money is involved.

The Hon. G.A. INGERSON: According to the Portfolio Statements, a total of some $300 million has been put aside in 1999-2000 for public housing spending. We have all seen the reports of abuse of Housing Trust property by problem tenants: what steps has the Government taken to improve the standard of behaviour of people in Housing Trust homes and to ensure that they treat their property in a reasonable way?

The Hon. Dean Brown: The two significant issues that we have introduced are, first, the probationary tenancy for a six month duration and, secondly, the two yearly reviews. Both those measures have been received with acclamation by the vast majority of tenants. In fact, the consumer advisory body's advice to me is that the Housing Trust tenants have welcomed it; many of them were asking for it. They like the home visits because there is someone there from the trust who sits down, spends some time with them—has a cup of tea or coffee—and takes an interest in the home: they can talk about things, whereas previously, in many cases, they were too embarrassed, perhaps, to pick up the phone and try to find someone who was appropriate. There might be small issues or large issues involved, but at least they can sit down and spend some time talking about some of the irritations from which they suffer or some of the maintenance work that needs to be done.

To date, about 1 300 reviews—that is, visits to homes—have been undertaken, and only eight tenancies have been terminated as a result. As I said, the probationary move has gone over extremely well. About 6 000 new Housing Trust tenants each year are placed under that probationary system, and this means that one immediately has some means of taking action. If someone shifts into a Housing Trust home and immediately starts to abuse the situation—has wild parties at night, and things such as that—if it were not for the probationary tenancy, one could be in real difficulty in trying to move those people. It is the sort of thing that we talked about earlier, where particularly the established tenants become very upset when that sort of thing occurs, especially if they are older people.

Incidentally, the home visits are designed to focus on observance of the condition of the tenancy, customer requirements and property information. When I inspected a number of Housing Trust homes, it struck me that there would be five or six really well looked after properties, where the tenants took real pride in their property and their garden, and then there would be a tenant alongside who had a heap of beer bottles stacked up against the fence near the front road, who had a garbage bin in the back yard with garbage bags overflowing out of it onto the ground and who had two or three dismantled cars in the back yard.

Ms THOMPSON: And loud music.

The Hon. Dean Brown: I did not hear the loud music. I would be devastated if I had a tenant like that living alongside. Why should people have to put up with it? Why should we be subsidising people, to the extent of $2 300 a year, to live in a house and abuse the home in that way? That is why we did it, and I think the results have been very good indeed.

Mr CONLON: I want to follow up the issue of difficult tenants. My electorate contains a lot of emergency housing. What do you do about difficult tenants who are at the margins of society, those who may be deinstitutionalised or close to requiring institutionalisation and who simply have to go somewhere? They seem to turn up in some areas of my electorate quite often.

Ms THOMPSON: And mine.

Mr CONLON: I do appreciate concerns about stacked up beer bottles but, when your next door neighbour tears off her clothes at two in the morning and runs down the street screaming foul language at the top of her voice, it is a real issue for elderly people who have lived in the area for some time. I wonder what can be done about those people, because they will always turn up like a bubble in a carpet.

The Hon. Dean Brown: I think you are talking about people with mental health problems. We do have what we call mental health tenancy issues. The trust has fairly long experience in housing people with mental health issues, both in terms of supported housing and its general rental stream. The trust works with a range of mental health teams and community groups to arrange support and intervention where

a tenant feels threatened because of problems coping with mental illness.

Links within the portfolio are strong, and this is one of the great benefits of the Department of Human Services. We have developed much closer links in the community between the housing area, which in the past would have been stand-alone, invariably with a different Minister—so previously you had to go to the other Minister, whereas now they are all in the one department—and the health area, including mental health teams.

It is very apparent in some of the country areas: you will find that they meet and deal with clients on a regular basis. There is a very defined team. The same happens in the metropolitan area. There are now much closer links and they are working closely together. In fact, many of these people who are looking for a Housing Trust home invariably have another problem, or people with mental health problems have another problem. They might have a mental health problem and a housing problem, and they might need general community support. We are able to bring together health (which takes in the mental health problem), maybe family support under FAYS (Family and Youth Services) and housing support to ensure that they get the more comprehensive support they need.

I think it is wrong to look at housing just in terms of the Housing Trust. One of the projects which I opened recently and which gave me a real sense of achievement was a community housing project at the Port Adelaide Central Mission. The Port Adelaide Central Mission deals with a lot of people in the north-western suburbs. It tends to try to work with and give support to people with mental illness in the community. It had set up in this particular area, in the one location, six community houses. They are two bedroom, attached units, I suppose, housing people with mental illness, invariably a single parent with a child.

Immediately adjacent but on the same site there was an employment agency funded by the Federal Government, and at the back of the site there was a training centre in which these people could be trained in skills and which could be used as a community area to get together at night, etc. I thought that project really started to meet the needs of what the community was looking for. What is great about community housing projects is the extent to which you can provide support as well as a home.

I opened a community housing project at Woodside for the St John's Lutheran Church. They have the same criteria in terms of the Housing Trust, so they must have particular needs; but one of the tenants had a very severe mental health problem. It was partly a disability and partly a mental health problem. Basically, that person had no support in life and no housing. He told me the story of how he particularly wanted just a home that he could call his home—he did not care how bad it was, but he wanted a place to sleep at night—and how he had often wandered past new building sites and thought that it must be a dream to live in a new home. Yet here he was moving into one of these new detached units at St John's, a community house, where for the first time he had a brand new house. It was the first place he could call home, and it was a brand new facility; but, more importantly, he had other people around him who took on the role of giving him the support he needed each day.

I thought that was an excellent example of a community providing broader support and our providing money for the housing. The community itself, through St John's church in this case, provided the land on which the housing was built. They are the sorts of models we ought to achieve more of in the community, and we are trying to do that. That is why we are trying through the Community Housing Association to build up the number of houses.

Ms THOMPSON: I refer back to the issue of the mental health difficulties that people confront. I have two situations in my electorate, one of which involves a tenant with mental health difficulties who is causing considerable disruption to the other tenants. In each case, the only support the trust has been able to give is to suggest to the other tenants that they take the matter to the Residential Tenancies Tribunal. In one case, they have been there twice. As I was thinking about it I remembered that I had not heard from them for two months, so perhaps something has changed. But the difficulty in taking the matter to the Residential Tenancies Tribunal seemed to be the criteria that says 'behaviour that would not be offensive to a normal person' or some such wording.

The situation as I saw it was that the people who were coming to me would not in some ways be considered 'normal'; they were all vulnerable. As the Minister said, most people who are accommodated in trust houses have some difficulties. One of the women had agoraphobia; one of the young men had bipolar disease. None of them was very resilient, so behaviour that you and I might be able to accommodate reasonably easily just by, say, going out, they found very distressing. The trust was not able to deal with that.

In the other case (which I can name), Cooder Crescent, Morphett Vale, which consists of aged cottage homes, a Vietnam veteran who moved into one of the homes was causing considerable disruption to the other tenants, particularly on pension day. Two of the residents have certificates from their doctors which indicate that this is causing them considerable difficulties. In fact, one of the residents was taken to hospital with a heart condition that they all attribute to this distressing tenant. In neither of those cases has the trust been able to help. The only answer has been, 'Go to the Residential Tenancies Tribunal,' but its criteria do not meet the needs of my constituents. Does the Minister have any thoughts about how this sort of situation could be better handled?

The Hon. Dean Brown: Yes, I do. That was the sort of thinking behind the six month probationary tenancy period. I suspect that many of the cases with which the honourable member has dealt involved tenants who were there prior to that.

Ms THOMPSON: The last one involves a new tenancy arrangement.

The Hon. Dean Brown: In that case, action should be taken under the six month probationary tenancy period, and this issue should be raised with the trust as a matter of urgency, because something can be done within that six month period; after that it becomes much more difficult—unless, of course, the person was put back onto a further six months of probation. This is the very reason why, in the past, before this probationary period was introduced, if someone was put into a home the only way they could be removed in unfortunate circumstances such as these was through an appeal to the Residential Tenancies Tribunal. That process is slow, cumbersome and distressing—I am aware of that; it was set up by the Parliament, and it does not always bring the sort of satisfaction that people want. Constituents of mine have been in that type of situation and have had to go through unfortunate hearings to achieve some change. With the

probationary program, those problems can be overcome because—

Ms THOMPSON: The tenant at Morphett Vale is a new tenant. He has not been there for six months yet. Do these people have to wait for the six month period to finish before he can be moved?

The Hon. Dean Brown: If the honourable member provides me with the name and address of this tenant, I will have the matter followed up. I have not touched on the fact that the trust is trying to provide more support, specifically supported accommodation, for people with mental illness or severe disabilities.

Regarding mental health problems, 200 Housing Trust staff have been specifically trained to raise their awareness of mental health issues, how to help people with mental health difficulties and how to deal with those sorts of circumstances. There are a number of other programs, but I will not go into the detail of those. We are conscious of this problem, and we are trying to deal with these sorts of circumstances more effectively.

Ms THOMPSON: The Minister would not be surprised to know that I want to talk about emergency housing. I thank the Minister for the action group that has been established in the south to look at emergency housing in that area. A number of issues have emerged from those discussions. People in the field want to have a better understanding of some of the definitions of the terms and some of the approaches that have been adopted by the trust and the department. How is 'emergency housing' defined, how are current unmet needs assessed, and what groups are seen as having the most pressing unmet needs in this area of emergency housing?

Ms Charles: I am not sure whether the question relates to access to priority housing and emergency housing or whether it relates to the general issue of housing need and the management of waiting lists.

Ms THOMPSON: I am referring to emergency housing. If someone says they have no home at the moment, is that defined as an emergency housing or a priority housing situation?

Ms Charles: A range of programs are available for people who have crisis needs. It depends to some extent on the group of people or the issue with which they are dealing. For instance, if the situation is the result of domestic violence, it is likely that these people will be accommodated through women's shelters or family support. The Supported Accommodation Assistance Program (SAAP) provides housing for young people. Some support is provided through boarding houses. We have emergency housing, which is straight crisis housing accommodation, to which other criteria are attached. It is all based on need. The idea is to match people with their housing needs. Sometimes, that might be by finding them accommodation in the private rental sector—they are supported in that way—or it might be through a range of existing programs.

It is difficult to answer your question generically about how a person qualifies for particular types of housing. We are conscious of the fact that, in respect of some of our programs, if people are affected by drugs or alcohol, accessing SAAP services becomes a problem because they do not want to deal with people in that condition.

Drying-out centres and other emergency accommodation through non-government organisations are an option, but they also have limits as to who they will accept. This is an area in which we are spending a fair amount of time working with non-government agencies and the portfolio to develop linkages across. We have been working with a range of non-government organisations looking at linkages and homelessness to try to pick up those people who are falling through the net at the moment. For some groups the process works very well, but we are very conscious that some groups of people are often in quite extreme circumstances for whom our programs just do not come up to the mark.

It is usually a requirement for not just accommodation but support services, too. That is where the system often really struggles—not just finding a bed in which someone can sleep but providing the appropriate supports to allow a crisis situation to work. The Commonwealth has also been a partner to that. Some specific work called 'linkages and protocols' is done within SAAP services, which brings together a holistic approach to mental health, drugs and alcohol, health, housing, disability and support services for the high need target groups. We are very happy to provide the honourable member with additional information about that. I am not sure whether that is where the honourable member is coming from.

Ms THOMPSON: Two issues were raised at the meeting held down south about crisis accommodation that, I suppose, some people are calling 'emergency'. Some participants came away from the meeting feeling that not all of the people who attended were speaking the same language, so a couple of people asked me whether I would try to tease out what is meant by 'emergency accommodation'. It seems that you are talking about crisis accommodation and then priority housing needs.

Ms Charles: I was referring to medium term housing needs. People might, for example, as a result of a family violence situation, go into a shelter situation and then be moved into transition housing which we would still consider to be, I think, emergency housing given that those people need high levels of support. Hopefully, we would find a longer term housing option for them farther down the track. At the moment, in terms of definitions, there is no working difference between how we might use 'emergency' or 'crisis'; it entirely depends on the program a person is accessing.

Ms THOMPSON: A couple of the cases with which we have had difficulties in the past 12 months have involved homeless families, not for any of the reasons mentioned but simply because they have been in the private rental market, something has happened in relation to that tenancy and they have nowhere to go. That is becoming an increasing problem which I have mentioned to the Minister. That is where some confusion arises, too, because that situation does not fall into any of the groups mentioned. Where does the Minister see that group of people fitting in?

The Hon. Dean Brown: That is an area in the south in which I perceive a particular need. It may be that there was domestic violence. It may be that there was no domestic violence and it was just as the honourable member said that, for some reason, people were turfed out of a private home. It may have been their own home. They had to forgo their home because of problems with the bank, or something like that. They have a family and suddenly it is 4 o'clock in the afternoon and in two or three hours they will have nowhere to go and no money. That is the sort of issue in the south I thought we were trying to improve.

If the honourable member likes we will do more work and try to determine under which definition those sorts of people fall and how we normally deal with those sorts of cases. That is what I had in mind when I asked Tina Lloyd to work with

the honourable member. I think that is what they are trying to do. At least some people are being put into categories. They are allocating some housing for young people, which the honourable member and I might call 'emergency housing' simply because the people have nowhere else to go that night, but it is not the specialist housing one might have for someone who is suffering domestic violence.

Ms THOMPSON: It is not a family situation where previous arrangements have collapsed and they have not been able to move anywhere else.

The Hon. Dean Brown: That is an area in which there is some immediate need because the honourable member and other members from the south have raised that with me.

Ms Charles: Certainly we have emergency housing programs and emergency financial assistance if the issue is that people do not have money to pay for accommodation that night. We would be happy to look into the matter further with the honourable member.

Ms THOMPSON: In terms of the priority housing, can you talk about the criteria that are used? I will indicate some of the concerns that we have. One of the issues that comes up quite often is that one of the children in the family has some special schooling needs and is attending a special school or is on a special program, and the family is very anxious that that child be able to maintain that schooling. However, it seems that often they are not able to be allocated a house that enables that to occur, and that causes children who are already disadvantaged to experience more disadvantage. Another sort of situation involves, for instance, a young single mum whose only family and social support is in one area, but they get allocated a house in another area after immediate escape from a DV situation, although they are trying desperately to get where their social support is. They are told that they are not entitled to priority housing because they have already got one.

In refer to one case in particular where the person involved is in an area where she is very isolated. She is at Woodville, while all her family is at Hackham West. She has no car. She would by now I think have had a second child, and the other one is two. It just seems to me that we are creating a time bomb of social problems by leaving her at Woodville, when she could be at Hackham West among family and community support. How does that situation fit into your very difficult task of allocating priority housing?

The Hon. Dean Brown: I will ask Paul Smith to answer that first.

Mr Smith: From the case the member has just outlined it sounds to me as though that is one that we should be giving some further attention to. Ordinarily, in order to qualify for priority housing, a household would need to have a combination of difficult social and/or medical and/or financial issues all impacting upon each other. But clearly it would be in the best interests of that household to be located in a place where other supports are available, to ensure that that household succeeds. Our approach would be to consider what the factors are, where location becomes important in the stability of that household, because in the longer term it will save that household and the community resources if we can ensure a successful tenancy outcome. So, location would be important in the instance that the member has described and we would be happy to have a look to see whether there is more that we can do for that household.

Ms THOMPSON: What about the general issue where children have special schooling needs; how is that taken into account in the priority housing allocation?

Mr Smith: It is certainly a factor, because in that instance the location of that household's Trust housing is going to be critical to ensure that on-going stability. If there are children with special education needs in particular, that is one factor that we would consider in terms of suitable location. We would not ordinarily expect a household to uproot itself where there is an ongoing attachment to a particular school because of its special supports for that child. It is not always easy to meet those kinds of needs with the limitations in location of housing stock, but, where we can, we would see that as a very relevant criterion, provided that it was in the interests of that household to remain in that area. We would not see that it was useful to uproot that household and send them elsewhere. However, in some particular cases we find that for issues of, for example, domestic violence, when the school happens to be a location where an ex partner or a violent partner can quickly locate a household, that becomes another criterion for that family to weigh up in terms of the risk of leaving the child at that school.

The Hon. Dean Brown: Finally, if you still have someone who is dissatisfied, I would urge you to write to me, and I use the ministerial discretion to apply tons of commonsense to resolve a situation.

Additional Witness:

The Hon. R.D. Lawson, Minister for Disability Services, Minister for the Ageing and Minister for Administrative Services.

Additional Departmental Advisers:

Mr R. Deyell, Associate Executive Director, Disability.

Mr J. Fiebig, Director, Office for the Ageing.

Mr P. Davidge, Director, Operations, Metropolitan Division.

The ACTING CHAIRMAN: Thank you Minister Lawson for your attendance. Have you any comments that you would like to make?

The Hon. R.D. Lawson: I would like to mention but a few significant current highlights in the area of disabilities and the ageing because I will be presenting only those budget estimates relating to those services. This year 1999 has been designated by the United Nations as the International Year of Older Persons. In this State we have enthusiastically embraced the national theme 'A Society for All Ages'.

The international year is particularly relevant to South Australia as we have the oldest population of all Australian States: 14 per cent of our population is aged over 65 and that percentage will increase for the foreseeable future. The State Government has made a grant to the Council for the Ageing to coordinate activities during the international year. A coalition of non-government organisations called 'Coalition 99' comprising over 150 groups has participated and is participating in a large number of community events and programs.

We have been promoting two particular themes, the first of which is the message of positive ageing. Old Australians are a diverse group of people and advancing years should not automatically imply failing health, disability and dependence. Negative perception of ageing should be broken down. The talents, aspirations, contributions and participation of older people should be emphasised and celebrated.

The second theme is the importance of intergenerational activities and links. A Youth Seniors Forum in conjunction with COTA and the YMCA will be held late this year to celebrate and encourage intergenerational activities. Another significant event will be a rural ageing seminar to be held in conjunction with the South Australian Farmers Federation, the Country Women's Association, the RSL and other rural stakeholders. The diversity of participants will emphasise the need for fostering community partnerships in the field of ageing.

South Australia was the first Australian State to develop a comprehensive plan for services for older people in this Government's 1996 report 'Ageing: A 10 Year Plan For South Australia'. We remain committed to the implementation of the recommendations of that report and I am pleased to say that the Ministerial Advisory Board on Ageing, under the chairmanship of Dame Roma Mitchell, has continued to function very effectively.

In this State the cornerstone of our service delivery to community care for the frail elderly is the joint State/Commonwealth Home and Community Care (HACC) program. This year has seen a further expansion of projects and services for older people and also for people with disabilities and their carers through HACC. For the fourth consecutive year this Government has either met or exceeded the Commonwealth's offer of growth in HACC. Since 1992-93 this Government has contributed to an increasing funding to the program from $47.1 million to $72.6 million, an increase of over 50 per cent from the 1993 base.

Another highlight this year has been the State Carers Strategy under which an additional $1 million has been directed towards the provision of respite care and other services. This will assist carers to continue to look after their loved ones in their own homes and their own communities.

Many well-known organisations in this State receive the bulk of their funding through the HACC program. These include the Royal District Nursing Service, the various domiciliary care services in the metropolitan and country areas, Meals on Wheels and Aged Care and Housing, to name only a few.

A new development which will be progressively introduced in the coming year is a program called 'Moving Ahead', a five year strategy containing major initiatives to improve the responsiveness of the human service system to the needs of older people and to promote functionality, independence and quality of life. It proposes a better integration of health, housing and community services and emphasises prevention, rehabilitation and the coordination of acute and community services.

On the subject of disability services, in the coming financial year $160.4 million has been allocated specifically to disabilities through the Disability Services Office. Major recipients of disability funding will continue to be Julia Farr Services, Minda Incorporated, the Intellectual Disability Services Council and over 70 community-based organisations.

I have decided this year to undertake a major review of the way in which funding is allocated. This is not surprising, given the great diversity of needs and organisations. Disability services in this State have grown along historical rather than rational lines, and the time has come to examine the whole system and make considered decisions about what a holistic services framework should include and, within available resources, where the resources should be directed. A new disability services framework is to be developed. It will provide a new foundation and will reflect the principles and objectives contained within the current legislation. It will set the directions for the provision of disability services in South Australia over the next few years but will be promulgated only after all interested parties have been consulted.

I envisage that the new framework will describe what service types are required to provide services for people with disability throughout their lives and, within available resources, what proportion of services should be dedicated to each service type. It will prioritise need and recommend where new resources should be allocated. It will set the vision for a balanced and whole service system, and will provide a direction for disability services in this State. Finally, as in the ageing portfolio, the emphasis of disability policy will continue to be on tailoring services to the needs of individuals and on improving their quality of life at home and in the community wherever possible.

Membership:

Ms Rankine substituted for Ms Thompson.

Ms Stevens substituted for Mr Conlon.

Ms STEVENS: I have no statement to make; I will go straight to questions. I want to talk about unmet need in the disabilities area because, quite clearly, that is the overarching issue for anyone with a disability. The Minister would know that a report undertaken by the Australian Institute of Health and Welfare in 1996 identified that there was an urgent need to inject $300 million to meet unmet need in disability across Australia. On 9 April 1999 Commonwealth, State and Territory Ministers responsible for disability services agreed that, despite the increase in funds provided by Governments under the Commonwealth-State Disability Agreement, additional funding will be required from all Governments to address the backlog of unmet need.

I note that in the Minister's press release of Friday 9 April 1999 he said that he was disappointed that the Commonwealth Government failed to act that day to confront the needs of people with disabilities, their families and carers. Further, the Minister said that Ministers went to Canberra with a track record and willingness to financially support the backlog of unmet needs. If the unmet need represents $300 million nationally, I estimate that, on a calculation of South Australia having an 8 per cent share (which is probably conservative in terms of the number of people we actually have with disabilities), our share would be $26 million and that the State Government, in order to fulfil its portion of the $26 million (according to the ratios that have been used to determine Commonwealth and State funding), would need to put in $17.5 million in order to meet that amount of money to address that unmet need. You said that you were willing to financially support the backlog of unmet needs. Can you tell this Committee what offer you put on the table to the Commonwealth and what your plan is to achieve the backlog of unmet need from this State's point of view?

The Hon. R.D. Lawson: It is true that we went to Canberra with a track record and a willingness to financially support unmet need. I think this issue ought be viewed in context of that track record because you cannot view the necessity for disability services in a vacuum. In recent years we have made a significant commitment to disability services in this State.

Since 1996 we have provided an additional $11 million of recurrent funds including $3.3 million announced in the 1999-2000 budget. In addition to that, we have redirected

over $6 million of recurrent efficiencies back into services to clients. Also, since 1996, we have attracted an additional $2.4 million of new funds through the Home and Community Care (HACC) program, which is used to specifically support people with disabilities. A further $6.1 million ongoing has come from the Commonwealth as part of the Commonwealth-State disability agreement, and this State's share of the Commonwealth-State disability agreement funds, at something over 12 per cent, is a significantly larger proportion than the 8 per cent of the Australian population which we support and which we would ordinarily expect to obtain in service delivery.

So I do not think you can approach the question of unmet need in a vacuum. There is a very substantial (and there is absolutely no doubt about it) need for disability services. We have been committed to meeting them, and I believe that, over the last few years at least, we have certainly met them.

The member for Elizabeth refers to the meeting with the Commonwealth in Canberra on 9 April. At that meeting all State and Territory Ministers had agreed upon a particular list of priorities. It was felt that the best opportunity of obtaining from the Commonwealth a substantial commitment to meet what is a national problem was to have a united rather than a divided position. Consequently, the State and Territory Ministers of all political persuasions met before the meeting and did agree to adopt a plan which had been developed by officers prior to the meeting and which identified a number of priorities.

Those priorities were, in order: the provision of accommodation, and it was agreed that 750 individuals with profound disabilities requiring intense support was national priority number 1. It was secondly agreed that the needs of people with profound or severe disabilities and their ageing carers, defined as those who had been caring for their son or daughter for at least 30 years, was a priority, and it was suggested that some form of in-home support, accommodation support or respite services for up to 8 000 would be required to meet that national priority.

The third priority was to deliver support to individuals with severe or profound disabilities at home with younger parents—that is, those caring for less than 30 years—and it was thought that some 4 000 people across the whole of Australia would come within those categories. Those priorities were identified and agreed.

It was urged upon the Commonwealth that the issue was a national issue and one which ought receive national attention the same way as the Commonwealth has seen fit to address the issues of, for example, drugs and guns, and other national issues. The Commonwealth was somewhat taken aback that the States and Territories had an agreed set of priorities but did not have any financial response. Senator Newman agreed to go away, develop a response and get back to the State Ministers with a view to a meeting later this year. As far as I know, the date of that meeting has not yet been set, but it is anticipated that it will be within the next three months or so, at which time it is expected that the Commonwealth will make a significant contribution.

Ms STEVENS: Are you saying that you expect the Commonwealth to make a significant contribution? Are you expecting to make a contribution at all?

The Hon. R.D. Lawson: Is the State of South Australia expecting to make a contribution?

Ms STEVENS: Yes.

The Hon. R.D. Lawson: Obviously that depends upon the nature of the Commonwealth's response.

Ms STEVENS: So, you may not make one.

The Hon. R.D. Lawson: As I have already said, within the current budget we have allocated an additional $3.3 million for disability services, as well as agreeing to continue funding of the highly successful Moving On program, a program which this Government introduced for the first time and which provides not only programs for people with disabilities but also a form of respite. It makes it possible for people to stay at home who otherwise might not be able to stay at home, supported by parents, carers and family members.

Ms STEVENS: Is any sort of funding response outside $3.3 million conditional upon a Commonwealth response?

The Hon. R.D. Lawson: We believe that the Commonwealth should take the lead in devising programs. It is not simply a matter of throwing money at this problem. As the honourable member has noted, a considerable number of people in the community require additional support. One way in which we have managed to meet that to date has been by redefining the way in which services are delivered, reorganising our institutions and developing programs such as Community Support Inc., which enable people to access individualised services. We are looking at things such as consumer funded services, whereby funds are allocated to consumers. For example, in the HACC program we are looking at the possibility of private operators providing services. All the time we are looking at more efficient and effective ways of delivering the services. It is not simply a question of saying what funds are available for the program. That is why I want to develop the disability framework I mentioned at the outset; it will give us a better view of how we can reorder our services to ensure that we get the best value out of the funds that are applied.

Ms STEVENS: If it is not just about getting money, why have we not seen you moving on the other matters so that you can make a dent in the level of unmet need that exists in South Australia, because it is appalling?

The Hon. R.D. Lawson: We have been moving on other matters constantly. We have been developing services. We have been altering the way in which—

Ms STEVENS: That is not what they say in the community.

The Hon. R.D. Lawson: That is not what some people might say, but there are—

Ms Stevens interjecting:

The ACTING CHAIRMAN: The Minister is answering the question.

The Hon. R.D. Lawson: I have been to many community meetings. I have met all the major service providers. I have met many parents. I understand the needs as well as the member, if not better.

Ms STEVENS: I refer to an article in Disability Action's latest newsletter of June 1999 about the Minister's funding for disability services in this budget. The article states:

> An extra $3.3 million will be spent to ensure services provided for people with disabilities are maintained.

That is out of the Minister's own statement, anyway. The article continues:

> Yet most of this money will be used to counteract the effects of inflation and other 'cost pressures'. So the only new moneys to be spent include a $300 000 subsidy for new smoke detectors to be installed in the homes of people with profound hearing loss. Though this subsidy scheme has in fact been happening for some time already. An extra $400 000, secured under the Commonwealth-State disability agreement, will also be used to continue and expand Moving On, a program. . .

The Minister just mentioned that program. Is the article correct when it says that out of $3.3 million only $700 000 is being spent on that new program and the rest is simply for wage costs and other pressures of that nature?

The Hon. R.D. Lawson: No, it is not correct. The additional funding is not simply being applied to meet increased wages and inflation. We believe that we will get better outcomes, more hours of service, more accommodation and more of every other measure by the more effective use of the funds that we have allocated this year than last year. It is not simply a holding operation. The member would have heard the Minister for Human Services say earlier that there is budget pressure across the whole of the human services area, and that is no less true of the ageing and disability portfolios than it is of the rest of human services. However, within our allocation I believe that our outputs and our measures of effectiveness will be improved and will be more effective.

Ms STEVENS: I have been asked by a number of agencies whether the Minister could explain the following matter. It relates to the Minister's announcement that there would be an additional $3 million to meet cost pressures. They would like to know how this will be divided between the Government and non-government sector and whether there will be parity in meeting increased costs such as the costs of increased wages.

The Hon. R.D. Lawson: We do not look at allocating funds on the question of whether or not it is a Government service or a non-government service. I think it is true to say that traditionally in disability services, more so than any other service, many of the programs are delivered by non-government organisations. The budget for this year is currently being formulated and indicative budgets will be issued to all agencies across the whole sector, I am told, within the next couple of weeks. I assure those who are asking the member to pose these questions that there has been no predetermined formula in respect of Government/non-government. The funds will be allocated in accordance with need and to meet those whose need is greatest.

Mrs MAYWALD: In today's *Advertiser* a letter from Lillian Mattner of Loxton draws attention to the urgent accommodation needs of adults with an intellectual disability. She goes on to say that there is an increasing number of aged sole parents caring for their intellectually disabled children in their homes and says that many have been going about caring for these children for some 40 or 50 years. These parents are now facing a crisis of what the future holds for their children as the frailties and limitations of age diminish their ability adequately to provide care for their children. Mrs Mattner says that appropriate accommodation with trained staff is needed in their own community to assist these people. She asks whether the powers that be will hear their cries for help. What is the Government going to do to help these people?

The Hon. R.D. Lawson: I did see Mrs Mattner's letter. She is talking about the need which the member for Elizabeth identified and which I agreed exists in the community. To reassure you and her, I should say once again that we have been meeting these needs. The Commonwealth Government last year, in a program called 'Staying at Home', allocated additional funds for carers (that is, carers of people who have been caring for more than 30 years), and some of that funding came to South Australia. I mentioned earlier the 'Moving On' program, which enables people to stay at home longer.

Mrs Mattner lives in the Riverland, to which we provide significant services. Under Home and Community Care about $1.8 million is allocated to the Riverland area. I was in the Riverland recently when a community transport network was launched for people with disabilities. That is not what might be termed a conventional transport network simply taking people into town for the purpose of shopping but is really a form of taxi service that is run by volunteers to enable people with disabilities to access services, medical appointments and the like. That is supported through the HACC program and also by Home and Community Care.

Programs of that kind make it possible for people to care for longer. Experience has shown that if people are given respite and services they are able to do the things they would like to do, namely, look after their aged son, daughter, spouse or the like. As the honourable member would know, as she was present, we were in Loxton a couple of weeks ago launching a carers network—the fourth of the country carers networks in the State—being established by the Carers Association with funding from the Government.

There are many accommodation services across the State. Mrs Mattner and people in the Riverland must look at models such as that adopted in Kingston in the South-East where the local community, with local government, local service clubs, local families and carers got together to establish a residential facility for people with disabilities, of course supported by the Government. The way of the future is community partnerships, and the Kingston model is a good one. Group homes are the preferred option these days, and the establishment of group homes is a high priority for the Government.

On the Riverland, we allocated last year an additional $90 000 of recurrent funding to the Riverland Regional Health Service for the purpose of providing brokerage services for accessibility to dementia services and carer support. They are illustrations of the sort of services we are able to offer.

Everyone should understand that as a Government and as a community we will not be able to provide residential care for every person in our community with disabilities, irrespective of the level and type of disability. The Government recognises that there is a substantial need. We place a high priority on it and will continue to apply funds towards it, but community partnerships are absolutely necessary.

Mr HAMILTON-SMITH: I would like to pursue that line with the Minister and refer to Output Class 5.2 (page 5.12 of Volume 1 of the Portfolio Statements) which deals with accommodation and support for people with disabilities. A number of people in my constituency of Waite have approached me about this issue of residential and institutional care for the disabled. I could not help noticing last week media accounts of a report prepared by Disability Action Inc. called '1 424 South Australians'. The report suggested that the standard of residential care in our institutions leaves something to be desired. Does the Minister agree with the report and, if not, why not?

The Hon. R.D. Lawson: I have read the '1 424 South Australians' report of Disability Action. The report, which I think should more accurately be described as an instrument of advocacy, was prepared from the perspective that the State should do away with its major institutions, namely, Minda, Strathmont, Balyana, Hillcrest and Glenside, the latter two of which have people with mental illness rather than disability, which falls within my responsibility. The authors of the report stated that there were 1 424 people in this category. We

do not agree with the figures, and I think in a sense that undermines something of the credibility of the report.

It was written from the perspective that institutional care should be done away with. The authors sought to make the argument that the Disability Services Act of this State requires us to do away with institutions. We have very substantially downsized the number of people in our institutions in recent years. You will see on page 5.30 of the Portfolio Statements, Budget Paper 4, Volume 1, that a snapshot of the clients receiving accommodation support on a particular day identified some 1 081 rather than 1 400 people, but it identified that about 615 people are in Government institutions, 581 all told in Government and non-government group homes and 466 in non-government institutions.

At the moment, although I have great sympathy for the philosophical position that institutions should ultimately be done away with, we are not able simply to do away with institutions; the cost of doing so would be considerable. Many people within institutions want to stay in institutions. For example, the report identified Balyana as an institution which, in the view of the authors, should be closed down. Balyana is a facility for about 60 people situated on a lovely campus in the honourable member's electorate. Most of the people at Balyana are workers at Bedford Industries or other supported accommodation services. You cannot be a resident at Balyana unless you have that capacity; these are not people requiring high support. It is a far cry from what might be termed the old bluestone Victorian institution, where people lived in appalling conditions. This is a lovely campus, with very good facilities and a terrific atmosphere. I must admit, it reminded me more of a university residential college than any sort of disability institution.

The authors of the 1 424 report would like us to close down institutions of that kind. I do not believe that there is any demand for it. I also do not think that it is appropriate to lump into one group those with disabilities, as understood pursuant to the Disability Services Act, and those from Glenside and Hillcrest who have mental health problems, for whom entirely different considerations apply. At all events, the 1 424 report concludes with a number of recommendations and, notwithstanding the fact that I do not agree with all its contents or all its arguments, some of the recommendations would appear to be quite sound.

As part of the disability framework process that I mentioned before, I will be establishing a smaller group, called a deinstitutionalisation working group, to advise on ways in which we can maintain the pace of returning people from institutions to the community. I remind members that, for example, Julia Farr services (which is an icon in South Australian terms) once had, I think, over 1 000 residents; it is now down to about 250. We envisage that, as long as we can provide sufficient and appropriate support in the community, people will move out of that facility. Likewise with respect to Strathmont Centre—which is run by the IDSC and which has adults with intellectual disability residing in it—we have a plan to return about 100 of the 250 people there to community settings, and that is a long-term plan. With respect to the unmet need, which the member for Elizabeth mentioned, these situations cannot be turned around overnight.

Ms RANKINE: I would like to speak briefly about the provision of equipment for disabled people. I have written to the Minister on a number of occasions about these issues, and I would like his comments about the operation and response of Options. I would also like to highlight a couple of cases and get the Minister's response about those.

I have been contacted by the mother of a 10 year old autistic and intellectually disabled boy. Her concerns about Options were that it would not accept the reports prepared by the head of psychology at Monash University—in fact, they paid a private psychologist to test him. It was established that he had a profound disability. This young boy is not night trained. He has been provided with two lots of nappies for a six month period and his family has been told that they will receive no more. This mother is very concerned that the contracts that the Options workers have signed are of three to six months' duration, and there is a real difficulty in building rapport.

I know of another man who is an amputee. He suffers from coronary artery disease and hypertension. He had a myocardial infarction in August 1998. He has continuing angina problems, and his shoulder, elbow and hand weakness and pain prevent the use of mobility aids. He is restricted to lifting weights of up to only five kilograms. His orthopaedic surgeon has advised that he is not fit for surgery. His wife cannot push him in the wheelchair, which is too heavy, so he pushes himself backwards with one leg. He has been told that he will have to wait for three years to obtain a lightweight wheelchair. I raised this issue with the Minister, and he told me that this man had not been assessed as requiring emergency intervention. I just wonder what would require emergency intervention if pushing oneself backwards when one has a heart condition does not meet that criteria.

I know of another young woman who is confined to a wheelchair as a result of surgery. She was provided with a five year old electric scooter six years ago, and it has been repaired up to nine times. Extra Care repaired her chair and told her that she would not receive a new one for another five years. This woman is full-time carer for her aged mother, who is also reliant on an electric chair, and this young woman had to use her mother's chair while she had her chair repaired. She is unable to work. This young woman has a Bachelor of Applied Science in Disability Studies; a Graduate Certificate in Family Therapy; a Certificate in Family Psychiatry; and a Graduate Certificate in Ageing and Rehabilitation Therapy. She cannot wait five years.

I was advised last year that there were something like 125 people on the waiting list for equipment; the cases of a third of those people were considered to be urgent, which is critical. The remaining were priority one. Can the Minister comment on the concerns that we have about Options, their operations and their responses to people? How many people are currently on the waiting list for equipment? How many are deemed critical? What do you intend to do to address this situation, which can only be described as a crisis?

The Hon. R.D. Lawson: The honourable member in that one omnibus question has included quite a number of separate topics, which I will try to address individually, but they must be addressed. If in my response I do not cover all the points, I will be deemed to have taken those on notice and bring back a response within the appropriate time.

You mentioned Options Coordination and the fact that Options coordinators were contracted for, according to you, three to six months. That is certainly not my understanding of the situation. The Options Coordination system, which was established by this Government in 1995, has, by and large, been a very positive system and an improvement on the way in which we deliver services to people with disabilities; in

particular, it has enabled the system to appropriately prioritise those people requiring services.

We are presently examining aspects of Options Coordination with a view to improving its effectiveness. Mr Lang Powell, the former Director of the Disability Services Office, has conducted a management review and has made recommendations to me recently, some of which I will certainly be accepting, and there will be some management improvements. Professor Roy Brown of Flinders University is the Chair of an evaluation committee of people in the sector, and he is conducting an ongoing evaluation of Options Coordination. He delivered an interim report last year. Once again, I expect improvements to come out of that process.

I am unaware of any difficulty about Options coordinators leaving after such a very short time. In fact, to my own knowledge, from the discussions I have had at various meetings with Options coordinators, many of them are highly experienced in the sector and have been with the system since its establishment, and the turnover, which is implicit in the honourable member's question, has not occurred to my knowledge. Once again, I will get back to the honourable member on that.

The honourable member then spoke about the gentleman with the many health problems who is confined to a wheelchair and who has great physical weakness. That introduces the general topic of equipment. It is true, and I think one ought to recognise, that in recent years we have supplied a vastly increased and improved amount of equipment through the Government system. One goes into the domiciliary care area and sees stores of the sorts of walking sticks and walking frames and other rather rudimentary equipment that was once a feature of these systems. Now, of course, there are wheelchairs of all varieties, many of which are quite complex, scooters and the like, which are far more sophisticated in a mechanical sense. Once you supply equipment of that kind, there is an obligation to maintain and repair it, and the more you supply, the more the demand is. I am not running away from that. We have been committing additional resources.

There is the Independent Living Equipment program, funded to the extent of about $2.2 million. All the domiciliary care services in the metropolitan area have substantial equipment programs. The honourable member said that this particular gentleman was assessed by an Options coordinator as not requiring emergency intervention.

Ms RANKINE: You said that in a letter to me.

The Hon. R.D. Lawson: That would have been the advice I received. Obviously, I do not make assessments of people's requirements in this field. Anything I said to the honourable member in a letter would have been on advice. I would be very surprised if the very paragraph the honourable member is reading did not begin with the words, 'I am advised that'; but it must be implicit in what I was saying that I had no personal knowledge of the particular gentleman. Assessments of that kind are made by people in the field who have a knowledge of exactly what is the situation in the field, and it is not for me as a Minister or any executive officer in the department to question assessments.

Ms RANKINE: There are several doctors' letters in this particular case, and there are more doctors' letters saying that he cannot undergo surgery in relation to the difficulties with his leg. So, he is pushing himself around in a very heavy wheelchair that was provided by domiciliary care. He has had enormous problems in dealing with Options. Basically, it tells him to go away. Quite clearly, if it has advised you that he does not require emergency intervention, that should ring some bells of concern.

The Hon. R.D. Lawson: If the honourable member will provide me with further details of the identity of the particular gentleman, I will certainly examine that issue again. As I say, it is not really for me to say whether an assessment made by somebody in the field is appropriate. The fact that some other doctor's certificate or other expert certificate can be produced does not really much alter the situation. In practically every case of medical condition there can be more than one opinion.

Ms RANKINE: You don't need a doctors degree to know that someone pushing themselves back with one leg needs some urgent intervention.

The Hon. R.D. Lawson: Well, he is provided with some equipment. No doubt, it would be great if we could provide him with a new chair.

Ms RANKINE: It is exacerbating his heart problems; but that is not the point. The point is: how many people are currently on the waiting list, and how many are deemed to be critical? My other point about this is the inappropriateness of Options dealing with this man. There are real problems with Options. The Minister might say that improvements are happening. This is just a snapshot. I could give the Minister a full page list of complaints about Options and its treatment of people; it does not know. There was one case of a man with a puncture in his wheelchair where the young worker did not know how to get that fixed, so she provided a new wheelchair instead. Now, that is not saving money; that is not the best use of public money.

The Hon. R.D. Lawson: The honourable member says that she has many examples of complaints about Options coordination but, by the same token when I am out in the community and when I receive correspondence and the like, I often hear very positive stories about Options coordination and the wonderful contribution that individual Options coordinators have made to the case management of a person with disabilities who has through the agency of the Options coordinator been able to access services and obtain support that previously they were not able to get.

If the honourable member has individual examples, I am certainly prepared to examine each and every one of them. I do not for a moment dispute that we would like additional equipment for our equipment programs, but once again, as I indicated at the outset, there is a tight budgetary situation across the whole of Human Services, and we are working on measures to improve our equipment delivery services.

Ms STEVENS: I refer to domiciliary care and to home help and support for frail aged people in our community. In an article in the *Advertiser* of 20 January 1999, some of the issues of extreme need that have been evident for probably a good 18 months now were again raised. In particular, this article raises the fact that Northern Domiciliary Care (with which I am very familiar) has closed its books—this happened over a year ago—to all but post-operative and palliative care patients and that Southern Domiciliary Care, because of a two year waiting list, requires Mitcham council's home care services to take over emergency cases.

The situation is dire for many people. I noted earlier today that the Minister for Human Services referred to a priority of the department to keep people out of hospital. I can see that he will implement this through the cuts that have just occurred to hospital funding, but I should have thought that Domiciliary Care, the Royal District Nursing Service and services of that kind were critical in helping people to cope in their own homes and to keep well.

My questions are, first, what increase in funding to domiciliary care services will occur to enable them to meet the level of unmet need that exists in the community; and, secondly, what effect will cuts to the hospital system, including the cutting of 34 400 home visits and 102 800 fewer outpatient appointments, have on the demands for those services, and how will the Government meet these new demands?

The Hon. R.D. Lawson: It is true that the *Advertiser* published a somewhat alarmist article about Northern Domiciliary Care last year. Unlike other domiciliary care services, Northern Domiciliary Care ran over budget by more than $500 000 in 1997-98. The service was required to make a contribution towards repaying that budget overrun.

Ms Stevens interjecting:

The Hon. R.D. Lawson: That is a management issue. It is interesting that other domiciliary care services had surpluses in their accounts for that year. Last year, in order to assist the older people in the northern suburbs, a further $234 000 was granted under the HACC program to the Lyell McEwin Health Service to increase access to basic home support services such as personal care, respite, home help and equipment services. That was a particular allocation.

One of the things that we are anxious to do is reduce the cost of multiple assessments. Too often in the past, people seeking services such as domiciliary care have gone to a number of different agencies (some Government, some non-government) and at each port have been separately assessed, their application has been filled out yet again, and they might have received some service or part of a service, and then they have had to go to another agency and be serviced once again. This is very inefficient.

We established a program called the Northern Single Assessment Service, which has now been designated as Support Link. This service, which operates out of premises in Technology Park, was established with funding not only from the central area but also through the allocation of resources of various agencies such as RDNS, Domiciliary Care and local government.

The reason I mention that is that a service of this kind, which will spend considerable funds, has the capacity to improve efficiency across the whole of the northern suburbs and, from those efficiencies, better and more services can be established. Support Link is quite a substantial organisation. It employs a full-time equivalent staff of approximately 14. I attended the formal opening of the service a couple of months ago and the feedback not only from service providers but also from consumers in the northern area was extremely positive. It is by means of such innovations—that is, better and more efficient service delivery—that we will be able to meet the undoubted demands that exist.

I hope that Northern Domiciliary Care will be able to perform in much the same way as its other metropolitan cousins in coming within the budget that is laid down centrally this year. I might say, also, that part of the so-called crisis in Northern Domiciliary Care was because it made a decision, in order to meet that budgetary situation, to cut off additional services for home assistance and the like and to focus on what might be termed, in a medical sense, more significant services, such as palliative care and the like. It made a decision, which it is quite entitled to do, to focus on a particular type of service rather than the home assist type service, which is traditionally delivered through local government organisations.

The Hon. G.A. INGERSON: Minister, you mentioned earlier in your preamble that research was being undertaken as part of the program of the International Year of Older Persons. Page 5.13 states that over $2 million is devoted to research and development. I would have thought that the delivery of services to people was more important than academic research. Can the Minister indicate what sort of research is being undertaken and, also, what value consumers get from that large sum of $2 million being spent on research?

The Hon. R.D. Lawson: The HACC program does specifically allow funds to be allocated for the purpose of research to enhance service delivery. Bear in mind that in HACC we are spending about $72.6 million in this year, and the amount of funding for research is really an infinitesimal part of that. We also provide some State funds for research under 'Ageing, the 10 Year Plan'. It was identified as a priority that we should have a better understanding of the implications of an older community and, accordingly, we have funded some fairly innovative and, I believe, beneficial academic research programs.

One which I particularly want to mention is conducted out of the Centre for Ageing Studies at Flinders University. The Director of that centre is Professor Gary Andrews, who is recognised internationally as a leader in this field. The Centre for Ageing Studies in 1992 was successful in obtaining from the United States a very substantial grant for conducting a longitudinal study of ageing. That study was embarked upon in 1992.

It involved a cohort of over 2 000 South Australians who were then aged 70 years or over. The general purpose of the study was to gain an increased understanding of how social, biomedical, behavioural, economic and environmental factors associated with age relate to changes in the health and wellbeing of older persons. The survey involved in-depth interviews with that 2 000 people. There were follow-up interviews. Six years later there were three follow-up telephone interviews and as a result of that research a considerable amount of information has been obtained, which information has been used in a number of ways in developing services. So there have been positive benefits as well as simply adding to the general knowledge and understanding of researchers.

In the latest HACC round I have approved a further allocation of funding to enable that study to continue. It does seem to me that, having undertaken the study and having examined the 2 000 people, we ought now follow them through for the balance of their lives to ensure that we have a better understanding of what happens to that particular cohort. It is a study in relation to which, unless an allocation is now made, the good work that has been done in the past will, in effect, be lost, because the longitudinal study will have cut off too soon.

There are other studies that have been funded. 'A Study of Attitudes to Ageing Across Cultures and Generations' was one useful paper. In 'Ageing and the Economy', the costs and benefits were analysed. We have examined some Aboriginal and ageing issues. I believe that, notwithstanding the fact that one does not get many compliments for research programs, because people will say, as the member is saying, 'Well, could you not use the money better in direct service delivery?', I believe that you have to strike a balance, and we are not jeopardising our service programs by engaging in the small amount of research that we do.

Ms STEVENS: Minister, I am interested in talking with you now about the fees policy in terms of Home and Community Care programs. What is the position of the South Australian Government in relation to fee collection?

The Hon. R.D. Lawson: In its budget in 1996 the Federal Government said that it would assume that from 2000 onwards up to 20 per cent of the funds in the program would be raised by the collection of fees. At that time some 6 per cent of our total HACC program was raised from fees, largely through Meals on Wheels; but certainly many other organisations in the HACC program, especially those in the country, were charging fees, on a basis determined by the particular agency. There is nothing in the rules or regulations or in the terms of the agreement for HACC which dictates how fees are to be treated. They are certainly not prohibited.

As a result of the Federal Government's decision that it would, in effect, reduce funding on the assumption that fees would be collected, we are faced with the decision now that, unless fees are raised and used in the program, the amount of growth in the program into the future will not continue. Some State Governments have made positive decisions that there would be a requirement that agencies implement a fees regime. That was certainly true in Victoria and in Tasmania. I was interested to see that, although the Tasmanian Labor Party made noises about removing the fees regime prior to the Tasmanian election, after the election the Government there announced that the fees policy in that State would continue.

The Western Australian Government has also recently announced that providers there would be required to charge fees. In this State I have not made a decision of that kind. What I have said and what the Government has said is that it is up to individual agencies to decide whether they wish to charge fees. Agencies have a better knowledge of the nature of their services, of the nature of their client base and have a better understanding of what would be appropriate.

However, I have indicated that, if agencies do choose to charge fees, they should adopt a number of principles. Those principles have been promulgated and widely disseminated amongst the sector. They include things like the provision that the fees must be reasonable; there must be a mechanism to waive the fees for those people who are unable to afford them; there must be a concessional regime for those whose sole source of income is a pension; the funds raised by fees must be used in the program to expand services rather than to increase overheads or the like; and there must be appeal mechanisms in place so that anyone who applies for but is not granted a concession or fee waiver must have the opportunity to have some independent arbitration on that point. The major element is that the services should be granted to people not on the basis of capacity to pay but on need for the service.

The ACTING CHAIRMAN: I advise the member for Elizabeth that this is her last question.

Ms STEVENS: Minister, the downside of your decision not to require fees to be charged is that there will be less funds. If people do not charge the fees, there will be less growth money. That is the downside of your choice to go in that way. Do you agree? Secondly, does this mean that this reduction in growth money, which will come from not charging fees, will apply to agencies which do not levy fees? In other words, will those who levy fees get growth or will that be absorbed across the whole system?

The Hon. R.D. Lawson: We have an annual HACC planning process and a decision will have to be made centrally whether or not additional growth funds which come into the program are allocated to those agencies which do not charge fees. I have to say that, if an agency says on philosophic grounds it is not going to charge fees, irrespective of the fact that the sort of services it offers are the sort of services for which people are prepared to pay, irrespective of whether its client base might be in a situation where they could make a contribution, I would not think the central funding body would be all that sympathetic to such an agency.

I emphasise a couple of points. The fees envisaged to be charged in this program such as the RDNS, which has announced itself a fee policy which comes into force within the next couple of days, is not a full fee by any means: it is a contribution to a fee. The fee being charged is about $5. The cost of delivering the service is about $35. I do not believe that individual agencies which abide by the spirit of HACC will be adversely affected. I add that the member for Bragg indicated $2 million spent on research. In fact, our allocation this year was $200 000.

The ACTING CHAIRMAN: I declare the examination of the votes completed. I thank members for their attention.

ADJOURNMENT

At 10 p.m. the Committee adjourned until Wednesday 30 June at 11 a.m.