HOUSE OF ASSEMBLY

Tuesday 26 June 2001

ESTIMATES COMMITTEE B

Acting Chairman:
The Hon. G.M. Gunn

Members:
Ms R.K. Geraghty
Mr R.J. McEwen
Mrs E.M. Penfold
Ms J.M. Rankine
Mr G. Scalzi
Ms L. Stevens

The committee met at 11 a.m.

Department of Human Services, $1 478 698 000
Administered Items for Department of Human Services, $800 000
Minister for Human Services—Other Items, $9 020 000

Witness:
The Hon. D.C. Brown, Minister for Human Services.

Departmental Advisers:
Ms C. Charles, Chief Executive Officer, Department of Human Services.
Mr J. Davidson, Executive Director, Strategic Planning and Policy Division.
Professor B. Kearney, Executive Director, Statewide Division.
Dr T. Stubbs, Executive Director, Metropolitan Division.
Ms R. Ramsey, Executive Director, Country Division.
Mr B. Dixon, Executive Director, Aboriginal Services Division.
Mr F. Turner, Director, Financial Services.
Ms J. Murray, Manager, Executive Services.
Ms L. Huber, Senior Policy Officer, Executive Services.

The ACTING CHAIRMAN: Welcome to the committee. Would you like to make a statement to the committee, minister, before we open the proceedings for general examination?

The Hon. DEAN BROWN: Yes; if I could just pass preliminary comment. In the human services area, which covers a broad area from health to housing, family and community services, general community services, ageing, and disabilities, one can see that there is a wide range of services within the community. We aim to ensure that we maximise the services out to the community and to those people with need and that we have some system of making sure we understand where the needs are and the priority for the needs so that those in greatest need receive attention first. It is an area in which there has been and will continue to be a huge increase in demand. As a community we need to understand this.

It is interesting to see the extent to which internationally there is growing recognition, particularly in developing countries where the birth rate has dropped and we now have the post-war baby boom which is getting to the stage where those people are getting close to 55 to 65 years of age, that demand for services right across the whole spectrum from health to community services, in home care and services for the aged is escalating dramatically. I was looking at a graph only two nights ago which showed a comparison of countries around the world and how this demand is expected to grow over the next 20 to 30 years.

I have talked previously and have given speeches to highlight the point in terms of its impact on health. It is not only on health but very much the whole spectrum of services required from those who are over 60 to 65 years of age. There are two factors coming together here. First, we are living longer and in so doing we are living healthier lives. At the same time we have a greater percentage of the population over 65 years of age. So, we have two factors, one being the sheer percentage of the population getting to 65 years of age, but on top of that you have another driving factor where, instead of retiring at 65 years and many people dying with heart attacks and other illnesses within the first two years of retirement, which was a very common occurrence in the community back in the 1950s and 1960s, we now have people living much longer. They may be retiring a fraction earlier, but it is now very common to find people in their 80s and 90s and even a growing number over 100 years of age. The fastest growing age group in the community is the 80-plus years age group.

We are doing a lot of work in trying to understand what this increase in demand will do and how we should respond to it. In this budget we have responded with a record increase in funding. Never has there been such an increase in funding for health care—a $213 million increase this year. That represents an increase of 10.6 per cent over last year, and it includes both operating and capital. If we took out the capital component, operating expenses have gone up by $173 million in health care. That represents an increase of 9.1 per cent in operating expenses. If our inflation rate is about 3 per cent, which it is, you can see that there is a very significant increase in funding there to try to meet that increase in demand and some of the increases that have occurred in costs within the health sector.

Those costs have been partly driven by things like a higher inflation factor for health care than for the consumer price index. Certainly the drop in the Australian dollar has compounded that problem in terms of costs because many of the items are purchased overseas, both consumable items and other capital equipment and therefore costs have gone up. As we go into this year we are acknowledging a number of key factors driving an increase in demand. That increase in demand in particular is occurring in the emergency area where we have had in the past year an increase of 5 to 6 per cent in emergency attendances. That has varied between hospitals and communities, depending very much on the age of those populations.

We are also making sure that we put our additional resources into those areas where there is greatest demand. Of that $213 million extra for health care, $67 million is for nurses and doctors enterprise bargaining for this year. I hear a lot of statements made that it is all going to an increase in salaries. It is not; the vast bulk is money over and above increases in salaries for doctors and nurses. I will touch on a number of initiatives we are taking to deal with the demand. One is the $15 million extra for emergency department workloads. Included in that is the winter bed strategy which

means more staff, doctors and nurses in emergency departments and opening up emergency extended care beds in conjunction with emergency departments.

There are other initiatives we take there, including the staff flu vaccination program. We have a program for trying to make sure that there are appropriate types of care for older people who have had to be admitted to hospital for acute care and should be then out in the broader community, perhaps in a nursing home or hostel or even back in their own home with appropriate support. At the beginning of this year we started the transition for older people program, which assists in their transition back into the community and ultimately if possible back into their own home.

There are additional moneys for the patient assistance transport scheme and a record capital works budget. In fact, the overall capital works budget is $248 million and the capital health budget is about $143 million. I compare that with where we were in 1993 in this state under another government when the figure spent each year on capital was about $50 million.

There has been a very substantial increase. For the first time we have seen money specifically allocated to aged care in country hospitals. When I say 'for the first time', we have undertaken projects in those areas but there is now a specific line in the budget under 'capital works' for aged care in country hospitals. Also, there is another specific line for major renovations of country hospitals and a third specific line for upgrading mental health facilities, and we can touch on that later.

There is extra money for dental care. The committee may recall that, during estimates last year, I talked about the extra money and how we had introduced a new scheme of using private dentists to do public work. That scheme has been an outstanding success and we can touch on that during the day. As a result of that scheme, we have decided, again, to inject additional funds into that area. There is extra money for mental health. I think that this is now the fourth consecutive budget in which there has been a real increase in funding for mental health. It is interesting to see that, on a national comparison, South Australia puts more funds per capita into mental health than any other state of Australia. They are the main issues in terms of health.

The committee can see that it will be another challenging year as demand continues to increase and the government puts a significant amount of additional resources into helping to provide those services for the community. I stress that our priority is on identifying the services needed by the community and delivering those services on a timely basis. We are certainly working hard. Sure, at times, with so many thousands, in fact hundreds of thousands of people whom we are helping with the services that we provide, there will be a break down—I am not denying that for a moment.

In fact, I think that we are doing it much more effectively than it has been done before, and if one looks at services being delivered they are ever increasing. With those remarks I would be happy to go now into estimates committee.

The ACTING CHAIRMAN: I declare the proposed payment open for examination.

Ms STEVENS: Given the critical resource issues facing our public hospitals that have resulted in emergency departments in gridlock, ambulances on bypass, the cancellation of elective surgery, a blow-out in waiting lists, insufficient beds, cuts to out-patient services, doctors warning about patient safety being at risk, and hospitals running up multimillion dollar debts, and given that the minister's budget bid for $93 million for hospitals to improve the quality of health care and reduce unacceptable delays was largely refused (with only $15 million allocated to keep 69 beds open), I want to start today by asking the minister questions about priorities and the huge expenditure by his department on computers.

The capital works budget, volume 6 at page 20, under 'capital program', outlines this year a very large expenditure budgeted for information technology. In 2001-02 three big projects are proposed for IT: the clinical information system OACIS project at a total cost of $64.658 million with a budget this year of $17.4 million to be completed by 2005; the clinical information system renal project at a total cost of $24.2 million with an expenditure this year of $4.2 million; and information management systems, the cost of which is unknown and ongoing, this year budgeted at $17.769 million.

My first observation, as a member of the Public Works Committee, is that it seems extraordinary that the department can commit $89 million to OACIS, plus an unknown, ongoing amount to other systems, without scrutiny by the Public Works Committee. Is the capital expenditure of $39.4 million this year alone on IT compromising hospital budgets or the purchase of vital medical equipment? In one year we will spend more on IT than the whole of stage 1 of the Queen Elizabeth Hospital's redevelopment.

The Hon. DEAN BROWN: I am glad that the honourable member has raised this because it is an important area for two reasons. First, we have a major thrust throughout the whole of Australia with what we would call 'adverse events' within the hospital system. A number of national studies have been conducted on this and I have talked about it in the parliament previously. It is fair to say that, probably, one of the highest single costs—resulting in billions of dollars of costs to the health care system around the whole of Australia—results from inadequate quality of care.

One of the most important single contributors to that is the lack of appropriate health and treatment information and clinical care information about the particular patients. One can imagine in any hospital system that, at any one time, 1½ million people could go into hospital. You do not know which one of the 75 hospitals they could go to. How do you make sure that you get appropriate information about, for instance, previous clinical or pathology tests those people may have undergone, or information about previous treatments as to what pharmaceutical products they might be on? OACIS is at the very core of making what I think is the biggest single step forward in improvement in quality health care.

What the honourable member did not mention, and what, I think, she should have known, was that $15 million of that amount is, in fact, coming from the federal government under the National Development Fund. An agreement was made under the last Australian Health Care Agreement that the federal government would put some money into capital investment specifically for information systems. We have been bulking that up from year to year to the point now where we can go ahead and make a purchase. I acknowledge that what we are suddenly spending on OACIS is stepped up significantly this coming year. In fact, we have brought the $15 million from the federal government into that.

Therefore, it is a very important area, indeed, in terms of that quality of care and, for those who do not know, it is about making sure that you have appropriate clinical information about the patient you are treating, whether they have just come into an emergency department, whether they have come in for elective surgery or whether they are an ongoing patient

to the hospital for treatment. You must know what has occurred the last time that they were treated. In addition, you will be able to use that information to feed back to GPs and, ultimately, you will be able to bring together all the health care information about that individual.

We are some way away from that. This is now being pursued by every government in Australia. OACIS has been operating in this state on a trial basis. I am surprised that the honourable member says that we are spending this money without scrutiny of the system. This initiative has been under scrutiny now for four years in South Australia.

Ms Stevens interjecting:

The Hon. DEAN BROWN: Well, it has been under full public scrutiny. It has been investigated, talked about and written up and, in fact, it has been applauded throughout Australia as the first significant clinical information system to be trialled in the public hospital system of Australia; and it has been applauded, particularly, by the clinicians. As I go around Australia, I hear people in other states say how they have been to see the system in South Australia and how impressed they are by that system.

I can give information about some of those areas where the money is spent. The biggest single area is OACIS, where $21 million is being spent. However, I highlight that $15 million of that $21 million is coming from the federal government. Are we to say to the federal government, 'We do not want your money?' That is a ridiculous proposition, particularly as it is specifically earmarked for this area. I point out that the finance sector spends 10 per cent of its revenue on total information management and information technology. In virtually every other industry sector in Australia (and I have given a comparison speech on this matter), about 3½ per cent of their total revenue is spent on information management. Health care in Australia spends something like 1 per cent to 1½ per cent. Even in America, about 2½ per cent to 3 per cent of their total revenue in health care is spent on information management. Until now, Australia has been one of the most backward countries in the world in terms of where that money is spent on information management and using the modern technology and all the benefits that can result.

With respect to the other areas, $4.7 million is spent on the human resource management system. That is the pay system for the 27 000 people who work in the Department of Human Services. We had a very old system. It has reached the point where, in December this year, that system will no longer be functional. The company that supplied the system years ago has withdrawn any further support for it. It is an out of date system, and we have had to spend $4.7 million to make sure that the 27 000 people who work in human services get paid—and I challenge anyone to dispute spending $4.7 million on that. It keeps the whole system functioning, and it is very valuable in a large government department in terms of human resource management.

There is the wide area network. Currently, I think about 25 per cent of the whole of the Department of Human Services is linked together. Because Family and Community Services offices, Housing Trust offices and hospitals are scattered around the state, I would have thought that we would want to make sure that we could ultimately link all those together. Yesterday, Mr Acting Chairman, I was in your electorate at Pika Wiya, and I was interested to see that, in fact, this is one area where, for the first time—and this has occurred in the past fortnight—they have the computers that will now be able to link their health information, their management information and their financial information back into the head office of the Department of Human Services. That is something that most other countries around the world would see as being absolutely basic today and we have just started to achieve it and we are starting to roll it out. We are still well below 50 per cent of the offices being linked together, which is one of the objectives. There is $1.3 million in disability services, and the member can ask the Minister for Disability Services about that.

There is $900 000 in HealthConnect. There is $460 000 on a patient administration system (one of the hospitals needed a new admission system), and there are a number of other projects, including carryover of projects already started in terms of linking a number of the FAYS offices together, particularly in the north-western suburbs. In fact, Christine Charles was at a function on Friday night where, for the first time, the people out in the north-western suburbs are bound to link all their computers together and exchange information.

I talked about the increase in demand. If we are to meet that increase in demand, the only way in which we will do it with a significant lift in productivity is through the linking of computers. I can highlight that we have developed and are using what we call 'thin client technology'—which means we are very thin. This thin client technology has a main computer and it links a whole series of dumb terminals into that computer. In the Housing Trust, which was the initial site tested, 650 other terminal facilities, or dumb terminals, are linked in. There are about 450 dumb terminals, and the rest are PCs all linked into the main computer. The big advantage in doing this is that not only are the initial up front capital costs less but also we are saving $1 200 per desk in annual operating expenses as a result of that. That is a huge quantum step. It has been so successful in the South Australian Housing Trust that we have now decided to roll it out in other parts of the department, as part of this rollout of technology, and Family and Youth Services is one of the key areas for that. The other area is community health.

They are the figures in terms of what makes up that $39 million. One can see that a significant part of that has been covered by the federal government, and some of it is absolutely essential services, such as the human resource management system.

Ms STEVENS: I have a supplementary question. The minister mentioned the wide area network linking hospitals, FAYS and other services in country areas, and I think the minister mentioned that it linked health information and management. I do not think the minister mentioned the cost of that—or, if he did, I did not catch it. I also want to know whether the linking of the health information is compatible with OACIS?

The Hon. DEAN BROWN: The wide area network is $1.2 million. I did mention it. That has been done in a number of different ways, and we have trialled a couple. One was in the Riverland, where we linked all the hospitals in the Riverland together with a high quality telecommunications link. That also included the capability of using that for video conferencing. Then there is a direct link from the Berri Hospital to Adelaide and, in particular, to the main computers that are used for that, and so all the health information and all the financial information that is collected there can be transmitted down that line. In fact, the quality of the line is such that you can also use it (and this is very important) for the transmission of imaging information. It is only being trialled at this stage in a number of hospitals, or being used on a pilot basis, but you are able to digitise that information

and send it down a telephone link. I have seen the quality and the speed with which they are able to take, say, a detailed x-ray and send it down to specialists in Adelaide—say at the Women's and Children's Hospital. The time has been reduced from about 20 minutes for one film to a matter of about 30 seconds. One can see that that is a huge step.

Ms STEVENS: What about OACIS?

The Hon. DEAN BROWN: OACIS is being rolled out initially in the metropolitan hospitals. Certainly, what is being done in terms of the wide area network could be used in terms of OACIS. Most of the linking together at this stage is occurring in community health, FAYS, the Housing Trust, I think, and some of the individual hospital systems. The country hospitals do not have OACIS at this stage.

Ms STEVENS: Why are they on different systems?

The Hon. DEAN BROWN: The member should understand that the wide area network is simply a capability to link together information between two points—whether they are hospitals, community health offices, or whatever. That can be used for any data, whether it is OACIS data, or whatever.

Ms STEVENS: I have a further supplementary.

The ACTING CHAIRMAN: I do not think that supplementary questions can be asked.

Ms STEVENS: It arises from the minister's responses. In answer to my first question, the minister mentioned that $0.9 million was made available to HealthConnect. I understand that HealthConnect is a national health information network providing for the creation and storage of electronic health records. How does that relate to OACIS? Are the two systems compatible?

The Hon. DEAN BROWN: Let me touch on the member's second or third supplementary question. The wide area network (WAM) is the infrastructure and OACIS is the software system. It is not a matter of compatibility: one operates on the computers and the other is the infrastructure that links the computers together, so of course they are compatible.

Ms STEVENS: But you said before that you are not using OACIS.

The Hon. DEAN BROWN: You have been criticising the fact that we are rolling out OACIS. Until now—

Ms Stevens interjecting:

The Hon. DEAN BROWN: You were critical of it, and I am surprised because it will produce the biggest change in health quality that any single step will do. Until now, OACIS has been a pilot program in the renal units for about four years and it has worked very successfully. The decision that I announced last year was to start to roll that out to the rest of the major metropolitan hospitals and that is what this expenditure is for.

The honourable member then raised a question about HealthConnect. One of the big advantages in the fact that across the whole of Australia in the health sector we have not spent money on information technology until now is that we can use the best current technology to try to get the right framework. Very few doctors—GPs—currently use information technology to record case notes. A growing number do, but until 12 months ago less than 10 per cent recorded their case notes about patients on a computer.

No state had committed to a major client information system for their public hospitals in that they had not put in the expenditure; we were the most advanced. As health ministers, we have tried to make sure that we develop a system for the whole of Australia, not just for the public hospital system but for the whole health care system, and that is feasible because the level of expenditure until now has been very low indeed. Therefore, HealthConnect is all about making sure that we develop the right framework for that—the right standards, the privacy standards, confidentiality of patient information and various things like that—and a national project is working on that. The federal government has committed significant funds to that and the state governments are also contributing some money towards it. A series of subcommittees are looking at different parts of it.

The work that is being done nationally with HealthConnect is entirely compatible with what we are doing in South Australia. First, we have to ensure that we have a suitable system for recording client information that can be exchanged between hospitals and between health providers, and the basis under which it is exchanged between health providers. It is going to take much longer to bring in some of those health providers, such as doctors. The first thing is to get them using systems and to have compatibility in those systems and the second is to have internet access between those systems and the public hospital system, and we can only do that after all the privacy and confidentiality provisions have been put in place. That means change in legislation, and we are looking at that in South Australia and I can deal with that separately, and it also means that we have to make sure that there are appropriate security systems as to who can access that information. Obviously security codes will be an important part of it.

Ms STEVENS: My next question relates to those three major categories of IT projects. Can the minister provide the total amount spent to date in each of those categories, that is, the OACIS project, the clinical information system renal project and the information management system, costs unknown and ongoing?

The Hon. DEAN BROWN: Yes. I will have to get that information for the honourable member. The renal information system is part of OACIS. That is an existing part of OACIS, and there is a cost to maintain and operate that on an ongoing basis. Then there is the roll-out of OACIS to other areas. OACIS and the renal information system are all to do with OACIS and the hardware that sits around that. In fact, the amount that we have spent on software in OACIS is very small, and that was largely purchased in 1996. We virtually bought a system and we have adapted it to Australian conditions.

Members must appreciate that we have to make sure that it collects the information and uses Australian terminology and everything else. We have rolled that out in the pilot program and we can use exactly the same system to roll out. The main purchase then becomes how we get the hardware and put the infrastructure in place for the rest of the system. By August 2002, we hope to have it rolled out to all the metropolitan hospitals.

Ms STEVENS: How was OACIS selected? Was there an original requirement specification? Was a tender called and were prudential checks made? Is there a limit on the final total price?

The Hon. DEAN BROWN: I will have to get a considered reply for that because it occurred in 1995-96 when I was not minister. My understanding is that it went through the Prudential Management Group, that it went to a tender call and I know that cabinet signed off on it, so it was a full-blown purchase. I will get a more considered answer to that because the member has asked specific questions about it and it occurred five years ago.

Ms STEVENS: I have a supplementary on that question.

The ACTING CHAIRMAN: I have been most tolerant of the honourable member at this stage. I do not know whether there is much difference between supplementaries and questions.

Ms STEVENS: You have been; thank you, sir. This is a supplementary on what I just asked because it follows through on some of the background. Who developed OACIS? Is the company still operating or has it gone into liquidation or bankruptcy? Who now owns the intellectual property of the system and where are they based?

The Hon. DEAN BROWN: The original software was developed by a group of people in America and in 1998 I met the people who developed this system and I am sorry that I cannot name them off the top of my head. It was a system developed specifically for clinical information systems. It was seen as probably the most advanced of its type and it has been further upgraded since then. Along with other people from the Department of Human Services, I saw it operating in the South Texas Methodist Hospital, which is which is a huge hospital in Texas.

The staff of this hospital used this system throughout the entire hospital. This was in 1998 when every doctor was compelled to record all client information on OACIS. There was no paper used in the system at all. You can imagine what it was like having to record information on patients on a paper-based system and being able to recall that information almost instantly if an emergency arose. The staff of this very large hospital were full of praise for this system, which is quite outstanding. For instance, if a particular medication is prescribed, this system will say whether that medication is likely to react with other medications. In this way, some of the human error is automatically reduced. Secondly, if a new pathology test is prescribed, an alert is placed against that patient's information record until a doctor formally records that they have seen that pathology test, taken note of it and recorded it as part of their total clinical judgment for that patient. So, a lot of safety mechanisms are built into the system. I have named two, but there are many others.

Ms Stevens interjecting:

The Hon. DEAN BROWN: There are a number of hospitals in America. I would have to get that information. The honourable member inquired about ownership, etc. I will obtain that information for the honourable member. The original company that developed this system was bought out by another company, and I think that company has been bought out again, but I will obtain that information for the honourable member.

Ms STEVENS: I ask a further supplementary question. I am keen to know where else in the world this system is running and how effective it has been in those places.

The Hon. DEAN BROWN: I can obtain that information for the honourable member. The South Texas Methodist Hospital, which I visited, was thrilled with this system. This hospital is significantly bigger than the Royal Adelaide Hospital.

Ms STEVENS: Will the minister tell the committee how much was paid to OACIS for licences; are there any ongoing payments and, if so, what are they; is there a licensing agreement; and, given the Premier's statement about open government, will the minister table that agreement?

The Hon. DEAN BROWN: Obviously, I do not know the details of the licensing system. The honourable member asked a question about sites. Approximately 20 major or very large hospital sites in North America use OACIS, so the honourable member can see that this system is widely known in America.

Ms STEVENS: Are they linked with each other or are they separate?

The Hon. DEAN BROWN: No, they are separate, stand-alone hospitals.

Ms Stevens interjecting:

The Hon. DEAN BROWN: Well, that is the American health system, and that is why it was so important to have HealthConnect, which took account of the Australian system which comprises a series of hospitals that are government-owned, and was able to link that information together. It would be easy for one hospital to do one thing and another to have different software. This is the problem that I confronted when I became Premier in 1993. We had 26 account receivable systems in 23 government departments. The previous Labor government could not even standardise one account receivable system within one government department let alone have a system that was compatible across government. There were 32 different human resource packages in those same 23 government departments. Again, the previous government could not even standardise a system within one department. Every time we wanted to produce a document or exchange information across government, we had to re-set all of the information just to go from one government department to another.

It was like designing a car at the beginning of the 1900s which had four different types of wheels, none of which was compatible, and a different wheel in the spare wheel compartment so that when a tyre blew you would have to get another one. That is the argument and logic behind trying to take a national approach and making sure that, ultimately, we can link information at a state level into a national health care system.

Dinmar Consulting owns the product and the intellectual property. We hold the software in escrow so that our interests are fully protected. When developing any software, there is a particular code that is important, and that code is held in protection for our ultimate use. So, no matter what happens to the company that owns the product, ultimately, if need be, we can always come back and understand the code that has been used to develop the software system. This is a very important protection.

Mrs PENFOLD: My question refers to output class 6 on page 6.23 of the Portfolio Statements—hospital-based treatment services. In the light of the claims made by the British media about radioactivity tests being carried out on stillborn babies from Australia and the subsequent announcement by the minister that he would have the matter investigated, is he able to report on the outcome of that investigation; and, if so, are there any other cases of concern where less than adequate consent may have been obtained for the removal and retention of organs and tissue for medical research purposes?

The Hon. DEAN BROWN: Media reports of several weeks ago alleged that in the 1950s and 1960s the bodies of stillborn babies were sent to the United States and the United Kingdom and used for nuclear testing. I understand and sympathise with the concerns of parents who may have lost a baby during that period and who have raised a series of questions as a result. In fact, I received one such letter only this morning.

I requested a formal investigation of the matter. A review was facilitated by the Department of Human Services and carried out by the Women's and Children's Hospital's, Chief

Executive Officer, Mr David Swan, in consultation with Professor Robert Roland of the IMVS. Much of the information for the report was obtained from discussions with a number of medical practitioners in South Australia. Additional information was obtained from press releases issued by Dr John Loy, the Chief Executive Officer of the Australian Radiation Protection and Nuclear Safety Agency (ARPANSA).

I have received an interim report, the key points of which are as follows. Given the time that has elapsed since this period (the 1950s and the 1960s), it has been difficult to trace persons, evidence or documented records relating to the alleged practice of transporting the bodies of stillborn babies to the United States or the United Kingdom for nuclear tests. Medical specialists who were working in Adelaide at the time were contacted, and none of those persons contacted had any knowledge or recollection of the practice of transporting stillborn babies from any South Australian hospital to either the US or the UK for nuclear tests.

No evidence supporting these claims has been found. Further information was obtained from press releases issued by Dr John Loy, CEO of ARPANSA, which indicated that, firstly, ARPANSA does not appear to have any evidence supporting claims that the bodies of stillborn Australian babies were transported to the United States for experiments relating to nuclear tests. Bone tissue specimens of babies and persons under 40 years of age were collected and used to measure the atmospheric fallout of radiation. Strontium-90, a radioisotope, was measured in those bone samples.

Pathologists in Perth, Adelaide, Melbourne, Sydney and Brisbane provided bone tissue specimens of people up to 40 years of age. Representative samples, based upon age group and city, were then prepared as ash in Australia. For a number of years, the ash samples were transmitted to the United Kingdom and the United States for actual measurement of the strontium-90 content. Australia was later able to carry out the measurements itself, and between 1957 and 1978 Australia had a program of measuring strontium-90. Bones from stillborn babies were included in those studies. According to ARPANSA, the program was frequently reported on by the Atomic Weapons Test Safety Committee and in the scientific literature.

Pathologists in South Australia do recall that there was collection of bone tissue samples for strontium-90 testing, and samples from the then Adelaide Children's Hospital were included. However, there are no written records of this practice occurring, and it is not possible to identify the children involved. ARPANSA and the commonwealth Department of Health and Aged Care are collaborating to collect and assess archival material and other records for this period, and will provide a report to the federal Minister for Health as soon as possible. Certainly, South Australia is awaiting further information from ARPANSA, and in fact we have put a series of questions to ARPANSA and to Dr Loy asking him a whole series of searching questions about how many samples of bones were taken, and other information like that, and we have asked to have information on that as soon as possible.

In terms of other organs and tissues, following interstate reports in New South Wales about inappropriate collection and retention of organs and/or tissues, further investigation has now been undertaken here in South Australia. While some organs or tissues have been retained for post-mortem and then cremated, it is now evident that there have been cases of inappropriate retention of tissues and/or organs following post-mortem examination or surgery, prior to 1990. The Women's and Children's Hospital holds just under 1 000 organs or tissue specimens. There are approximately 650 specimens held in the Clinical Sciences Museum, with records indicating that they have been acquired during the period 1957 to 1987, some collected at both the Adelaide Children's Hospital and the Queen Victoria Hospital, which were amalgamated to form the Women's and Children's Hospital.

In addition, 284 paediatric hearts are held. These have been kept for the period 1963 to 1990. I am advised that these specimens appear to be appropriately identified, stored and maintained, and were collected at a time when the need for such specimens was important for teaching and clinical care. For example, the reason for paediatric hearts being collected was that the investigational techniques at the time did not allow the cardiologists to visualise in three-dimensional form the abnormalities that needed to be treated, and the only practical way was for the cardiologist to learn from anatomical specimens.

Similarly, it was commonplace during the period for museum specimens to be collected for teaching purposes, although consent forms were not specific, particularly in the 1950s and 1960s, in relation to the retention of organs. Practices were contemporary with practices of pathology departments throughout Australia at that time.

I am advised that over the past 14 years the Women's and Children's Hospital has had a specific authorisation for retention of tissues and organs requirement and has not retained organs for long periods beyond those necessary to complete either a diagnosis on a surgical patient or the completion of a full autopsy examination.

By today's standards these practices were inappropriate and unacceptable. Although consent was given in some cases, in other cases it was clearly not given. While the information may cause distress to some families, it is important that past practices be revealed. My thoughts and sympathies are with those families. The Department of Human Services has established a special information service: on telephone number 8161 6550, and we will offer counselling to any individual or family who now requests it.

A number of recommendations, which I have approved for implementation, have come out of the further examinations, and I would like to list those as follows.

1. It is recommended that the Women's and Children's Hospital continue to store, catalogue and maintain the organs, as described, and to respond to individual requests from appropriate next of kin for burial, cremation or retention of the organs, as is appropriate following full disclosure and consultation.
2. The description of tissue and organs varies between a number of different state acts. It is recommended that the Department of Human Services review the Cremation Act, the Transplantation and Anatomy Act and the Coroner's Act, and other relevant acts, and make recommendations on consistency of definitions of tissues and organs to the minister.
3. There are national standards for retention of slides and tissue blocks. These standards are developed by the National Pathology Accreditation Advisory Council (NPAAC). There do not appear to be national standards for retention of organs or tissues from post-mortems or surgical procedures and it is recommended that the Department of Human Services request NPAAC to develop national standards.

The Department of Human Services is reviewing the authorisation form for autopsies and retention of organs, and the Women's and Children's Hospital is cooperating fully in that process. It is recommended that the Department of Human Services produce a standard authorisation autopsy consent form, with an explanation, as a matter of urgency.

The general issue of the role and function of the Women's and Children's pathology service, and in particular the Tissue Pathology Department, should be considered in the forthcoming Department of Human Service's review of pathology, and several weeks ago I formally approved and authorised all of those steps to be taken.

There is a wider inquiry taking place nationally into the unauthorised removal of organs and tissues for medical research and education purposes being conducted by the commonwealth Department of Health and Aged Care in conjunction with the National Health and Medical Research Council, the Australian Health Ethics Committee, state and territory governments and the Royal College of Pathologists of Australia. The further work done by ARPANSA, to which I referred earlier, in relation to bone tissue samples and strontium-90 will feed into that inquiry, and the inquiry will obviously be relevant to South Australia's further deliberations on the matter of organ and tissue removal and retention.

Mrs PENFOLD: My next question relates to country renal services and I refer to page 6.23 of the Portfolio Statements. I note that a clinical services review has been completed for renal services in metropolitan Adelaide and an implementation plan has been launched. Given that renal failure is a common health problem, especially among the indigenous population, those people living in country regions needing renal dialysis have been greatly disadvantaged over the city. Will the minister advise what is being done to improve the situation?

The Hon. DEAN BROWN: I thank the honourable member for that question as she has no doubt heard me talk about the clinical reviews being carried out in a number of areas, and renal services is one of those. We have completed that and announced it. We carried out a specific review for renal services in country areas. A number of specific initiatives came out of that. We want to ensure that we have a flexible self-managed system that will allow renal dialysis for people living in Mount Gambier or Port Lincoln in addition to those already provided at Ceduna, Port Augusta and in the Riverland. We saw a need, with the high indigenous population at Port Augusta and because of the huge level of diabetes in the indigenous community—something like eight times greater than for the rest of the population—to expand the services there. We have also looked at what could be done at Coober Pedy where again you have a high indigenous population. A number of initiatives have come out of this.

Recently I approved $500 000 additional funding for kidney dialysis in country areas. That includes $120 000 each for Mount Gambier and Port Lincoln, so people will be able to live in their own homes and have dialysis within their own community, which is an important outcome. I have allocated another $199 300 to the northern and far west regional health service to enable an additional five to seven patients to access renal dialysis rather than having to travel to Adelaide. In fact, I was at Port Augusta yesterday and they were indicating how thrilled they were to receive that additional funding and how it had eased the situation in terms of the demand for dialysis services at Port Augusta.

In addition, here in the metropolitan area we are making sure that, particularly in the southern suburbs, we expand the capacity in dialysis. A new dialysis centre at the Noarlunga Hospital is being opened up, I think by later this year. That will comprise eight chairs and will certainly alleviate the pressures within the metropolitan area for dialysis. I talked earlier about the ageing of our population and the impact that has in terms of increase in demand for services, and dialysis is one area in which that is occurring in a big way. As people live longer, the likelihood of their requiring dialysis increases as it is very much related to age as well as other factors. At the same time, because they are living longer they need to be on dialysis longer. It is one area in which we are having to expand services, but we have made huge strides in the past 12 months.

It shows the value that has come out of the clinical review. The Riverland, Mount Gambier and Port Lincoln all have dialysis services that were not there 12 months ago and Ceduna has a service that was not there two years ago. We have expanded significantly the service at Port Augusta. We are mindful of trying to ensure we continue to respond where the demand occurs.

Mrs PENFOLD: I refer to page 6.3 of the Portfolio Statements and integrated planning. This is one of the ministerial priority areas: promotion of Aboriginal health and well-being. Will the minister provide the committee with advice on how the health issues of the Coober Pedy community are being addressed?

The Hon. DEAN BROWN: The Cooper Pedy community has a high indigenous population and is a remote area. It services a much larger area of South Australia, effectively the north western part of the state. We are taking several initiatives within the health service, and the Coober Pedy Hospital and Health Service has the potential to achieve better delivery of service to both indigenous and non-indigenous communities in the area and include the following: development of a $1.5 million age-care facility collocated in the hospital; the development of a regional health service at a cost of $250 000, which includes improved medical and primary health care services; the employment of an additional general practitioner to work with the Umawa Health Service; the employment of a primary health care worker and a mental health care worker; a project officer to be employed for six months to develop a strategic plan for the whole of the regional health service; and a Department of Human Services manager recruited for two weeks to coordinate local DHS agencies and to oversee changes in the Coober Pedy area. That is very important. It is a matter of making sure that we integrate the delivery of services to the community and get the best value for money from them. Having more effective management in this remote area is an important part of that.

Ms STEVENS: I return again to the subject of OACIS and information technology. The minister said that the OACIS system will be rolled out at a cost of $65 million to all metropolitan hospitals to much improve service delivery for patients. Will the minister explain how the system will be used for a person who perhaps has private health insurance but has attended the Queen Elizabeth Hospital as a private patient, has medical records and data at the Queen Elizabeth Hospital, but on this occasion goes to the Ashford Hospital? How does the system link in with the private sector? As the minister has pointed out in recent weeks and days, we need to link in and work together with that sector. How does the system work with Ashford Hospital and in relation to the

general practitioner who probably sees that patient on a regular basis?

The Hon. DEAN BROWN: Let us be clear: the $65 million to roll out OACIS is over a five year period. It is not this year, as the honourable member almost implied—it is over a five year period. Secondly, much of that $65 million is either for hardware or infrastructure, so that you have computers or dumb terminals in which to put the information within the hospital system. The software largely has been purchased already. There will need to be further refinement in terms of different parts of the hospital system. Most of the cost is in buying the computers that go together or the thing that links the computers together—the telecommunication system, the routers, the network and so on. OACIS as a software system is internet based and therefore you are able to link together on the internet. The whole thing about HealthConnect as a national framework was to—

Ms Stevens interjecting:

The Hon. DEAN BROWN: They are both related—HealthConnect is the national project and OACIS is the system being put in in South Australia as part of the broad HealthConnect program for the whole of Australia. An important part of HealthConnect was that, ultimately, all the health providers ought to be able to be linked together once various protocols are developed in terms of how they can be linked together to maintain security, confidentiality, etc. Therefore, yes, when the system is fully developed the idea will be that private hospitals, if they wish, will be able to access that. We have no compulsion and no power to compel private hospitals to develop that system but, certainly, that is the objective. It is part of the whole thrust of HealthConnect, as it is with the GPs and with pathology and pharmaceutical matters.

Imagine the benefits if the doctor is able to prescribe drugs in his or her clinic and transmit the prescription electronically to a pharmacist who will then issue the pharmaceuticals. All this bad writing from doctors which, in some cases, has been a cause of mistakes will no longer exist. Instantly the doctor will be able to check those pharmaceuticals with existing pharmaceuticals that the person might be having. A doctor would be able immediately to check on the potential side reactions and adverse events and therefore ensure that the patient is aware and looking for it, and other aspects such as that.

To highlight the point that I have made, the College Grove and Hartley private hospitals are already involved in the OACIS clinic that is being used in the renal area, which highlights the point. The honourable member has asked: what is the benefit for the patient? That is the very point I make: it does not matter, ultimately, when this initiative is operating. If it is taken up by the other private hospitals it will not matter to which hospital a person is admitted. A hospital will be able immediately to recall information on the treatment of that patient. One day a person might be in a private hospital and the next day a person might be in a public hospital, or vice versa, and that information can be transmitted.

At present that cannot happen without a great deal of difficulty. That is time consuming and is the very cause of adverse events within the hospital system. I would hope that the honourable member, before asking her next question, will say that she supports implementing an appropriate clinical information system that will lift the quality of care in our health care system. Or is the honourable member of the sort of thinking that would take us back to the dark ages, with bits of paper being rushed around a hospital and, in fact, information not being available when a clinician needs that information to treat a patient?

Ms STEVENS: My concern, minister, of course, is that your system might be great in theory, but from what you have just said in answer to my question it seems that, as a result of spending $90 million, we have a system in the metropolitan public hospitals into which we cannot guarantee that private hospitals will be linked. I was talking about Ashford and, in relation to that hospital, I think that we might still encounter paper shuffling. If we are thinking about a whole system that is laudable, the fact is—and you have just said, minister—that there is no way that you can guarantee that the private system will be involved, that is, the private hospitals.

Let us talk then about all the GPs and all the specialists. We have a huge issue here in that we have spent $90 million on a project that is limited in its scope. That is one area. Minister, you mentioned that protocols needed to be developed in relation to the private sector. Well, what protocols and how far down the track are you in terms of working those out and why were those not worked out before you started the system? Surely, that will affect the software system itself?

The Hon. DEAN BROWN: I do not think that the honourable member has listened to what I have just said in answer to the last and previous questions. First, the $90 million to which the member for Elizabeth refers is over about a nine-year period. In that same period we will have spent—

Ms Stevens interjecting:

The Hon. DEAN BROWN: No, $90 million will be the money spent over about a nine-year period. We started this expenditure back in 1995-96 and we have still got, I think, four years to run in terms of the further roll out of OACIS. One can see that it is about a nine-year period. In that period, the public hospital system in South Australia will have spent something like $18 billion on health care in the public sector. The honourable member is trying to make a political issue out of spending $90 million on a client information system out of an $18 billion expenditure on public health in South Australia. That is an appalling lack of judgment in my view.

I think that the honourable member should talk to some of her colleagues around the rest of Australia because they are committing enormous amounts of money—much bigger than we are—on client information systems. The other ministers around Australia have all agreed to this process. The claim made by the honourable member that, in fact, there cannot be benefit for private patients is wrong. I just said that, already in the pilot, two private hospitals are connected into the system.

Ms Stevens interjecting:

The Hon. DEAN BROWN: There are two in the clinical trial, which is a pilot. The whole idea of HealthConnect was to involve the private doctors, over which, as a state, we do not have any absolute compulsion in terms of their implementing clinical information systems. That needs to be done through the Medicare system, which is a national government responsibility. In terms of payments for private hospitals for services, that is a national issue. The whole idea of HealthConnect nationally is that we do not have a system only for the public hospitals and into which the private hospitals cannot connect.

I do not know where the honourable member has been for the last two or three years because I have given, probably, 15 speeches on this subject. A national conference was held in Adelaide where public and private people from the community health area, the hospital system, the medical area

and the specialist services all came together. If the honourable member says that we should now become troglodytes and turn our back on the information technology advance, heaven help us in terms of what the outcome would be for health care. Let us just work it out in very rough terms.

The honourable member is objecting to the fact that we are spending $100 million in $18 billion and, I think in percentage terms, that would be—I will get the exact figure in a moment. I will ask Frank Turner, our numbers man. What is $100 million in $18 billion? It is less than .5 per cent.

Mr McEwen interjecting:

The Hon. DEAN BROWN: Did the honourable member say '$18 billion'?

Mr McEWEN: Yes.

The Hon. DEAN BROWN: It is costing us about $90 million to $100 million over a nine-year period and we spend on public health in South Australia about $2 billion a year.

Mr McEwen interjecting:

The Hon. DEAN BROWN: As I said, $2 billion a year over nine years is $18 billion, and we are spending the $90 million to $100 million to which the honourable member is referring over a nine year period. So, it is about $100 million, or $90 million, over $18 billion—half a per cent. That is incredible in terms of the potential outcome, when one sees that virtually every other industry sector is spending about 3 per cent, 3½ per cent, and some up to 10 per cent.

Ms STEVENS: The minister mentioned the nine year period, but I note from the capital works budget under OACIS, 'total cost $64 million', and, 'the five year program to roll out OACIS'. However, I would like to proceed a little further. The minister has mentioned the other states: can he tell us which of the other states are rolling out OACIS, and the extent to which they have proceeded down that track?

The Hon. DEAN BROWN: I can indicate that every minister in Australia has agreed to the HealthConnect program. We have had a formal sign off of that at the ministerial council, so every state and territory government of Australia is committed to that project. The honourable member asked which states are rolling out OACIS. It is up to individual states as to what system they get, but under HealthConnect they do not all need to have OACIS. The whole idea is to make sure that there are appropriate protocols and standards to allow the linking together of the information.

Ms STEVENS: Is there a compatibility problem?

The Hon. DEAN BROWN: No. The point is that, in fact, under HealthConnect we will get that compatibility. That is the whole reason for making sure that we established a national protocol and national standards for this, so that in fact we did not have systems that were not able to be connected. I am happy to provide a briefing for the honourable member. I am just disappointed that, on such an important issue, she seems to be so ignorant about what is occurring—particularly as it is not new. We have been doing this and talking about this since about 1995.

Ms STEVENS: You might have, but you have not done so in parliament at all.

The Hon. DEAN BROWN: Yes, I have. I have talked about OACIS in the parliament.

Ms STEVENS: It has been very minimal, believe me—we have checked.

The Hon. DEAN BROWN: Why haven't you asked questions over the past six years?

Ms STEVENS: I am doing it now, to give you the opportunity. I understand that there is now a consulting firm managing the project here in South Australia. Can the minister tell us who that consulting firm is, how much it has been paid since the project started, whether there was a public tender to select it and how much it will be paid next year?

The Hon. DEAN BROWN: The consulting firm is Accenture. I will have to obtain the information in terms of the specific amounts paid, etc. I point out that the protocols are already in place. I stress that this is internet based, so anyone with appropriate protocol can link into the system. Apparently, protocols already have been developed for pneumonia, deep vein thrombosis and hip and knee replacement, in addition to the renal. So, one can see that it is not just renal where that information can now be exchanged; it is other areas as well.

Mr SCALZI: Earlier this year, the Department of Human Services held an expo and conference called Life Journey. On page 6.8 of the Portfolio Statements there is mention of health promotion strategies and campaigns. Can the minister indicate how successful was the Life Journey expo and conference and how well it tied in with the Department of Human Services' priority area of promoting and protecting health and wellbeing?

The Hon. DEAN BROWN: The expo was very successful. It brought together a whole range of people with a strong interest and commitment to human services in the community. One of the main initiatives that we are trying to take here is to look at the benefits that we have derived out of things such as the breast screening program, to make sure that we then start to apply some of those principles in other areas of health care. I mention breast screening because, on the latest figures from the cancer registry, there has been a 20 per cent reduction in the death rate from breast cancer in South Australia. If one looks at the figures for South Australia, one can see that, in a 12 country comparison (and these are major developed countries), we have the best five year survival rates for breast cancer of any of those 12 countries. So, our performance there is very good.

I think there are some fundamental lessons to be learned out of that program; that is, if we go out into the community with the appropriate screening programs and an information system available, backed up by good clinical treatment, modern equipment and modern medical research, we can achieve very good outcomes. The same thing has occurred with cervical cancer, where there has been a 40 per cent reduction in the death rate. With respect to breast cancer, those who monitor the register have indicated to me that they expect that, within a few years, the death rate will have dropped from 20 per cent and there will be a 40 per cent reduction. That is a very significant outcome. We now have an 82 per cent survival rate for a five year period with respect to breast cancer.

The sort of thinking behind it is that we have said: how do we go out and start to make the community really understand what is important in terms of health care and primary care in the community and, as part of our health promotion, instead of just running a broad mass media promotion, how do we get people involved, get them to understand and to be a part of it? Life's Journey was a very important part of that. And it was broken up into different age groups. There were some programs for young people and the important issues concerning them. These included vaccination programs and diet—making sure that teenagers, and so on, are eating enough fresh fruit and vegetables, so that the likelihood of future cancers

is reduced—particularly bowel cancer—and that the likelihood of diabetes in the community in future years is reduced. Exercise also is an important part of that. With respect to middle aged people, invariably, it tends to be around cardiac disease and areas such as that and, again, the type of diet and the level of exercise is an important part of that. With respect to slightly older people, it is important that they start to enter screening programs for diabetes. We would urge, for instance, in the cardiac programs, that there be regular checking on blood cholesterol levels.

We attracted something like 6 250 people to Life's Journey. I think that it is an outstanding achievement that over 6 000 people were concerned enough about their health to come in over a weekend to obtain that sort of information. It was one of the areas that was very successful in terms of attracting whole families to come in and to take it on as a family.

The aim is to take a reduced version of the health expo out to seven regional field days and shows over the next 12 months. In fact, for the past two weeks, we have been visiting a series of shopping centres in the western districts. I was talking to one of the people involved in that promotion only yesterday, and he told me that, at any one time, they had 20 to 30 people in the shopping centres obtaining information, and they were basically open from 9 a.m. until 5 p.m. So, one can see that, over the period of a week, we were starting to touch literally thousands of people. It is important to go out to the community and to get them involved in the community, rather than expect them to go to their doctor.

Reconciliation was another theme of the Life's Journey expo and a very important one. A free community celebration was held in Elder Park and something like 20 000 people attended. I will not list all the performers, but there was a series of live performances on that occasion, and I think that plays a very important role in the reconciliation process between the indigenous and non-indigenous communities. On the Monday morning after the expo I opened the Life's Journey conference, which attracted 367 delegates. There was a whole range of discussions on various issues—health promotion, disease prevention, reconciliation, Aboriginal health and various issues like that. Overall, for a very small expenditure, it has been a very good program, but that was just the start. The expo was only the start of what I see as a much bigger program. Other significant components of it are to be rolled out next month.

Mr SCALZI: Page 6.3 of the Portfolio Statements indicates that one of the minister's priority areas is promoting and protecting health and wellbeing, as we heard in the last answer. Can the minister indicate what initiatives the government will be pursuing in assisting people who have diabetes? I am sure that the minister is aware that there is some public concern that drug users have access to free needles but diabetics do not.

The Hon. DEAN BROWN: This issue has been raised by a fair number of people who have written to me. I will not go into all the arguments behind the free needle program for drug users, except to say that we should look at the instance of HIV in Australia, and South Australia in particular, and compare that with other places that do not have a free clean needle exchange program or a clean needle program, and the incidence of HIV is 10 to 100 times greater, so it makes a great deal of sense both in terms of cost to the health care system and more importantly to stopping the spread of HIV/AIDS within the community.

However, there has been a feeling that one group has got it and that the other group, the diabetics in the community, do not have the benefit of it. As a government we have taken the initiative to roll out a free clean needle program for diabetics within South Australia. We have allocated $258 300 for the scheme, which is what we expect the demand to be, and it includes an increased usage of the scheme. In the past, we have offered a subsidised scheme where a box of 100 syringes and needles was available for $8 compared with a retail cost of $25, so it was heavily subsidised. People on low incomes could get it for $5. It will now be available to all diabetics free of charge.

We will work through Diabetes Australia, which will administer the scheme, and I expect that a number of branches or agents for Diabetes Australia will be set up so that people in country areas are readily able to access those free needles. The scheme is still being put in place in terms of distribution, but I anticipate that country hospitals will be one likely agent for the distribution of clean needles for diabetics. Members can see that the government does listen. We are responding to those who have diabetes and we are making sure that there is equity between the different users of needles within the community. I know that a lot of diabetics are very pleased with that initiative.

Mr SCALZI: That will be welcomed by constituents who suffer from diabetes in my electorate and in the electorates of other members.

The Hon. DEAN BROWN: I know that the honourable member has an older population in his electorate and he might like to ensure that that information is widely distributed because nearly 4 to 5 per cent of the population has diabetes. They would not all be on the needle program so it is important that we get that information out.

Mr SCALZI: My next question refers to the national medicinal drug policy. On page 6.8 of the Portfolio Statements mention is made of the promotion of proper standards of environmental health, including drugs and poisons. Further to my previous question, I want to ask about medicinal drugs. What initiative is the minister's department undertaking in relation to the accessibility of safe and effective medicinal drugs?

The Hon. DEAN BROWN: The department and the government very strongly support the national medicinal drug policy. That has four basic principles: medicine should be safe and effective; medicine should be accessible to the Australian community; there should be a viable Australian pharmaceutical industry; and there should be quality use of the medicines. The first three principles are the responsibility of the commonwealth while the South Australian government has an obligation to promote the quality use of medicines.

Quality use of medicines involves the judicious, safe, effective and affordable choice of drugs and drug management options. It involves the consumers—the patients themselves—the health professionals, governments, the media and the pharmaceutical industry. Several groups in South Australia have an excellent national reputation in the area of quality use of medicines. The department has a quality use of medicines program and works very closely with other agencies and organisations to promote the use of limited resources.

The department's quality use of medicines program has promoted non-drug options in the management of insomnia in the Southern Fleurieu Peninsula and has achieved a 20 per cent reduction in the use of some pharmaceuticals for that particular purpose in that region. The program successfully

brought together health professionals, consumers and government and has led to an ongoing commitment to quality use of medicines in the region. I will be announcing a further initiative there because, whilst it has been used for insomnia, the program will expand further and look at a number of other illnesses for which people use medication to try to reduce the adverse events, to make sure that there is more appropriate and reliable dosage and to ensure that there is not conflicting use of drugs in those areas. The Southern Division of General Practitioners has agreed to participate in this quality use of medicines (QUM) project. I know that they are working with a number of groups within the community who represent older people. The Heritage Club at Goolwa, for instance, is to be part of this expanded trial.

I spoke to the Pharmaceutical Society of South Australia about this two years ago and we talked about a number of the programs that we have been running with pharmacists within South Australia, as well. Our School of Pharmacy has been very heavily involved in this and I am thrilled at the extent of the cooperation with pharmacists in wanting to ensure that we get more appropriate and quality use of drugs in our community.

Ms STEVENS: My next question relates to Budget Paper 5, volume 2, page 6.24, hospital based services. The first priority in the minister's budget bid, which is contained in the green book, is to 'improve the quality of health care for South Australians and reduce unacceptable delays for medical treatment'. In relation to hospital funding, the following projections and bids were outlined under the heading 'Funding for increased activity': $50 million in 2001-02; $25 million in 2002-03; $37 million in 2003-04; and $49 million in 2004-05. What are the projections for future demand in public hospitals (on which those figures are based) in terms of percentage growth, and how does that translate into bed numbers, outpatient appointments and emergency services, etc.?

The Hon. DEAN BROWN: The honourable member refers to a document that was prepared about 10 months ago. I will need to get that information for the honourable member.

Ms STEVENS: Is the minister saying that this information is no longer current?

The Hon. DEAN BROWN: No. I am about to comment, if the honourable member will be patient. One issue which clearly is of interest to us relates to what is happening with private health insurance within the community. As a result of both the federal government rebate for private health insurance and the whole-of-life policy, we have seen membership in private health insurance increase from 30 per cent of the community to 46 per cent, and then it has dropped back slightly. There was an exclusion period for the first 12 months of taking out private health insurance for many people. Also, we wanted to see what occurred in terms of the shakedown period. The crucial question was whether those people would renew their membership in private health insurance 12 months later.

My understanding is that, in round figures, the percentage has dropped from about 46 per cent to about 43 per cent. However, we are about to enter the period where people who were excluded for 12 months will suddenly be able to have procedures carried out in a private hospital. So, I think we are in a period of transition and change in terms of demand. Since those figures have been prepared, we have done some detailed research which has identified two issues of concern. One of those is the so-called gap for people accessing private health insurance and private services. The federal government, as a result of the latest budget announcements, is running a program to eliminate the gap. The second issue of concern is the amount of excess that people have to pay. This was not a big issue until about 12 months ago.

Ms STEVENS: On a point of order, Mr Acting Chairman, I asked the minister a question that related specifically to the projections for future demand in our public hospitals.

The ACTING CHAIRMAN: I suggest that the honourable member not go down that track or I will start requiring members to tell me on which particular line in the budget they are raising questions. The chair has been pretty flexible. I do not want any of this sort of nonsense. The honourable member can ask her questions. It was all going pretty sensibly. I will get out this book and make the honourable member tell me what page and what line she is referring to. I do not think that we want to go—

Ms Stevens interjecting:

The ACTING CHAIRMAN: If the honourable member wants me to, I can start right away. It is entirely up to the honourable member.

The Hon. DEAN BROWN: I thank you for your protection, Mr Acting Chairman. I was asked what are some of the factors that have determined the demand that is likely to occur, and I am talking about those factors, which are: the level of private health insurance and the extent of the gap payment which influences the extent to which people use the private system; and the other is the excess payments that people have to make up front to use this system. I was somewhat surprised to find from our research that the average upfront payment is about $250 per treatment over and above the gap.

I think these factors will have a significant influence on demand. Last year was unique throughout the whole of Australia. The public hospital system throughout Australia has never experienced an increase in demand of 5 to 6 per cent in a full year. This is not unique to South Australia: other states are reporting exactly the same thing. In the past 12 months, the private hospital system has increased its elective surgical procedures and the demand for private hospital beds has increased dramatically.

One of the member for Elizabeth's opening comments related to ambulance diversions. Ambulance diversions in the public hospital system are at an extremely low level. I am fascinated that the honourable member has used this almost hysteria within the media about the high level of ambulance diversions. So far this year, I think that figure is 1.1 per cent of the time that the ambulance has been on diversion in the public hospital system. In April, there were no diversions for any of the public hospitals in metropolitan Adelaide. In May, the level was .9 per cent only, which is extremely low.

By comparison, in April and May, the diversions from the private hospital system to the public hospital system were 30 per cent and 31 per cent. So, when people refer to ambulance diversions, effectively they are talking about diversions from the private system to the public system. I have taken up this issue publicly, and we are working with the private hospitals to resolve it. From September to May, 1.2 per cent of the time has been spent on diversions and, if you go back to the beginning of July, you will find that the figure is even lower still.

In terms of where the demand and growth is going to be, I suspect that we will see a higher growth rate in emergency department attendances. We have seen within that subset a growth in triage 2 category and, particularly when we break

it down by age group, the 70-plus age group is where the demand has been. So, it is basically triage 2, 70-plus age group. These are people who more than likely will attend an emergency department and be admitted to the hospital. Certainly, that is where the big growth has been.

The three underlying factors in terms of bed modelling and future demand include the shift from in-patient surgery to same-day surgery, which is increasing by about 2 per cent per annum, that is, the percentage of total surgical cases (same-day cases) is growing by 2 per cent, and approximately 45 per cent (in some hospitals, I think it is 50 per cent) of all surgery is now done on a same-day basis. The second factor is the length of stay of patients. This reflects changes in medical technology. There has been a slight reduction in this area, although it depends again on the number of older people in the public hospital system who are waiting for a nursing home. That factor tends to push that figure out to a longer length of stay. The other issue is the growth in the total number of people in the population, particularly the ageing population.

Again, I saw a national graph in terms of use of the health care system, by age, and it is a true exponential curve, and once you start to get to 60 or 65 years of age, or in fact 55 years of age, the use starts to increase quite dramatically. At 65 it is about four times more; at 75 it is about six times more; and it goes up very sharply after that, with age. So as you can see, if you live longer, as the population is doing, then the demand on the health care systems will grow exponentially, with that curve.

Ms STEVENS: A supplementary question: I would just like to repeat the question so that the minister can hear again what I asked. Perhaps if he is not going to answer it we could leave it and go on to something else. The question was: what are the projections for future demand on our public hospitals on which the figures that I mentioned before were based, in terms of percentage growth, which you have referred to; but how that translates into bed numbers, outpatient appointments and emergency services?

The ACTING CHAIRMAN: I remind both the member for Elizabeth and the minister that repetition is out of order.

The Hon. DEAN BROWN: Yes, and therefore I would refer the honourable member to what I said at the beginning of answering the question. I said those figures were prepared about eight to 10 months ago and I will have to take that on notice and get the exact detail.

Ms STEVENS: Minister, I would now like to talk about the arrangements that you have been speaking about in recent days with the private hospitals in relation to using empty bed space in public buildings to cope with their demand. After initially refusing the Wakefield Hospital access to empty beds at the Royal Adelaide Hospital, you announced that the government will offer public hospital beds to the private sector, with the exception, I understand, of beds at the Royal Adelaide, Flinders, Queen Elizabeth and the repat hospitals. Can the minister provide a detailed summary of vacant wards and beds in each of the major metropolitan hospitals, or other public buildings, such as Julia Farr, that are being considered for this purpose?

The Hon. DEAN BROWN: First, the honourable member is wrong in saying that we have refused the Wakefield Hospital access to vacant beds at the Royal Adelaide Hospital. There are no vacant beds or vacant wards at the Royal Adelaide Hospital. So how can you refuse someone something when in fact they don't exist to refuse? In fact, Wakefield Hospital has been told that. So the premise of her question is wrong. I have met, as the media has already talked about, with the three private hospitals, with the Royal College of GPs and with the AMA last Thursday evening, and we explored a number of different possibilities. One of them was to see to what extent there might be spare bed capacity or ward capacity, potentially, in government institutions within the state.

A condition was that we all agreed that we would not identify publicly any specific location, and therefore I live by that agreement, because I gave that agreement, and the others, the three private hospitals, equally gave that agreement, and I would not like to breach it. So I am not going to talk about any specifics in terms of institutions, except we have agreed to work with them trying to identify where there might be spare bed capacity. I think this is interesting, because this meshes in very nicely with the answer I was giving before, and what the honourable member has just highlighted is the fact that a significant shift is occurring. If you go back 12 months ago—and 18 months, 24 months even more so—there was very significant empty bed capacity in the private hospital sector, even in the major public hospitals.

The Flinders Private Hospital was sold by Ramsay after having only something like a 50 or 60 per cent occupancy. In fact, I think it was less than 50 per cent there for a while. Now suddenly that hospital is full, and the other major private hospitals are equally full. In relation to the Ashford group, which now includes the Ashford Hospital, Memorial Hospital, Western Community Hospital and the Flinders Private Hospital, they have full capacity. The Wakefield Hospital and the St Andrew's Hospital have reported that they are effectively full as well, and that they would like to very rapidly increase their capacity, if they can.

That is why they came along and asked to see what spare capacity there might be. Therefore, we are exploring with them as to how that increased capacity might be met, but it highlights that, in terms of who is delivering what health care within our community, we are in a transition stage because there are dramatic changes going on, and we have to be able to be flexible enough to deal with those dramatic changes.

I might add that Wakefield had made a very specific request—because I saw what the honourable member said on TV: she said why did we not offer services elsewhere earlier. Well, Wakefield had made a very specific request in terms of the Royal Adelaide Hospital. We had indicated to them that we could not do it at the Royal Adelaide Hospital. The issue of other institutions only was raised with us last week, and we immediately responded to that, and agreed to work with the private hospitals. So we did it within literally I think 24 hours or 48 hours of a request coming in.

[Sitting suspended from 12.57 to 2 p.m.]

Ms STEVENS: I return to the topic we were talking about before lunch in relation to private hospitals and the unmet demand for beds, Budget Paper 5, volume 2, page 6.24—hospital based services. Given the apparent unmet demand for private hospital beds, will the minister now review the decision to allow Healthscope to avoid the company's contractual obligation to establish a 65 bed private hospital at Modbury and, if not, will you rule out using the vacant Modbury space, which as you know was a temporary private hospital for a short time until it was closed, for other private hospital beds?

The Hon. DEAN BROWN: One of the key issues in terms of Healthscope and its private hospital is that the

largest private health insurer in South Australia is Mutual Community and it had not issued or approved of any private beds at Modbury Hospital as a provider. Therefore, your private health insurance companies can largely dictate where the demand will be, particularly where you have one company that controls something like 50 per cent of the market. It is able to dictate where the demand will be and in which hospitals the demand will be. The rest of the market is shared between a myriad of small insurance firms: there are about 30 or 35 other private health insurers. Some do not operate in South Australia, but many do and some are very small.

Unless we can be satisfied that a private hospital by Healthscope is likely to be viable by winning approval from health insurance funds, there is no point in proceeding. There is a feasibility study under way into that issue. A condition was that Healthscope had to cooperate with the Department of Human Services on carrying out a feasibility study to see whether the change in the nature of private health insurance and the way in which beds are approved by the insurance company meant that a private hospital at Modbury would be viable and sustainable. That is our main concern. We put into any agreement we had with Healthscope a trigger mechanism in terms of a feasibility study between the two bodies, and that trigger mechanism has been triggered, so a feasibility study is under way at present.

In terms of the use of that space by other private hospitals, I have indicated that I will not comment. Clearly, contractual and legal issues would have to be looked at, but I will not identify any specific areas that will be looked at for use by private hospitals.

Ms STEVENS: As a supplementary question, was the minister aware when the contract was signed with Healthscope that it was not approved by Mutual Community and that there was a problem there?

The Hon. DEAN BROWN: I was not the minister, so I do not know.

Ms STEVENS: You were the Premier, so I presume you knew what was happening with the contract.

The Hon. DEAN BROWN: As Premier I did not go around and negotiate with private health funds in terms of individual bed approvals. I have had discussions with health funds on that matter as minister for health, so I am very aware of it and made sure that we got relevant facts.

Ms Rankine interjecting:

The Hon. DEAN BROWN: There is a feasibility study under way presently in terms of the viability of a private hospital at Modbury.

Ms STEVENS: As a further supplementary in relation to the issue of the feasibility study, I remember clearly when Healthscope appeared before the Public Works Committee it making the point that it was not viable because there was not the demand for private beds. Surprisingly after this had all been agreed to it was discovered that there was not the demand and, if Healthscope's arrangement went ahead, North Eastern Community Hospital beds would be at risk. At that point there was less demand for private hospital usage, but that situation has changed markedly now it seems.

The Hon. DEAN BROWN: We are in a changing world. The contract was signed at the beginning of 1996. Since then we have had a significant reduction in private health insurance as well as a significant increase. I do not know the figures at the beginning of 1996, but I guess it was about 36 per cent, maybe more. It has since plummeted to 30 per cent and now it is up to 46 per cent. That is the reality of the modern world: circumstances change and we need to react to those changes. What the honourable member said about the North Eastern Community Hospital is correct. The indication was that there was not enough demand in the north eastern suburbs for two private hospitals in 1999-2000. They did set up a private hospital in an existing facility out there and I have given parliament the details about the level of occupancy and it was extremely low indeed.

Ms STEVENS: One.

The Hon. DEAN BROWN: An average of one or two beds—not 1 per cent. That would have equated to about 6 per cent occupancy. You do not run private hospitals and make them pay on that basis. Equally, I do not want to see the North-East Community Hospital collapse because the government tries to proceed with something, or forces someone to proceed with something, that might result with two unviable hospitals and they both collapse.

Ms Rankine interjecting:

The ACTING CHAIRMAN: Order! I think the member for Gordon now has the call.

The Hon. DEAN BROWN: I am happy to adjourn and have a—

Ms Rankine interjecting:

Mr McEWEN: Perhaps you would like to frame this question at some stage in the afternoon.

Ms RANKINE: Well, when I get the opportunity I just might.

Mr McEWEN: That would be good. Minister, the budget for the Mount Gambier Hospital has a tradition of being overspent by about $1 million a year. I think its claim is that it has been under-funded by $1 million a year. Where are we with the debt and, as importantly, where are we with future balanced budgets?

The Hon. DEAN BROWN: I appreciate that question from the member for Gordon. We have put a lot of effort into the hospital at Mount Gambier and there has been a dramatic change, as you would appreciate, over the last year with salaried medical officers operating within the emergency department of the hospital. Through the department we have put in place a deficit management package of $3.6 million to deal with the debt issue. This has been agreed with the South-East Regional Health Service Board to eliminate that accumulated debt. In other words, the debt has been cash carried on the books of the Department for Human Services, as it has with other hospitals in the metropolitan area. So, the hospital has not suffered as a result of that debt.

An additional $560 000 has been given to the emergency department because of the huge increase in demand that has occurred there since there have been salaried medical officers in that hospital. There has been a 40 per cent increase in emergency department activity—and I emphasise that—in the space of a few months. That is a huge increase and I think would clearly indicate that the people in Mount Gambier who are unable to access adequate after-hours or weekend services have used the emergency department. This may even suggest that people who feel they cannot access, in a timely way, GP services have also gone to the emergency department. I guess this is a clear statement of the level of community confidence in the new arrangements that the government has made at the hospital. Otherwise, why would demand have increased by 40 per cent if there was no confidence from the public in the service provided at the hospital. So, we have put $560 000 extra funding into that to cover the situation because of this unique circumstance.

Also, as you would appreciate, there is a new—a third—surgeon. We have two existing general surgeons at Mount

Gambier. One of them—we are all getting older: they are both getting older—is approaching retirement within a few years' time but not at present. The third surgeon has gone there with the hope of then establishing an ongoing practice. That third surgeon is Dr Kirkby, who told me that there is more than enough work for two surgeons but there is not enough work to keep three surgeons going, although there is some local demand. Previously, there was a locum service being provided by the Queen Elizabeth Hospital to the Mount Gambier hospital on weekends; I think it was two weekends per month. We have withdrawn from that locum service arrangement because there is now a general surgeon down there. It was a very special locum service in terms of surgery. We are now able to provide that locally and so the money for that locum service, which was paid for by the Department for Human Services as a special payment, has now been made directly to the hospital to provide additional activity for Dr Kirkby.

The money must be spent specifically on surgery work, which means that now there will not be a locum service for two weekends a month: that will be provided by Dr Kirkby, as well as being able to provide for additional surgical work to be carried out. I think that is encouraging news because it means that there is no overall additional cost to our health care system. We have now secured a third surgeon at Mount Gambier. In fact, Dr Kirkby has written and thanked me for the arrangements that we put in place. That we have secured a third surgeon means that we have secured surgery services in the event that one of the specialists in the Mount Gambier area retires, but it also means that additional work can be carried out.

In fact, I attended the Kingston Hospital on Wednesday night of last week and it was indicated that the hospital is considering commencing surgery again and using Dr Kirkby to do some of that surgical work. This would be day surgery work. The total support package that has been put into the hospital to deal with all of these circumstances amounts to $4 260 000 this financial year. I trust that the honourable member and the community appreciates that.

Mr McEWEN: The other figure relates to public mental health. The deinstitutionalisation made rural communities rethink the provision of services to mental health and, in addition, there seems to be an increase in demand in the mental health area. How are we managing to cope with that extra demand on those two fronts?

The Hon. DEAN BROWN: We have introduced into the state a new strategy for mental health. That was released in June last year—exactly 12 months ago—and it was called 'A New Millennium a New Beginning—Mental Health in South Australia'. When there was closure of the major institutions going back to 1989, 1990 and 1991 there was an inadequate response, and certain promises were made by the then Labor government about funding where no provision had been provided at all in the forward estimates. As a result of that, I believe that there was an inadequate response to deinstitutionalisation.

In the country areas the problems were even greater because you had general practitioners who generally did not understand mental health problems. I say 'generally' because Mount Gambier in the South-East has a particular GP in Dr Pyne who, I think, is an outstanding GP in terms of dealing with mental health problems, and I want to acknowledge that. There was a lack of understanding and expertise by general practitioners. The MBS scheme made it equally—and, perhaps, financially—unrewarding for GPs to try to get into that area because generally mental health requires longer consultation and there was no recognition of that in the way in which the MBS was structured.

It has been recently changed to encourage that. In those days there was no counselling or planning MBS fee, which has been introduced in only the past 18 months, or something like that. There were very few trained mental health nurses in the country, so generally it is fair to say that country services were grossly inadequate and, in some cases, almost non-existent. I appreciate the work that Roxanne Ramsey has done with Dr Margaret Tobin, the Director of Mental Health. Both women have demonstrated, I think, tremendous leadership in trying to build up country services in mental health.

As a result of that, and with the extra money allocated in this current year (2000-01), the total was $5 million for the state and $2.3 million for the country. So, the country was disproportionately favoured in terms of the allocation of that money. Of that $2.3 million, we have allocated $116 600 specifically to the South-East region; $25 000 for consumers and carers; $19 900 for older people with mental health needs; $26 700 for services for children; $25 000 for an in-patient pilot scheme; and $20 000 for services for adults. Before the honourable member says, 'But that is not a seventh of $2.3 million', I point out that much of that money is being spent centrally to provide a statewide service, particularly in terms of telepsychiatry services and improved advice and support for GPs in country areas.

A further initiative is that Mount Gambier has been identified as a preferred pilot site for a country supported accommodation demonstration project. Funds have been identified and a project proposal is currently being developed with not only the community but also key groups within the community. I have already opened the first of these supported accommodation programs for people with mental health problems in the northern suburbs. I was thrilled with the sort of response I received from the people involved and the sort of support they are now able to get. In the past we may have provided a public house for them through, say, a boarding house or a Housing Trust home, but there was not the support.

Frankly, these people need support. With appropriate support, particularly in working through their crisis, invariably they are able to return gradually to a pretty normal life, if not a fully normal life and, with modern medication, that is being facilitated, which is some of the reason why the institutions were originally closed. The aim of the supported accommodation program is to—depending on the needs of the people involved—give people that level of support to help them go through that transition and to rehabilitate them back into normal accommodation, if they possibly can.

Some people may need some ongoing support. We conducted a project, about which we had community consultation, at Victor Harbor because a very high level of people in that area need that sort of supported accommodation. It has been a favoured area of these people in the past. Some of the existing accommodation has been bulldozed so it is important to tackle what was a demand there. We have the project in the northern suburbs under way and operating. The project at Victor Harbor has had very strong council support, and I have signed off on the money for that. It has been through the community consultation process and I think it is about to be presented for building approval.

There will be two services in the southern suburbs: one in the Marion area and one at Noarlunga. I think that we are

working on the Noarlunga project at present. There is also a service in the north for indigenous people. There will be one service for men and one service for women in the western suburbs, and we are looking at putting in a supported accommodation service at Whyalla. We are also now planning a service in Mount Gambier. We have tried to look at where the demand is and to target those areas.

Mr McEWEN: I think that the community would support Ms Ramsey, and particularly Dr Pyne. My third question relates to dental health. Our select committee heard evidence a fortnight ago about the impact of poor oral health on more generally the health of an individual and how some sort of investment in preventative measures in oral health can mean a lifetime saving in terms of the accumulated health debt, as it were, of an individual. How does that relate to the message you are sending in relation to children, in particular, and preventive oral health?

The Hon. DEAN BROWN: There is, indeed, some very good news here. A recent study compared the level of dental decay in 12 year old students in Australia with the level in other countries around the world. It was found that the number of teeth with decay in South Australia for a 12 year old was 0.6 per cent, and that figure is the lowest in 23 0ECD countries around the world. I think it is quite outstanding that we are able to say that, on a definitive study, we have the best oral health for 12 year olds probably in the developed countries—and, I suspect, therefore, probably even in the world, because I doubt whether any of the developing countries would be in the comparison. I highlight that our figure is 0.6 per cent in South Australia compared to 0.8 per cent for the whole of Australia. So, it would suggest that we are also ahead of the rest of Australia.

I think that two major factors have contributed to that situation over a number of years. The first is fluoridation of water, which was introduced in the late 1960s and early 1970s. The second is our school dental clinic system, whereby all students in primary school receive oral care on a free basis, and all students are tested on a regular basis. So, putting those two factors together, we have produced, clearly, a standard that we need to cherish and to ensure that we maintain.

Only 92 per cent of the state is, in fact, covered by fluoridated water. The member's electorate is the biggest single community that is not covered by fluoridated water. It is interesting to see a comparison of the level of decay in the Mount Gambier community compared to those areas of the state where there is fluoridation. The level of decay in 12 year old teeth is twice that of the Adelaide level, which shows that fluoridation is a significant factor. I think that, through our schools, in particular, and through our community health programs, we have to make sure that parents in Mount Gambier and other areas where there is non-fluoridated water regularly give their children a higher level of fluoride to reduce the level of decay.

That can be done in several ways. One way is by the use of fluoridised toothpaste. There is also a fluoride mouth wash (which I think dentists recommend once or twice a week), and we have to make sure that teenagers, in particular, but also younger children, have access to that sort of mouth wash. There may also be other treatments recommended by individual dentists, and I suggest that we ought to look at working on a program, through the school dental program and the schools, to make sure that there is better information for parents and children in the Mount Gambier area and that we get that message through, because I think that we could halve the level of decay in the Mount Gambier area through more effective treatment. It is a community choice as to whether water is fluoridated out of the Blue Lake, but I think there is an argument (that I would certainly support) that it should be fluoridated. In fact, about 12 months ago I followed up with the Minister for Water Resources the issue of fluoridation of water supplies and what could be done to further extend that across the state. I would be interested to know the reaction of the local community. Perhaps we can discuss that issue when the select committee visits Mount Gambier.

Ms STEVENS: My next question relates to aged care beds (Budget Paper 5, volume 2, page 6.24, Hospital Services). On 27 March 2001, the minister told the House of Assembly that 123 high care nursing home beds were not operating because of nursing home closures, that 62 new licences were issued but were not operating and that, of these, 17 had been issued only at the beginning of the year—in other words, there were 185 high care licences not operating which could be operating. The minister also said at that time that 165 people within the public hospital system were waiting to go into high care nursing home beds. My question is: what is the current number of ACAT assessed people currently in public hospital beds waiting for high care nursing home accommodation?

The Hon. DEAN BROWN: We are trying to obtain that information. If the member will finish her questions, I will come back and answer all of them.

Ms STEVENS: My next question is: what has been the daily or monthly average over the last 12 months (I am not sure how that data is kept, but I want to know what it has been across the year), and what is the daily bed cost of keeping those beds in the hospitals?

The Hon. DEAN BROWN: The figure varies, obviously, from day to day, but the current figure is about 150 beds. It has fluctuated from, I think it is fair to say, about 150 up to about 200 at the beginning of the year.

Ms STEVENS: Can the minister give me a daily average? I am not sure how the figures are kept.

The Hon. DEAN BROWN: We get figures on a daily basis.

Ms STEVENS: I do not need them now, but can the minister provide me with the daily average?

The Hon. DEAN BROWN: Yes, we will try to produce some sort of average. For instance, in the last three weeks or so, it has fluctuated from about 148 to about 160.

Ms STEVENS: The other part of the question was the cost to keep each one of those beds on a daily basis in hospitals.

The Hon. DEAN BROWN: We will try to give the member an overall figure. I do not think that we can go through and work out every individual case and the exact cost for every individual case—and they all have different levels of need. We will try to give the member an overall estimate of the average sort of cost.

Ms STEVENS: I am surprised that there would not be an average cost.

The Hon. DEAN BROWN: We will try to obtain some figures for the member—an average.

Ms STEVENS: My next question relates to Budget Paper 6, capital works, page 18. In 1999-2000, the budget announced $7.5 million for the Flinders Medical Centre Psychiatric Centre, a 50 bed mental health facility, with $1 million to be funded in that year. That was to cover acute beds for the south, rural and remote secure acute beds and adolescent beds. Last year, 2000-01, this project dropped

from the program. The minister told the estimates committee that it had been decided that two secure adolescent beds would go to the Women's and Children's Hospital, that rural beds would go to the country, and that Flinders would get 30 beds. The capital program for next year includes a $14.5 million program for new and redeveloped mental health facilities in selected metropolitan hospitals, with $4 million funded in 2001-02. Completion is due in 2003, which indicates that the balance of $10.5 million must be in the forward estimates for next year's budget.

I am not aware whether any of the three things that I mentioned that were referred to last year—that is, the two secure adolescents beds, the rural beds and the new beds at Flinders—have been started or completed, but perhaps the minister can confirm that. Given that the government plans to spend $14.5 million over the next two years, which hospitals will get what, when will the tenders be called and can the minister refer in particular to the rural beds and the adolescent beds at the Women's and Children's Hospital?

The Hon. DEAN BROWN: The budget papers show that $14.5 million will be spent over a three-year period, not a two-year period. It goes into the third financial year, and I refer to page 18 of the capital works program. The member is correct in saying, and I mentioned in my opening remarks, that we specifically have a line for capital works in mental health—$14.5 million—and three overall projects are to be included in that. There will be redevelopment of the Boylan Ward at the Women's and Children's Hospital and, for the first time, the hospital will provide secure facilities for adolescents, which have not been available in terms of overall facilities and were needed. The second project is to upgrade parts of Glenside and the third is to be allocated to mental health facilities at the Flinders Medical Centre.

I know that I made an announcement previously about the Flinders Medical Centre but I also announced that we were not proceeding with that until after the review, and the review, which I have referred to earlier, picked where we should then put the emphasis in capital works, and one of the things that Dr Tobin has done is work through where she believes the emphasis should be on new capital facilities in mental health. We wanted to make sure that we did not spend money for the sake that of it, that we spent money as part of that new strategy.

Ms STEVENS: How much will go to each of those projects? How much will be spent at the Women's and Children's and at Flinders? I want the details in terms of the $14.5 million. How much will be spent on the adolescent beds at the Women's and Children's and what are the details of that project?

The Hon. DEAN BROWN: I will give you those figures in a moment but first I will enlarge on what I said earlier. In the mid term, it is planned that country mental health beds will remain at the Glenside site. We have opened beds in country hospitals, but that is not for detained patients because certain requirements have to be met for detained patients. A trial in the Mid North at Crystal Brook Hospital has worked very well, and it is interesting to see the significant increase in the number of patients at the Crystal Brook Hospital as a result of a program that has involved the local GP, together with the hospital, in making sure that the hospital nursing staff, in particular, have greater skills. That trial has worked effectively and we are looking at picking up similar models where those skills are available in other country areas.

To answer the honourable member's question, the total redevelopment of Boylan Ward at the Women's and Children's Hospital will cost $2 million with $1 million coming from state funds and the other $1 million from funds at the Women's and Children's Hospital. I will have to get the exact figure for Glenside because ongoing work is being done at Glenside and I asked specifically that money be allocated to that hospital in the current year as well.

Ms STEVENS: I would like the details of that, too, please.

The Hon. DEAN BROWN: I will get the details of that. At the Repatriation General Hospital, ward 17 and ward 20 are being redeveloped, and I think that $3 million is being spent there. It is estimated that $10.5 million will be allocated to the Flinders Medical Centre.

Ms STEVENS: What number of beds will that involve?

The Hon. DEAN BROWN: About 40 to 50 beds. I will get the exact figures. I have made announcements on some of those and we do not have all the detail, particularly in terms of the Repatriation hospital. I will have to get the exact figures. Some of it is for the redevelopment of ward 17. I have announced that specific project, it has been through cabinet and I think it is under way. In terms of specific projects, cabinet has approved this basket of funds for these combined projects. Members must appreciate that some of the Repat work is not included in the $14.5 million. The $14.5 million was for specific new work and I think that I am right in saying that it did not include the Repat work. Probably the total basket is greater than $14.5 million.

Ms STEVENS: The $14.5 million is for the Women's and Children's, Flinders and Glenside?

The Hon. DEAN BROWN: I think that is correct. I will get the exact figures for you. The $14.5 million was the new package and that is on top of existing work.

Ms STEVENS: The mental health plan highlighted how the system is skewed towards institutionalised acute beds and stand-alone facilities. It highlighted how services are concentrated in the metropolitan area. What is the plan to undo that skew?

The Hon. DEAN BROWN: I think it is probably appropriate that I get a detailed answer for the honourable member from the Director of Mental Health. She is not here so I will get her to put that down because it warrants a detailed reply.

Regarding mental health reform, 12 strategic directions are detailed in the Action Plan for Mental Health, which I released in March this year. Implementation of those 12 strategic directions is under way, including: restructuring the Mental Health Services and the Mental Health Unit; senior staff appointments; the appointment of a country mental health network coordinator; and the establishment of the outer southern ACIS team. The honourable member may recall that I made a commitment to establish an additional ACIS team in the south at Noarlunga, and that was done in December last year.

As far as supported accommodation facilities are concerned, I have already mentioned those which have been established in the northern suburbs around Salisbury and Elizabeth, and I have mentioned others that are under way. The primary mental health care strategy has been progressed. The information development system—that is, installing patient information systems—is very important so that there can be ready access to patient records. This refers also to the information technology initiatives which I mentioned earlier.

The Commonwealth-State Agreement on Mental Health has been signed. There is participation and leadership in the national mental health initiative (suicide prevention) and the

national depression initiative. South Australia has a suicide prevention task force which has been reoriented to take account of the new directions for mental health. An amount of $2.9 million of extra commonwealth funding has been allocated for an integrated mental health information system. I think that amount is included in the overall figures for information technology. I am told that that $2.9 million is in addition to the OACIS funding from the federal government under the National Development Program. There is $2 million in recurrent funding for metro and country agreed new initiatives.

Other priorities include: to reduce the mental health emergency demand; to enhance supported accommodation options in the country and the metropolitan area; and to build capacity in non-government organisations in the mental health area. For the first time, we have allocated funds to both carers and patients (referred to as 'clients' in the mental health area). For the first time, there has been significant recognition of both carers and clients.

There is a planning framework for children and young people in the mental health area; a targeted improved emergency response; and services for high risk young people. We are working with Family and Youth Services (FAYS), Juvenile and Justice, and the Youth Crisis Centres. There is a focus on improving services for Aboriginal forensic clients at James Nash House. We are developing a master plan for the Glenside campus and implementing the recommendations of the Detention Review. Those are the key issues. I will ask Dr Tobin to look at this and see whether she wants to add anything further in writing by way of a supplementary answer.

Ms STEVENS: Is there any plan to cut the number of acute beds in the mental health system?

The Hon. DEAN BROWN: No. As I have already outlined, we are building extra capacity at the Women's and Children's Hospital and the Flinders Medical Centre.

Ms STEVENS: Regarding Mental Health Week and mental health promotion, in previous years small grants have been made available to community organisations and government service delivery agencies to run mental health promotion activities during Mental Health Week, which is held in October. Since 1996, this has been auspiced by SACOSS on behalf of mental health organisations and consumers.

The total budget for this purpose is small (approximately $20 000), but it goes a long way towards providing community activities for mental health promotion. Last year, over 2 000 people across the state participated in these projects. I have been told that, this year, these funds will be used to promote mental health awareness amongst Department of Human Services staff. Mental health organisations and consumers are concerned that a fund which previously has been used for community health promotion activities effectively will be absorbed into professional development expenses for DHS staff. My question is: what is the allocation to Mental Health Week activities for 2001-02, and how will that allocation be spent?

The Hon. DEAN BROWN: Before the honourable member jumps to a conclusion on that—

Ms STEVENS: I am just asking a question.

The Hon. DEAN BROWN: Dr Tobin is not here, as I indicated. She is developing the program around Mental Health Week. I will obtain a considered reply for the honourable member.

Ms STEVENS: I would be most concerned if their suspicions are true.

The Hon. DEAN BROWN: In answer to an earlier question, I said that one of the strategies is to make sure that there is early identification of mental health problems in other areas of my portfolio and other portfolios. One of the sad things has been that, often, people who might become involved in the justice system are really seeking mental health treatment but are being inappropriately treated by other means—in particular, under the justice system. Equally—

Ms Stevens interjecting:

The Hon. DEAN BROWN: I am referring not just to my department but across the system. There is also the issue of training for GPs and others. It is a very broad issue, and one which—

Ms Stevens interjecting:

The Hon. DEAN BROWN: No, but as part of our overall mental health strategy. Christine Charles, who has some idea of some of the initiatives that are being looked at, has spoken to me. We are able to make a commitment that the grants scheme will continue.

Ms STEVENS: For community groups?

The Hon. DEAN BROWN: For community groups. I highlight the fact that, as part of the country mental health initiative, we have already specifically given additional money to carer and client groups. One of our initiatives is to build up representative peak bodies so that these people have a clear voice statewide on behalf of mental health people. I might add that this funding does not include the additional funding that we now receive through the budget process and the Department of the Premier and Cabinet for the national initiative on suicide prevention, Beyond Blue, which was launched by the Premier about a week ago. Christine Charles informs me that we are proposing to continue to provide support to groups in the community. The way in which that is done may be refocussed, but it is proposed to maintain support for those groups in the community.

Ms STEVENS: My question related to the actual allocation for Mental Health Week activities. The minister has assured me that the money will be spent on the community activities which have been taking place anyway.

The Hon. DEAN BROWN: My understanding is that we are expecting to see a bigger range of activities and a bigger commitment from the department to those activities this year.

Ms STEVENS: And you will tell me what it is?

The Hon. DEAN BROWN: Yes, when it is finalised.

Mr SCALZI: Minister, you've already answered part of my question earlier in response to the member for Elizabeth with regard to IT, and I refer to the budget outline on page 6.29 of Portfolio Statements. Minister, in the health care system particularly, IT will be very useful, as you have outlined to the House previously, in providing coordinated service delivery, and the savings that that will entail. However, there are some concerns about the privacy implications of expanding IT to house very personal data. What is the Department of Human Services doing to ensure that our personal information is kept safe and private?

The Hon. DEAN BROWN: The privacy issue is a huge issue in terms of how information is used. If we are going to have a lot more information on health records of people then we need to make sure that those records are safe and secure and we need to make sure that they are accurate. There is one issue that I am still not satisfied has been dealt with nationally and that relates to a unique identifier number. I have raised the matter in parliament before. It needs a national thrust. I

know the federal government has looked at it. They have had seminars on it, they have had major discussions, and I would urge them to hurry up and finalise setting up a national medical identifier number, which is unique to health care and in relation to which every Australian will therefore know what their number is. We will be able to have one number that we quote whenever we seek medical treatment. If we do that, then it simplifies the whole collection of records and information about people and will deliver greater accuracy, and delivering accuracy means greater quality in health care.

But the issue that the honourable member raises is an absolutely fundamental issue: both the privacy and the ethics of what we are doing. There are two mechanisms that the department has picked up here. The first is that a department ethics and privacy committee has been established to deal with information privacy management and practice issues, at both the ethical and operational levels. The committee is comprised of Department of Human Services staff and individuals from outside of the department to ensure that the department priorities are considered and that external factors are given adequate attention. The independent members include three community representatives, a specialist in ethics, a lawyer and a representative of the South Australian Privacy Committee. So you can see that there is very strong representation from outside of the department, as there should be, and a very broad range of skills has been brought in.

We have also developed a code of fair information practice to outline what service providers and clients can expect regarding the protection of personal information. This protection must be balanced against the genuine controlled and legitimate use of information to provide an improved service delivery. The code will provide a framework to ensure that personal information, privacy issues, are handled in an appropriate manner across the department and its funded service providers. The information privacy principles set out in the code provide for guidance on all aspects of handling personal information for both the department's staff and the providers of health services. The privacy principles are based on the national privacy principles defined by the federal privacy commissioner.

In addition to that, I have raised the matter with the Attorney-General in terms of making sure that there is suitable legislation that should be introduced, and so that is a matter before the Attorney-General at present. Some states of Australia have recently amended their privacy laws to take account of what is going to be a change in the way we have health information available, and it is very important indeed that there are pretty stiff penalties for anyone who misuses information or tries to incorrectly access information on an individual.

Mr SCALZI: Minister, on the matter of dental health—and you mentioned this in your initial statement—the Private Dental Purchase Scheme is to receive additional funding, according to page 6.46 of Portfolio Statements. How successful is this scheme and what other initiatives are being planned to decrease dental waiting lists? Again, that is a major concern in my electorate.

The Hon. DEAN BROWN: This issue of public dental patients has been a very important issue and an area where there has been dramatic change. I appreciate that the honourable member is not on our select committee. There was very good evidence presented to the select committee, of which the member for Elizabeth, the member for Gordon are I members. Let me summarise some of those points.

Twelve months ago—to the day, because I did it on estimates day—I announced that we were introducing a new scheme whereby we would allow public patients to be treated by private practitioners in the dental area and that, as a result of that, we would be able to expand the services. I put $2 million into that. We charged a co-payment of 15 per cent. I think that is means tested as well, and, as a result of that, whilst having additional money within our South Australian Dental Service, we have had this substantial additional money.

We also put the co-payment money back into the system for additional treatment as well, so we had something approaching $3 million of additional treatment. That was one-off funding and it came out of a benefit we received on a new lease on Riverside Building. We gained a $5 million or $6 million benefit out of that, as a one-off payment on the new lease, and so we put that into public dental patients and also in terms of elective surgery. In addition to that, though, I have found that there is also $1 million available and I have put in an additional $1 million for this current year.

So something close to $4 million has been spent in additional dental services, as well as some additional money for SADS. We have tried to make sure that that goes across the whole range of where there is a need. There are the waiting lists. We have put in additional money for oral surgery. We have put in additional money for people waiting for dentures and we have put in additional money to provide orthodontic care as well for children. So we have looked at where the demand is and tried to respond to that total area.

In the coming budget there is an additional $2 million now allocated; so whereas up until now that was one-off funding, we have now got that in and that is in the program for two years. We have found that, in relation to the waiting list, depending what you take as the waiting list, but if I take the waiting list for public patients for standard dental treatment, it has dropped from just under 100 000, about 99 000, down to 81 000 in the first 10 months, and I understand that, because of additional money, by the time we get to the end of the financial year there will be a further significant reduction, quite a significant reduction, because a lot of that is that those extra people have been treated in May and June. So my guess is that we will be below, and I hope significantly below, 80 000 on the waiting list, by the end of June, and I see that waiting list continuing to decrease. It is very encouraging. The response from the public has been very good in terms of the initiative with private dentists. There are people who are able to afford 15 per cent and are willing to pay it as a co-payment. It has relieved that pressure.

We still provide emergency dental treatment within 24 hours through the SADS (South Australian Dental Service) clinic. We have also embarked on a significant capital works program in the dental area. Several weeks ago I opened a new four chair facility at Hindmarsh. A couple of months ago a new facility, which had not been available previously, was opened at the Mount Barker Hospital, and some other new clinics are being established. We have embarked on a significant capital works program as well to upgrade dental chairs around the place. That was needed as many were in tired and less than satisfactory facilities for treatment.

In some areas we have tried to bring the school dental clinic together with a public dental clinic in modern facilities, because in the past many of the school clinics have been provided through caravans, which are now really out of date and unsuitable, so we are trying to put them into a fixed location but with much better equipment. An amount of

$1 million has been allocated to the purchase of public dental services from private practitioners. In addition, I have allocated $1 million to provide care for 3 110 patients requiring general dental care through a referral to private dentists from SADS and 300 patients requiring dentures, 200 patients requiring oral surgery and 14 children requiring an orthodontic care course.

Another initiative we have taken is that for the first time those students who are completing their Bachelor of Dental Surgery are now, in their final year, able to practise on the public under supervision. That has allowed a greater number of people to receive treatment. We have a special scheme which we will introduce in a couple of weeks' time in the South-East and which has brought together those students, private dentists and other initiatives.

Mr SCALZI: Those dental initiatives are certainly welcome. I trust that the government will continue to support those initiatives. My next question refers to doctor participation in clinical trials. I refer to page 6.23 of the Portfolio Statements, which refers to hospital based treatment services. How can we ensure that patients' interests are given due recognition when doctors participate in clinical trials of new drugs and treatments?

The Hon. DEAN BROWN: Recently I gave a speech in Sydney on this topic. I was asked to speak from a state government perspective on clinical trials and the standards and ethics that surround those trials. The number of clinical trials in Australia has increased dramatically—I think it is a 10 fold increase in 10 years. There is an explosion of new drugs out there being tested. It is very important that we make sure that appropriate ethics and standards are put down so that you do not have the problems which occurred, say, in the pathology area prior to 1990 and which I talked about earlier.

Within the department we have human research ethics committees. We balance the membership, involving the researchers and the community. They need to be very transparent. An ethics committee is set up with each trial and standards in terms of what those people conducting the trials have to give to the patient in terms of their consent. It is very important that they provide adequate information about what the adverse events and risks from the clinical trial might be. It is important that they get appropriate consent from the patient and a clear understanding from the patient that they understand what risks they are facing, because they are effectively using untried drugs. We have to be very careful of the way we advertise for recruits and to avoid making unsubstantiated claims about the benefits of the treatment. The relationship between the investor and the research participants needs to be carefully considered, and safety and quality are very important in any clinical trial.

We have before the parliament the new Medical Practice Bill (which I do not think I am allowed to talk about), but I refer the honourable member to that bill as a number of these safeguards are protected under that bill, which I hope we will be debating next week. In particular, there are specific requirements that any interest of the medical practitioner involved must be fully disclosed. Equally, they cannot receive inducements for getting in patients. They can be reimbursed for costs but they cannot receive inducements, and information about patients cannot be sold at all or supplied to other people without the approval of the patient. If the honourable member would like, I am happy to make a copy of my speech available to him as he would find it very interesting indeed. It was a comprehensive speech and covered all the different facets and not just the Medical Practice Bill but also the Health Complaints Bill and a number of other pieces of legislation that we have in South Australia.

Ms RANKINE: I refer to output class 1, page 6.5, relating to promotion and protection of the health and well-being of our community generally. I am not sure whether or not this question fits into that category, but there is nothing I can find specifically that relates to it. Will the minister provide a guarantee that the free kindy health checks that have been provided to four year old children will continue and will he guarantee that the government will not again attempt secretly to cut out these very important health checks? Late last year an attempt was made to abolish these health checks. I have been advised by one of my local kindergartens that no health checks will be available for four year olds this term and no guarantee has been provided that they will be available for them next term either.

The Hon. DEAN BROWN: I am only too happy to provide an assurance that kindergarten health checks will continue. When I heard that there was a proposal to discontinue them, within a matter of hours I had spoken to the chair of Child and Youth Health and asked her to see me next morning, together with the CEO. They had given me no indication that they were intending to do that. They claimed that it was because of budget measures. However, they had a whole range of other new initiatives on which they were going to spend the money. They had made their own judgment on that without any consultation with me. It was not as though their budget had been cut—that was not the case. The so-called budget measures were to allow them to do other things with the money they would otherwise have saved. I disagreed with their judgment and as a result of that those kindergarten health checks have continued and, certainly while I am minister because of my personal belief in them, they will continue.

Ms RANKINE: I have a supplementary question. Minister, are you aware then that some kindies are not being provided with those health checks this term and they could not give a guarantee that they will have them next term, either?

The Hon. DEAN BROWN: I was not aware of that. If the honourable member would like to provide me with specific details as to which kindergartens she is referring to and all the information that she can provide me with, I will be only too happy to follow that up.

Ms RANKINE: That was Golden Grove kindergarten, but I will certainly obtain more information if you require it.

The Hon. DEAN BROWN: All right. Thank you.

Ms RANKINE: Minister, last year in the Capital Works Statement there was a significant investment for the IMVS and I can see nothing in the statement this year in relation to that. Has that project been completed and can you give an assurance that both the physical environment of the IMVS and the procedures undertaken comply with occupational health and safety standards?

The reason I ask this question is that I had a long-time employee of the IMVS come to see me some time ago, raising a number of concerns about her workplace situation. She told me that no material safety data sheets were ever provided to employees; no occupational health and safety information was ever provided to employees; no advice or training was ever provided in relation to the safe handling of chemicals; no electrical safety switches were in the building that they were currently occupying and she was nearly electrocuted at one stage; the decanting of ethanol took place with no fume hoods; for two years she was never told to use

gloves when handling dimethyl sulphoxide and, when she did, it melted the fingers of her gloves; and no autoclave was used, and there was a large amount of contaminated plasticware sterilised in an old unit, so there was a full range of concerns in relation to that. I would like to be assured that the occupational health and safety standards of the IMVS are improved along with the working facilities to ensure that those people who go in there—in some instances not from a trained background—are protected in their workplace.

The Hon. DEAN BROWN: I do not have last year's budget papers before us, but I think I understand what we are dealing with here. A major project is underway at the IMVS and, basically, these are the components of that project. One is to relocate Medvet; and that is being done with the new building down at Thebarton. The second is to relocate the IMVS and to build a new car park. That is being privately funded. However, it had to be brought in to the accounts because the accounting procedures require that—even though it is privately funded, it still had to be shown on our expenses. So, you may be picking up that provision.

A condition of this was that, when we went out to tender on this, we went through the Public Works Standing Committee. It was a privately funded and constructed facility, and privately operated car park, but, being on government land, there is a requirement for it to go to the Public Works Standing Committee. Equally, because most of the spaces in that car park are being leased by the Royal Adelaide Hospital, there is a long-term commitment under accounting standards. You have to account for that in terms of your expenditure even though in cash terms you would not put this into your cash budget.

That is the main thing. The other project that was undertaken in the past 12 months was the new spinal research centre. We put money in to upgrade the facilities and there was a very significant grant from an overseas company towards that of something like $750 000 for the ongoing research work, but the department put the money up for the new facilities for that spinal research centre.

I think that those facilities cost just over $250 000. I will check that and provide the honourable member with a clearer picture. In terms of the occupational health and safety issues, clearly, I cannot comment on the individual matters raised by the honourable member. If the honourable member would like to give me details of the section to which the matters relate in the IMVS, because it is a fairly large body, I will certainly have those allegations immediately investigated. Occupational health and safety committees should be established in every workplace. From what the honourable member has outlined, it would sound as if all of those requirements have not been met and, if that was the case, I would want that immediately investigated. If the honourable member can facilitate by giving us the information, I would like to carry through that investigation.

Mrs GERAGHTY: Minister, you would be aware that, for several years, Australian and international authorities, including the WHO, have been warning that the world will experience another influenza pandemic in the foreseeable future—in fact, I was reading about it in the newspaper this morning. As we know, that certainly can occur at any time and, obviously, it could be very soon, the way that things are going. A pandemic has the potential to cause massive social and economic disruption. Minister, can you say what your government is doing to prepare the state for such an eventuality and what resources will the government commit to deal with this threat of an influenza pandemic?

The Hon. DEAN BROWN: I will give the committee a broad overview and, perhaps, Professor Kearney might like to provide more detailed information. The committee may recall that I answered a question on this in parliament last year and I indicated that, yes, we were very conscious of the possibility of a pandemic episode of influenza. Of course, South Australia was a lead state in providing free vaccine for people over 65 years of age to be vaccinated. It is interesting to see that the federal government has picked up that policy nationally.

We have had a program of vaccination for staff working in our hospitals. Incidentally, with respect to the free program, we have had a very high level of acceptance. In the year 2000, 80.5 per cent of the population over 65 years of age availed themselves of that free service, which was 3.3 per cent higher than the previous year. Again, we have conducted that program this year, although I cannot give figures at this stage. The federal government provides the flu vaccine, and I would hope that we would be able to increase that further. We also conduct a program through Aboriginal Health Services and 758 doses of pneumococcal vaccine were distributed in 2001.

The commonwealth government funded influenza and pneumococcal vaccines to the Aboriginal and Torres Strait Islanders over 50 years of age and for those persons over 15 years of age who have a chronic respiratory problem. That is very wide—everyone over 15 years of age with a chronic problem and everyone over 50 years of age. I mentioned the vaccination program for the staff. This year 13 190 doses were distributed to our staff, which is an increase of 5 000 compared to 2 000 previously. Christine Charles is a member of the State Emergency Advisory Council (a standing committee), which is the body of senior officials that advises the Ministerial Council (of which I am a member) on all potential emergencies within the state. Ms Charles is a member of that body. She might like to comment and then I will ask Professor Kearney to talk about the possibility of a pandemic.

Mrs GERAGHTY: I will clarify one point. My understanding is that the current vaccines may not necessarily cover these new strains. I mention that because I took my mother-in-law to the doctor for her flu shot and his advice was that the vaccine given to my mother-in-law may not necessarily cover these new strains.

The Hon. DEAN BROWN: I will ask Christine Charles to cover the emergency aspect and Professor Kearney to cover the medical issues.

Ms CHARLES: It is fairly topical, because the Emergency Management Standing Committee has been undertaking a risk assessment under the state disaster legislation across a range of areas. In the health area we have carriage of a range of public health issues and the question of pandemics, particularly influenza, has been raised. A working group is currently looking at the preparedness and the issues around it. Of all the areas, we have identified this as one with very strong statutory powers and much of the information gathering and the response are already in place. It is a bit of a question about how you elevate that at the time of a pandemic.

Professor Kearney can certainly talk to the committee about our surveillance and epidemiological response to pandemics; but the question of vaccines is already in the disaster response community and, certainly, health agencies are discussing this, too.

Prof. KEARNEY: First, South Australia is a leader in monitoring the type of influenza in our community, again, mainly through the IMVS, which is able to type and subtype. For example, the existing influenza A vaccine, called A/Sydney Moscow, was typed in the IMVS laboratory, sent to the CSL laboratories and then became the basis of the current vaccine. It is important to have those sophisticated sentinel monitoring systems. The most likely emergence of a pandemic would come from the crossing of the other influenza strains from bird species to humans. A and B clearly have, and there are another nine types in birds.

They are mainly located in South-East Asia, around Hong Kong. You see a lot of publicity about not importing chickens and other birds for human consumption into Hong Kong from China because of the risk of that transmission. Australia is part of that WHO monitoring system in the Asia-Pacific area and also internationally. Clearly, it would take some time to produce a vaccine for a new strain of influenza. The pandemic plan to which Christine Charles refers relates to how the community would respond to such a pandemic until a vaccine was available. Clearly, it would require a huge effort on the part of our emergency services. It would require our hospital system, basically, to be turned over to managing the respiratory support of people infected with a new strain of influenza.

The Hon. DEAN BROWN: Of course, people do not realise that as recently as, I think, 1916 or 1917 (it is one of those questions for quiz nights) the last pandemic occurred in Europe. I think that I am right in saying that 22 million people were killed through influenza as recently as 1917 or 1918. In fact, it made the deaths through the First Word War, which was, I think, the war where more people have been killed than any previous war, pale into insignificance in terms of numbers. Professor Kearney said to me that that is when influenza type B first occurred. It just highlights that it is a very real issue and, when it occurs, it will have a devastating effect in terms of our health care, because we will have to put all the focus on that. We are very conscious of it and hope that it does not occur.

Membership:

Mr Meier substituted for Mr Scalzi.

The Hon. DEAN BROWN: I refer to the issue of kindergarten screening that was raised earlier. I am told that child and youth health has employed an extra six level one nurses to enhance the program. If Golden Grove was not done last term, I am told that it will be done next term, but we will further make sure and issue an instruction to that effect. Once again, I reassure the committee that the program is assured into the future.

Mrs GERAGHTY: In relation to the pandemic influenza and resources, can the minister explain what resources have been allocated to deal with this matter, should a pandemic occur?

The Hon. DEAN BROWN: I will ask Professor Kearney to answer that question.

Prof. KEARNEY: The Communicable Diseases Branch of the department is a very sizeable branch and has a significant capacity to deal with epidemics of all kinds. As I indicated, the plan suggests that not only would the health system have to be swung into action in the event of a pandemic but also the human services system and the state emergency system, depending on the nature of the pandemic and the burden of illness in the community. There is a plan, and there is a scale that can be escalated, according to the circumstances.

Mrs GERAGHTY: I know that all these other services will be provided should something happen, but there would need to be some funding put aside, or allocated, in the case of a pandemic occurring.

The Hon. DEAN BROWN: I will ask Christine Charles to answer that question.

Ms CHARLES: If we reach the stage where we have a declared state disaster (which a pandemic is likely to be), the funding arrangements are then under the control of the cabinet committee and are dealt with at the Premier's and the Treasurer's level, supported by those ministers. Agencies are funded for normal state disaster planning, and we all have a contingency capacity within the agency. But once we move into a disaster situation, the funding decisions are taken at that time, and we would expect that we would need significant supplementation.

The other comment I would make about the state disaster response is that, largely, the response needs to proceed as quickly as it should, and then a lot of the decisions about how we deal with the resource allocation happen as it flows through.

Mrs GERAGHTY: I understand that the pool at the Hampstead Centre had the heater turned off, and it was only after a number of complaints were made that the heating was turned back on. My questions are: was it turned off to save on electricity charges; and, given that the pool is particularly useful and well used by those with disabilities and other needs, can we be assured that that sort of thing will not happen again?

The Hon. DEAN BROWN: I think what the honourable member is talking about is a breakdown of the equipment. There was a breakdown of equipment at Hampstead recently, I sought information at the time and I was told that there had been a breakdown of equipment and that it had been repaired. I will investigate the claim that the equipment had been turned off to save costs, but I do not think that it is correct at all. It was an actual equipment failure.

Ms STEVENS: I would like to ask the minister some questions about public hospital debt. Over recent years the minister has made a number of conflicting statements about hospital debt and the repayment of that debt. In 1999, the minister told this committee that the North-West Adelaide Health Service had an accumulated debt of $13.25 million at 30 June 1998, which it had elected to pay off over 10 years, and he said that other hospitals had asked for debts to be carried over to the next year. In 2000, the minister told the committee that he was 'working through it with individual hospitals'. The minister said, 'The hospitals have created a debt and are responsible for that debt.' The minister also said, 'I point out that, if we suddenly forgave all the debts, they would create a debt every year.'

The minister then changed tack and put in a green book bid for $35 million in this year's budget. He was unsuccessful. On 5 June, the minister said, 'A $35 million cut is not about to be imposed on the hospitals. The Department of Human Services has picked up that debt and we have covered it in cash terms for the last four years.' If these debts will not mean cuts to hospital services, can the minister confirm that by any reasonable interpretation this statement means that hospital debts have been forgiven?

The Hon. DEAN BROWN: First, there is some misunderstanding by the honourable member. When the expense has been incurred additional work has been carried out and,

as a result, services have been delivered in incurring that debt. It is not a matter of cutting services. Extra services were provided and that is how the debt was created. In fact, I can assure the honourable member, as I have said in parliament before, that we have now brought that debt onto the books of the Department of Human Services and it is provided for by the department. The hospitals have been provided with the cash to cover that debt. It has been covered by the department.

Ms STEVENS: I have a supplementary question. Where do these debts appear in the Human Services budget? Are the hospitals listed as debtors and how has this expenditure been funded in cash terms?

The Hon. DEAN BROWN: It is covered in the balance sheet of the Department of Human Services.

Ms STEVENS: Which page, please?

The Hon. DEAN BROWN: I refer to page 6.33. It is listed under receivables for current assets and receivables for non-current assets.

Ms STEVENS: Given the minister's statement that hospitals have overrun budgets again this year by $10 million or $12 million, and I understand that the North-West Adelaide Health Service is looking at about $5 million and Flinders Medical Centre at about $3 million, can the minister now advise the current total for each metropolitan hospital?

The Hon. DEAN BROWN: No, I cannot, because we have not yet reached the end of the financial year. We finalise statements by about the middle of August, so we will be able to indicate then. We have estimates and I think it is fair to say that, generally, our estimates have been close to the ballpark figure. We will come out with a figure in the middle of August when the accounts have been finalised.

Ms STEVENS: Your estimate is about $10 million to $12 million.

The Hon. DEAN BROWN: Frank Turner advises that he thinks it might be as high as $15 million.

Ms STEVENS: Given the minister's statement that his department was negotiating with Treasury, can the minister tell the committee Treasury's position on this matter and can he rule out the possibility of hospitals being asked to take out loans through SAFA or privately?

The Hon. DEAN BROWN: I have already indicated that, when it comes to the funding of public services, the hospitals have to be funded through the department and they do not have access to private loans. We would not give approval for that. I stress that that is in terms of public services. As far as Treasury is concerned, it has agreed with the treatment that we have provided in terms of how we deal with it in our annual accounts.

Ms STEVENS: I move on to capital works projects for hospitals. Because of a discrepancy in evidence given to the Public Works Committee and funding provided in capital budgets, we require details of the forward funding estimates for major works now being undertaken at three metropolitan hospitals—Queen Elizabeth, Lyell McEwin and Royal Adelaide. When evidence was given to the Public Works Committee, particularly in relation to the Queen Elizabeth and Lyell McEwen hospitals, the following amounts were provided as part of evidence to the committee. For the Queen Elizabeth in 2000-01, it was $1.835 million and it was $2.811 million in 2001-02. In the capital works program, $1.295 million was set down for 2000-01 and $5.837 million for 2001-02.

There were similar discrepancies in the evidence given to the Public Works Committee in relation to the Lyell McEwen, with $7.39 million in 2000-01 and $8.88 million for 2001-02, whereas in the capital works program there is $3 million for 2000-01 and $12.685 million for 2001-02. The question I am asking now has been on the *Notice Paper* since 20 March 2001, and I would appreciate an answer: can the minister supply the amounts by financial year that have been factored into the forward estimates for the completion of these projects?

The Hon. DEAN BROWN: It is no wonder that the question has not yet been answered if it was asked in March because the budget had not been brought down in March.

Ms STEVENS: It must have been in the forward estimates. They gave us the information in the Public Works Committee last year.

The Hon. DEAN BROWN: At that stage, cabinet was going through formally what the forward estimates would be for each of the next three years. If the member asked it in March, she could not have had a three-year estimate and no doubt the question has been put aside as waiting for the budget to be introduced.

I will get those specific figures. The honourable member has given us a lot of figures in terms of the Public Works Standing Committee (and we do not have those reports before us here) and what the claims were in terms of expenditure, and we do not have the previous budget papers here, so we will go through and look at those figures.

One issue regarding the Queen Elizabeth Hospital is that some of the expenditure that has been incurred was not part of the $37.5 million. The demolition work was funded elsewhere through the capital works program and was in addition to the $37.5 million. So, the honourable member needs to be careful when trying to compare the actual expenditure with what might have been spent out of the $37.5 million in any one year. I do not have the Public Works Standing Committee report before me, but it may have been given figures in terms of the $37.5 million and it may not have factored into that extra expenditure from elsewhere in the program. I will obtain that information.

The other point is that, in terms of big projects such as this, over time variations occur. We are dealing with very large amounts of money. If we put together the three hospital projects, we are dealing with almost $200 million. So, over time, small changes can have a significant impact on the actual expenditure that might occur. I also point out that the Public Works Committee hearing was in February 2000 (18 months ago), so we are 18 months further on. We have gone through a number of different steps since then. There may have been delay in some areas, but that does not, in any way, detract from the absolute commitment of the government to finish these projects as quickly as possible.

We have been going through the design process and the documentation. We have appointed a contract manager for the Lyell McEwen and the Royal Adelaide Hospital. We are in the final stages of documentation for the Queen Elizabeth Hospital. We expect to go out to tender in August and, obviously, to let the tender as quickly as possible after that. I hope that the honourable member is not suggesting that this is simply a matter of announcing a project, allocating some money, and then the building suddenly jumps up.

You have to go through a significant amount of design work and documentation. There is the design of all the services, such as airconditioning, electrical and plumbing work, etc., and then you have to do the quantity survey and then the final documentation before going out to tender. Overall, the scope and the budgets for these three major

projects remain unchanged from what was presented to the Public Works Committee. There has been no change in the nature of the projects at all.

Ms STEVENS: I am not talking about the nature of the projects: I am talking about the expenditure.

The Hon. DEAN BROWN: There has been no change in the nature or the scope of the project or the anticipated expenditure, recognising that the project still has not gone to tender, so one cannot be absolute.

Ms STEVENS: I refer to page 19 of the Capital Works Program. The completion date for the Queen Elizabeth Hospital redevelopment is April 2003. This means that the lion's share of the capital for this project, which the government will provide, must be funded in 2002-03. Is the minister satisfied that the development timetable is realistic and that the deadline will be met?

The Hon. DEAN BROWN: I think I am correct in saying that the honourable member is a member of the Public Works Standing Committee.

Ms STEVENS: You are correct.

The Hon. DEAN BROWN: Therefore, she would be fully aware of the fact that the Public Works Standing Committee asked the Department of Human Services to try to accelerate the program from what was proposed originally.

Ms Stevens interjecting:

The Hon. DEAN BROWN: I am not sure whether a response was needed, but we have responded with the fact that we are trying to do it. The April 2003 figure is in response to what the Public Works Standing Committee asked for, that is, to try to accelerate the program. This is now the best effort. If the program is successfully accelerated, the best endeavour in terms of a completion date is April 2003.

Ms STEVENS: The minister will receive a letter requesting a few more specifics on how you intend to accelerate the project. That is what the committee is after. I understand that reviews are currently occurring in a number of our teaching hospitals (including the Women's and Children's Hospital) in relation to laboratory services. Will the minister provide some information on the nature of that review?

The Hon. DEAN BROWN: Mr Jim Davidson is the Executive Director responsible for that review. I will ask him to outline the nature of the review.

Mr DAVIDSON: We are planning a broader review of pathology services across the state. As part of that review, some work is being done within the Women's and Children's Hospital by a consultant hired by the hospital itself to look at the laboratory services within that hospital. I do not have access to the report at present, but it will feed into the broader review of pathology services.

Ms STEVENS: Is it the intention of the minister and the department that tests normally performed by laboratories in these hospitals will be taken over by the IMVS?

The Hon. DEAN BROWN: No specific recommendation has been made to me as yet. When those reviews are completed, I will consider any recommendations.

Ms STEVENS: A number of reviews will take place. We have just talked about the one at the Women's and Children's Hospital. Which other hospitals will be reviewed?

The Hon. DEAN BROWN: Mr Davidson just indicated that there is to be a review of all pathology services.

Ms STEVENS: He specifically referred to the one at the Women's and Children's Hospital.

The Hon. DEAN BROWN: Yes. He said that the review at the Women's and Children's Hospital was part of the broader review.

Ms STEVENS: Who will conduct these reviews?

Mr DAVIDSON: It has not yet been decided who will do the broader review. The Women's and Children's review was set up by the Women's and Children's Hospital itself. We have drafted some terms of reference for the others, but they have yet to be seen by the minister or approved by the department. The chief executives of the hospitals have been advised that it is the intention of the department to review pathology services in the state.

One of the factors affecting the timing of that is that the commonwealth has also recently undertaken a review of pathology services nationally. It is not expected that the report of that review will be available for another two months. So, there is the question of the timing of the review: what is an appropriate time to look at some of the issues?

Ms Stevens interjecting:

Mr DAVIDSON: I think we will probably do some work around ascertaining what services are provided, by whom, how they are funded—a lot of background information—but I do not think we will move to bring forward a set of recommendations or explore options until the commonwealth review is in our hands.

Ms STEVENS: The Child Health Research Institute has been receiving funding from the Department of Human Services to help meet its infrastructure needs since its foundation in 1989. For the past three years, funding was at the level of $200 000 per annum. The institute applied for funding to continue beyond the current triennium, which finishes this June, and asked for an increase to $250 000 per annum. The department has declined to provide continued funding. There are many reasons why the institute seeks reconsideration of this decision, including its success in a range of areas. The point is made that, when compared with Adelaide's only other medical research institute (the Hanson Centre), the Child Health Research Institute is seriously disadvantaged.

When compared with other independent medical research institutes in Australia, it is also seriously disadvantaged. All other independent medical research institutes receive infrastructure funding from state governments and most from their host institutions as well. I am asking the minister to comment on that information and tell us why they are not going to be funded in this way in the future.

The Hon. DEAN BROWN: The infrastructure grants for the research programs come through, at least in the majority of the cases, through the individual hospitals, and in fact potentially it exists in this case as well for CHRI, and I want to acknowledge the excellent work that it has done and continues to do. It could be funded through the hospital. They have recently raised that issue with me as minister and so at this stage all I would say is that I am asking the department to further brief me on this matter; and I do not wish to go any further than that.

Mrs PENFOLD: Minister, page 6.3 of the Portfolio Statements mentions the promotion of Aboriginal health and wellbeing as a priority area: can the minister advise the committee on initiatives being undertaken, as the health status of Aboriginal people is an ongoing concern for all of us?

The Hon. DEAN BROWN: First, I think Aboriginal health is one of the most challenging areas of all. It is an enormous challenge for our society to produce a fundamental change in the health of our indigenous population, especially because the health outcomes are so low at present. I have been encouraged by some of the responses that have been

achieved, because I think in one or two areas we have been able to make a very fundamental difference indeed.

Aboriginal communities have higher levels of prenatal, infant and childhood mortality and morbidity related to poor nutrition and heavy tobacco use. Therefore there is an urgent need to increase the basic health awareness amongst young mothers, and potential mothers, and the children. There is a Healthy Ways project, which has been established, which is to encourage Aboriginal girls and women of child bearing age and their families to adopt healthier lifestyles. It is a major project, and being significantly funded. It will bring together both the department and other state, commonwealth and community agencies to develop a targeted health and wellbeing nutrition project based on community development principles.

Incidentally, you may recall that I recently mentioned to the parliament that I had launched an initiative with the Wholesale Market about more fruit and vegetables for school children. I understand that the Wholesale Market is also interested in being a part of this for Aboriginal communities, and I have someone following that up with the Wholesale Market. It is expected that the Healthy Ways project will operate in the AP lands, at Coober Pedy, Yalata, Port Augusta and/or Whyalla. Ongoing and self-sustaining strategies are to be developed over two years. The aims of the Healthy Ways project are as follows:

- To reduce and/or eliminate smoking during pregnancy amongst women of children bearing age and their partners. That is a major initiative that we are targeting, and some of the money for that is coming from the Anti Tobacco Taskforce.
- To increase their knowledge of risk factors associated with pregnancy. And of course that involves a number of things, such as inappropriate diet, excessive alcohol consumption, smoking and use of any drugs.
- To increase the consumption of nutritious food by both children and women. That is especially important in terms of fresh fruit and vegetables because that has a direct impact in terms of the kidney size and therefore the likely susceptibility to diabetes later in life.
- To support ongoing community programs to increase the knowledge and skills of community workers, teachers and leaders.
- To improve the quality and range of foods on sale at the community stores. When I went to the renal disease conference that was held for indigenous people up in the north of the state, someone told me the story about a health worker who had just advised a young Aboriginal mother that she needed to eat plenty of fresh fruit and vegetables. She lived in an Outback town and the health worker said, 'Tomorrow morning we'll go to the supermarket and I'll show you the sort of fruit and vegetables you should be buying.' They went down to the local supermarket and found that three heavily bruised apples were the only fresh fruit available. So there is a classic example of the lack of availability of suitable and consumable fresh fruit and vegetables. That is one thing that I have been working through with the Wholesale Market, and I think we need to do more work on determining how to get suitable fruit and vegetable into those areas.
- To increase the knowledge and skills of community workers, teachers and leaders.
- To improve the quality and range of food for sale in the community stores and to reduce the availability of tobacco in the community, and certainly to reduce the use of tobacco in confined spaces such as cars and homes.

I was at Pika Wiya yesterday; that is, the new Pika Wiya Health Service at Port Augusta, which has been operating now for more than a year. I was absolutely thrilled with the quality of the facilities and the quality of the service being provided. They have, I think they said, 63 staff, not all full-time, but 63 staff working at Pika Wiya now. One of the projects they are working on is improved nutrition for both children and women of child bearing age. I was impressed because this facility was opened about 13 or 14 months ago, and the range of services has continued to grow at the service. They had just finished the new dental clinic in the facility. I think there were three doctor consulting rooms there, and I met two of the doctors. I met a lot of the other community workers. I was taken around by the diabetes nurse, working in a field that is very important in the indigenous community, and I met a number of others as well.

It is a very comprehensive program, and I would urge all members here to have a look at this. I know the select committee is going to Port Augusta, and I would urge it to go and have a look at this facility during that visit. I know, Mr Chairman, it is in your area and you should be very proud of what I think is one of the best facilities like that that I have seen anywhere in Australia, if not the best. It is something that the community at Port Augusta ought to be very proud of.

One interesting thing is that, for instance with neo-natal mortality, the general level of neo-natal mortality has been very high indeed on a per capita basis, and is still high in the outlying areas, but it is interesting to see the huge drop that has occurred, where the level of neo-natal mortality is now about the same as for the non indigenous community in urban areas. That is a huge improvement, and it shows that, where appropriate advice and support can be given, you can make a huge difference in the quality of care and what actually results, and that is what we should be striving towards.

Additional Departmental Advisers:

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

Mr K. Teo, Acting Director, Metropolitan.

Ms STEVENS: I refer to the new social welfare services planning framework for South Australia. I have been given a copy of a letter sent out to a number of people inviting them to be part of the advisory committee to provide advice on the development of a social welfare service planning framework for South Australia. I am surprised that after 7½ years in government you are doing this task at this time. I note that the purpose of the framework is that it will provide a vision for welfare services and identify key directions for the Department of Human Services in supporting the needs of children, young people and their families, provide the framework for the development of specific business plans and strategies for family and youth services and form a basis for linked strategies and planning involving the other areas of the Department of Human Services. That certainly reads like the foundation for a new government, which will be very pleasing for us, I am sure, but what does it say about what has happened in relation to this area of the Department of Human Services for the past 7½ years that we are about to embark on doing this very basic document and planning 7½ years into your term?

The Hon. DEAN BROWN: What I love about the honourable member with some of her questions is that she comes from such a prejudice to start with. The inference is that the government has not reorganised, changed or re-evaluated any of the programs in the family and youth services area at all over the past 7½ years. David Wotton, who was minister for four years, was quite outstanding in the way he reorientated, gave new direction and made sure programs were effective. He was highly commended by the welfare agencies and others he worked with. What he did for foster children and, in particular, for former foster children in establishing Future Echoes is recognised around the whole of Australia. I pay tribute to the work he did.

On a regular and ongoing basis we are going through a reassessment of how we are delivering the services, of what are the changing needs and making sure we provide more effective integrated services and, specifically, as I said in my opening remarks, making sure we know what are the needs of the community and delivering services to meet those needs on the basis of priority. That is what this is about. It is looking at the broad framework for social welfare services. I would have thought that the honourable member would want to commend the department on being ever vigilant and making sure we are checking that we are providing the right sort of service.

This framework will focus on what service and the types of service being provided and how they are funded across the portfolio. It links with the work being undertaken by the Children's Interest Bureau and various other advisory committees and gives information in terms of children's services. I have in the past 12 months made significant changes to a range of committees. Last year I coordinated those committees, that is, the Children's Interest Bureau, the Child Health Advisory Council and the Child Protection Advisory Council. They were all separate bodies and I brought them all together and put a peak group over them so that they are coordinated in what they are doing. Two of the three are statutory bodies, required to be set up under statute. Therefore, for the first time we have a clear knowledge of what each group is doing so we do not have duplication. We have leadership of the lot and a representative of each of the three bodies—I think the chair—sits on the peak body with the three committees sitting below that, two of which are statutory committees. It is an important flow on from that.

The scope of the current review looks at anti-poverty programs, at services for children under the guardianship of the minister, at those adolescents at risk, at the justice system and at the child protection system. It looks at alternative care, and that is an area in which we have done significant work. It looks at the adoption service and at other funded services. I think I am right in saying that about 450 organisations receive significant funding from the state government through the Department of Human Services. That is about $150 million a year we hand out to various organisations. Almost all of them, if not all, would be non-profit welfare-based organisations within the community.

The framework will also include a particular focus on services for Aboriginal people. The framework will be developed looking at existing legislation, which includes the Family and Community Services Act 1972, the Child Protection Act 1993, the Young Offenders Act 1993 and the Adoption Act 1988. The letter the honourable member referred to was sent out last week, so it is a recent letter.

Ms STEVENS: I now focus on alternative care, which the minister briefly mentioned in his previous answer. I asked extensive questions last year and the year before in relation to this area and I still have a number of concerns. The result of funding arrangements for alternative care services introduced by the Liberal Government in 1997 has been to increasingly shift costs for that program to the non-government sector.

For example, the government has awarded an overall 3 per cent increase in funding since 1997 even though legislated salary increases alone amounted to 9.6 per cent for the same period; a once-off rescue package for the current financial year, whilst approved, has not been paid; and the restricted use of brokerage funds has left $1 million unallocated and it cannot be accessed by agencies, even though you said in estimates last year:

> The introduction of brokerage funds would provide flexibility to develop individual care packages because we feel that a number of children are better treated in other ways.

As well as those points, I understand that for the past 18 months the Department for Human Services has been investigating new care options for adolescents but has failed to complete the exercise. I have a number of questions to put to the Minister in relation to the points I have just raised. What does the Minister propose to do to ensure that the non-government agencies contracted to provide alternative care services can, over the next 12 months, receive sufficient funding to maintain service levels—in other words, what funding increases will be provided to family preservation and alternative care services in 2001-02 to avoid service cutbacks?

The Hon. DEAN BROWN: The honourable member has asked a series of questions—

Ms STEVENS: One question.

The Hon. DEAN BROWN: No, you have asked a series of questions and we will have to go through and get information on them. First, Anglicare had a contract with the government and—

Ms STEVENS: And others.

The Hon. DEAN BROWN: Yes, but the principal provider is Anglicare. There was $600 000 provided each year for brokerage funds and it is very important that those brokerage funds be used for what they are specifically allocated for. A review of the alternative care system has been commenced. We have extended the contract to June 2002. We are looking at what alternative care systems should be provided and we are concerned that alternative care has not been provided under the contract so far.

I might add, since you raised the point about additional funds, that we are putting $2.2 million more into foster carers. I have indexed foster care payments because they had not been indexed back to 1993, I think, or 1992. I have now fully indexed them for that entire period, from when they were last indexed right through to now, and again for this year. So, to claim that we are not putting more money into foster care is not correct at all. In fact, we have put in a significant additional amount of money.

In extending the contract for one year, I provided an additional $158 000 as one-off funding as part of that and there was a further 6.25 per cent, or $250 000, per annum allocated to the budget for developing options for adolescent placements. As I said, I will go through some of the figures that the honourable member gave and some of the questions asked and we will try to give a more complete answer, but I think that highlights the fact that there was a one-year extension and there was extra money in that one-year extension and, in addition to that, we have put $2.2 million

into foster care. We have fully indexed it. I gave that commitment 12 months ago to continue to index it and we have done it.

I would like to see that indexation now written in as permanent and not questioned in any annual budget. It should be there each year so that foster parents get that extra payment. Of course, the other very significant aspect, which was mentioned by the state health ministers nationally and also the state community services ministers, is that we argued very strongly for the federal government to give a Health Care card to all foster children, and I am delighted to say that that has now occurred. Therefore, regardless of the financial status of the foster family, the foster child will be able to afford full health care as required under that federal government Health Care card. That was included in the recent federal budget, and that is a very significant benefit for those foster families.

Ms STEVENS: As a supplementary, I want to return to what I have asked the minister because I am not clear about what he is saying. I mentioned that a once-off rescue package for the current financial year has been approved and has not been paid. Is that correct and, if so, how much is it and when will it be paid?

The Hon. DEAN BROWN: We have made an offer to roll over the budget for one year. Agreement has not yet been reached. We are still in negotiation on that matter and, therefore, to claim that that money has not been paid over is incorrect: the contract has not been signed.

Ms STEVENS: My understanding is that it is a rescue package for the current financial year, not next year.

The Hon. DEAN BROWN: Yes, for the current financial year.

Ms STEVENS: I am sorry but I do not understand. Would the minister say it again?

The Hon. DEAN BROWN: We have made an offer of $158 000, plus its current money, and it is still in discussion with us.

Ms STEVENS: So, when that discussion is complete the money will be paid, is that the process?

The Hon. DEAN BROWN: Yes. Was the honourable member suggesting that we had offered something and were not going to pay it?

Ms STEVENS: I simply wanted to know from the minister whether in fact you had done it, how much it was and when you were going to pay it.

The Hon. DEAN BROWN: As I said about three questions ago, we made an offer of $158 000.

Ms STEVENS: No, one question ago, after lots of fluffing around.

The Hon. DEAN BROWN: No; I did mention it in my first answer.

Ms STEVENS: With respect to the brokerage funds, can the minister confirm whether $1 million of brokerage funds is unallocated?

The Hon. DEAN BROWN: I will need to provide a more detailed response in terms of how much money is there. It is not a simple answer, I am told.

Ms STEVENS: I just want a yes or no answer.

The Hon. DEAN BROWN: No, it is not a simple yes or no answer. We will provide that information for the honourable member.

Ms STEVENS: What was the funding this year for the total alternative care services program—and perhaps we had better divide it into metropolitan and country—and what is the funding for next year?

The Hon. DEAN BROWN: Clearly, we will have to get that information.

Ms STEVENS: The minister does not have that information either?

The Hon. DEAN BROWN: The honourable member has asked about a specific program and she has divided that program into country and city. A range of different organisations are involved. No, I do not have the information sitting in front of me, but we will provide that information. We will have to get that because a range of different organisations are involved and the honourable member has acknowledged that.

Ms STEVENS: I want to talk about the brokerage funds in more general terms. I understand that $1 million has been left unallocated because it cannot be accessed by agencies which, to me, is appalling when one considers the sorts of programs that are needed for these children. However, how will agencies be enabled to use brokerage funds in a more flexible way to plug the gaps in out-of-home care for children and adolescents, including the trialing of a therapeutic foster care program that has been developed by FAYS, non-government service providers and Flinders University?

The Hon. DEAN BROWN: First, the funding that sits there, which is so-called unspent, does not sit with us: it sits with Anglicare. It is money that has come through from the SAP program. Very specific guidelines apply to the SAP program, and the service provider in this case has been wanting to spend that money in areas that do not meet the SAP guidelines. I cannot authorise that and the department cannot authorise that. Discussions are ongoing about what is the appropriate expenditure for this money. If it comes out of the SAP program it must meet SAP guidelines.

Ms STEVENS: Minister, what did you mean last year when you said that the 'introduction of brokerage funds would provide flexibility to develop individual care packages because we feel that a number of children are better treated in other ways.'

The Hon. DEAN BROWN: Exactly that.

Ms STEVENS: How?

The Hon. DEAN BROWN: We believe that a range of alternative care ought to be adopted. It is inappropriate to be spending money that has been allocated for those alternative areas of care on the traditional area of care when, in fact, the alternative area of care is being provided through SAP funds and will not allow it to be spent in the traditional area. We will work through that issue with Anglicare. It is inappropriate to be discussing it here when we have not finished working through it with the appropriate agency.

Ms STEVENS: With respect, minister, you mentioned this last year. It is a year later and you still have not worked it through.

The Hon. DEAN BROWN: The money does not sit with us: the money sits with Anglicare. I have had confirmed that the money sits in the Anglicare budget.

Ms STEVENS: It is Anglicare's fault, is it?

The Hon. DEAN BROWN: I have not apportioned blame to anyone. The honourable member just asked where the money was sitting and I said that it was sitting in the Anglicare budget.

Ms STEVENS: Now I am realising why we do not get any action, because we go year by year and nothing changes and that is what has happened here. The minister talked about this very same issue a year ago and we are still in the same position.

Mrs PENFOLD: The South Australian government's commitment to social welfare reform to create a system

responsive to the needs of the 21st century is mentioned on pages 6.2 and 6.3 of the Portfolio Statements. I understand that the commonwealth has a similar commitment to reform. What are the reform agendas for both governments in relation to human services?

The Hon. DEAN BROWN: The commonwealth government released its welfare reform package, which it calls Australians Working Together, in May this year, and $1.7 billion over the next four years has been allocated to bring about that reform. The commonwealth expects this to be off-set by savings of $923.6 million over the same period. So, there is additional money in that respect.

The key features of the commonwealth welfare reform program include: expanding the work for the dole scheme to include people aged up to 49 years; people receiving parenting payments and whose youngest child is 13 to 15 years of age will be required to participate in some part-time activity; an annual interview for parents whose youngest child is aged six to 15 years of age; tightening the eligibility criteria for the disabled support pension; additional employment, education and training services for mature aged workers; and no new entrants from July 2003 to the mature age allowance and partner allowance.

The commonwealth is encouraging the private sector to generate opportunities for people with disabilities, mature aged people, indigenous Australians and parents returning to work. Additional assistance will be available for indigenous communities to help people into work and to contribute to their communities. These reforms may impact on DHS service delivery—for example, it might include financial penalties imposed on income support recipients of welfare age and place further demands on public housing and financial supports. It is anticipated that the commonwealth will ask state government agencies to place people undertaking community work.

In regard to the South Australian government commitment to reform, the department is currently developing a social welfare services planning framework (and we have talked about that today), which will focus on service provision and funding provided across the portfolio and will establish key directions for the department in supporting children, young people and their families with a continuity of care over the next three years. The framework will incorporate an anti-poverty program (in fact, I gave the committee those details earlier) and a focus on Aboriginal people.

Mrs PENFOLD: Children and young people in alternative care are a particularly disadvantaged group in our community. Page 6.17 of the Portfolio Statements shows that an estimated 1 160 children and young people will be in alternative care as at 30 June, 890 of whom will be under the guardianship of the minister. What is happening in this area to achieve better opportunities for these children and young people?

The Hon. DEAN BROWN: Alternative care services are predominantly provided by non-government organisations. However, the department has the case management responsibility for children and young people in alternative care. In the metropolitan area, Anglicare and Aboriginal Family Support Services provide placement and family and preservation services. In the country areas, these services are provided by Anglican Community Care, Port Pirie Central Mission, Whyalla Centre Care, Port Lincoln Aboriginal Health Service and Aboriginal Family Support Services. The majority of placements are in the homes of foster carers (and we have been talking about that), and the majority of children and young people in alternative care have stable, ongoing placements.

There are instances where placements involving adolescents have not worked out, and that is the area that concerns us. This is partly due to the young people displaying very difficult behavioural characteristics. The department is looking at alternative care options to foster care, especially for adolescents who are very difficult to place. As a result of recent research by the department, a number of alternative care models currently are being explored for use to place these adolescents into. In addition, evaluation is being undertaken to track outcomes for children in care and to identify ways in which to prevent placement breakdown.

The member asked about the outcomes for children and young people under state care. I am pleased to say that, with the progress of the Dame Roma Mitchell Trust Fund, this will greatly assist people most disadvantaged in our community. Can I just mention something about that trust fund: it is unique indeed. The trust fund is a perpetual public charitable trust that will enable the children and young people under the guardianship of the minister to access resources to enable life opportunities. Some $1.7 million has been set aside for the trust fund. Businesses and individuals are also encouraged to donate money to that trust fund. It has tax deductibility status as a trust fund. The membership of the board currently is being considered.

This trust fund was established through discussions I had with SACOSS. People have to appreciate that we are speaking about foster children who are the most disadvantaged in our community: they do not have the normal help in life or the leg-up in life that other children would normally have. Where do they go, for instance, to get the money to buy a computer to help with their studies? Where do they go to receive the additional educational support that they might need at school? Where do they go to receive extra support if they have a particular interest in music or something like that? And what other special sort of assistance do they receive that children normally would receive from their natural parents?

We have been doing some work with the Smith Family, and I have arranged for additional educational assistance for these people through the Smith Family—and I am not sure of the exact number, but I have talked to the Smith Family about that. The Smith Family has a program to help children who are disadvantaged, and I have asked for the foster children to be part of that program, which we will fund. I have had discussions with SACOSS. This was state government money that was allocated for a very special purpose for SACOSS some years ago. It was not spent and, as a result, in discussions with me, they have come back and, instead of the money going back into Treasury, I have negotiated with the Treasurer and the money has gone into this trust fund. So, the interest from the $1.7 million will now be available for the first time for these children to receive the sort of help and assistance they have never had in the past. I think that that is a pretty special initiative, and I want to thank and commend SACOSS for its support. It has taken a while to negotiate, because it was quite unique to use Treasury funds in such a way.

Mrs PENFOLD: My next question relates to child abuse. Output 4.2 relates to the care of children and young people, as outlined on page 6.17 of the Portfolio Statements. The Parents want Reforms group claims that parents are not appropriately supported to ensure that they can keep their children safe and in the family home. They also say that

government is putting children's rights and young people's rights above the rights of parents. What is DHS doing to address these concerns?

The Hon. DEAN BROWN: This is a group of people who have had a public meeting and who have received a fair bit of publicity, particularly on the talk-back programs on radio at night. My department has met with parents who want reform to identify and discuss their particular concerns. We are working with the Children's Interest Bureau, and we will pass on that information and the issues raised by parents regarding what reform will be considered as part of this new social welfare framework that we are also working on. We brought in significant changes to the legislation in 1993, and I think that it is now time to sit back and examine how effective those major two pieces of legislation have been and what other changes or adjustments should be made as a consequence of them.

I know that this parliament spent a lot of time considering this matter in 1992-93. There were select committee meetings, and I suppose there was a lot of agonising over those reforms of 1993. Therefore, it is very important, indeed, to undertake that review and to take a very broad community approach in that respect, and that is why any views of parents who want reform should be considered as part of that process.

With regard to the issue of the government's upholding children's rights at the expense of parental rights, that is not quite true at all. Young people leave home for a number of reasons, many of them quite valid, such as abuse, neglect, or a very high level, and perhaps an unsafe level, of parent-child conflict.

It is the policy of both state and federal government agencies to support families and to keep families together and I see on a daily basis the extent to which we do that through the Family Court and in other areas. Financial support is not provided to young people to leave home, contrary to what I hear regularly. I hear people ring in, and some commentators have made those sorts of accusations in the past. As they become aware of the facts, they realise that that is not the case at all. Money is available only when a young person is at significant risk of harm from their parents or their parents relinquish any responsibility of care for those children, and there are a number of quite unfortunate cases like that.

As minister, when I think of some of the cases that are brought forward, I must say that at times it hurts me to think that parents could allow their children to be treated in such a way or neglected to such an extent. There are some kids whose parents let them go off to school in the morning without any breakfast. There are some parents, who, when their kids come home from school, do not want to have them in the home. I met some of them in the member's electorate one afternoon, but that was not an isolated case. We would find that in every electorate across the state. There are a lot of kids, particularly in the modern world of pressure, family breakdown, etc., who need one hell of a lot of support, and that is recognised.

Under the homeless youth protocol, FAYS identifies young people unable to live at home because of serious and imminent risk of abuse, violence or harm. Centrelink receives assessment reports and provides income support to young people under 15 years in exceptional cases only, and they are very exceptional. FAYS also assesses 15 to 17-year olds where there are child protection concerns. I stress that these measures are available only for young people in exceptional circumstances. The idea that we are willingly handing out money in such cases is not correct at all. Every effort is made to reunite families and to improve relationships.

Whilst there are some who argue that we are trying to encourage children to get out of the family relationship, there are others who argue that we work too hard to try to keep some of those family relationships together. I guess that indicates that perhaps the balance is not too bad when both sets of arguments are put on an almost equal basis.

One way that we support families is through the work of Parenting SA, which has received until now $500 000 a year. That was an initiative of former minister David Wotton and it turned out to be an excellent program. I remember the first period five years ago when we gave a commitment to fund the program with $500 000 a year for five years and then to review it. It has been so outstanding that we are continuing that and members may have seen some of the advice given in the fact sheets, of which there are about 80 and of which something like 17 million have been printed.

A number of different states use those fact sheets as their material, as well. I think that New South Wales, Queensland and Western Australia use those fact sheets. They put their own header on them, which we allow them to do, and that shows their wide use. They have been translated into 16 community languages and I have had requests from overseas to use the material. Our view is a bit like that of Mercedes-Benz and its ABS braking system—we want as many people as possible to use it because it is of benefit to the broader community. All we ask for is to cover our costs in anything we do.

Some of the initiatives and achievements of Parenting SA include the distribution of the Parent Easy Guides that I have talked about. There are 74 topics, not 80, and 16 million have been distributed throughout Australia and New Zealand. For Aboriginal families there are 12 Aboriginal Parent Easy Guides. The guides are printed in 16 languages, a web site has been developed and parenting tips are aired twice daily for six months on metropolitan and regional radio. We also operate a Parent Help Line, which is a 24-hour service, so if parents suddenly find a crisis they have someone they can ring up and talk to.

We have also distributed 100 000 Parenting SA calendars, which I think I arranged to be sent to each member of parliament. They were distributed through Coles and the initiative received financial support from Coles. The demand was great. We originally printed and distributed 50 000 but demand was so great that we had to print another 50 000. Again, it just highlights the role of parents in keeping families together. It is a great initiative. If members have not seen the calendar, I can provide copies.

Ms STEVENS: I return to the matter of the Dame Roma Mitchell Trust Fund. How much money has been spent from that fund on the purposes the minister described?

The Hon. DEAN BROWN: It is just being established at present. None has been spent and because it is a trust fund the idea is to spend the interest that is raised from it. It is designed to build up a capital fund and that is why it is tax deductible and we would like to see others contribute to it. I indicated in my earlier answer that we are in the process of establishing a board for it and the board will establish the guidelines, but the money has been accumulating and the interest has been going into the fund.

Ms STEVENS: The minister mentioned the very same matter one year ago and concerns have been raised with me that little progress has been made on establishing the trust fund, partly explained by delays in securing the deposit from

SAFA and Treasury. The SACOSS board is now concerned that the $2 million, which the minister says is $1.7 million, for this trust fund will be used to fund what are essentially core activities of the Department of Human Services in relation to children under guardianship orders. The words used by the SACOSS board were, 'The fund will be hijacked to fund the deficit within the Department of Human Services.'

SACOSS says that, in order to ensure that this does not happen, we need to be clearer about the distinction between core responsibilities and enrichment assistance to these young people. There is potentially considerable overlap and the potential to subsume the fund within normal budget lines with the children's payment budget. This budget is available to FAYS workers to pay for extra costs that would enhance the life of children under guardianship orders. I am concerned that another year has passed in relation to actioning this initiative. Obviously SACOSS is very concerned that this money will be subsumed into core DHS activities. Can the minister respond to this concern?

The Hon. DEAN BROWN: The honourable member said that she was quoting from a letter. Was it sent to her?

Ms STEVENS: It is information that they have given to me.

The Hon. DEAN BROWN: I am somewhat surprised, because that does not seem to match up with what SACOSS has agreed with me. SACOSS has seen me a couple of times about this, and we have agreed to put $500 000 of the money into youth accommodation. As the honourable member said, I think $2 million was involved. The rest of the money was to go into the trust fund. Because interest has been earned on this money, that amount is now $1.7 million. The total funds involved are $2.2 million, not $2 million, and about $1.7 million will go into the trust fund and $500 000 will go to youth accommodation.

SACOSS agreed with me. I put this to Treasury, and it agreed. It has also agreed to the $1.7 million going into the trust fund. We wanted to make sure that this is a trust fund. The very issue raised by the honourable member is what we have tried to make sure of: that we have a perpetual public charitable trust and that it is tax-deductible. We have taken tax advice and legal advice on this matter. If you set up a trust fund and you have a broad range of community representation on that, that overcomes the very fear raised by the honourable member.

SACOSS has not raised this concern with me. The department and I meet with SACOSS on a regular basis. I would have thought that, if it was a major concern, SACOSS would have raised it with us. The very fact that we are setting it up as a perpetual public charitable trust and setting down very clear guidelines on what it can be used for highlights the extent to which I want to make sure that it cannot now or in the future be used for anything other than the special purposes that we are talking about.

I would be very strongly opposed to this money being used for what should be normal departmental expenditure. It is all about giving these foster children, who, so far, have experienced every disadvantage and had every barrier put in their way, a leg up in life and enable them to buy and do things that otherwise would not be available to them because of the plight in which they find themselves.

Ms STEVENS: I suppose that when the years go by following the announcement of such things and delay upon delay occurs people start to wonder what is going on. When will the independent board of trustees be established to administer the fund?

The Hon. DEAN BROWN: I think an interim board will be appointed very shortly.

Ms STEVENS: Next year?

The Hon. DEAN BROWN: No, this year. We did not get final sign-off from Treasury until a couple of months ago. I think it was in about February. I would have to check the exact date, but I think it was in about February or March when we got the final sign-off.

Ms STEVENS: So, it will be a few months?

The Hon. DEAN BROWN: Yes.

Ms STEVENS: Will the minister explain why there has been such a delay in securing the deposit from Treasury?

The Hon. DEAN BROWN: This money was originally allocated by cabinet. It was a matter of going back and checking a range of letters, agreements and everything else that related to it.

Ms STEVENS: What is the 2000-01 estimated children's budget total expenditure, and what is the estimated children's payment budget line for 2001-02?

The Hon. DEAN BROWN: This information is a month or so old. Under children's payments, the projected budget for the current year is $6.784 million. The actual expenditure looks like being $7.609 million. So, we have spent about $825 000 more than the original budget. The budget for next year is still being finalised. Those figures were for the year to date (to the end of March). It would appear that, for the full current financial year, the revised budget was $8.932 million and for the full year the forecast expenditure is $9.932 million. So, it looks as though we will put in $1 million extra.

If it reassures the honourable member and other members of the committee, I point out that the total FAYS budget for the year 2001-02 is up by 7 per cent, which is significantly ahead of the current 3 per cent inflation. We have not allocated that to all of the different aspects of FAYS as yet, but the overall budget is up by 7 per cent for the coming year compared with the previous year. Does the honourable member welcome that big increase?

Ms STEVENS: I am pleased to hear that there has been an increase—not that it was a big increase. I have been given some information regarding Aboriginal foster care which I find most disturbing if it is true. Will the minister confirm or deny that—

The ACTING CHAIRMAN: The honourable member is not asking a hypothetical question?

Ms STEVENS: No, it is not a hypothetical question—of a given figure of 16 special investigations into individual Aboriginal foster care placements, nine involve child abuse or quality of care? If this figure is accurate, will the minister say what resources are being applied in the 2001-02 budget to address this service which obviously is in need of urgent repair?

The Hon. DEAN BROWN: Foster care for Aboriginal children is an issue on which I have had a number of meetings with people. Many accusations and claims have been made in this area. In any area involving the care of children, particularly within their own family and community and the broader community, invariably there are a lot of claims and counterclaims. The honourable member must understand that that is the nature of the sort of problem with which we are grappling in the community. Specific claims and allegations have been made to me, and I asked for a full investigation of those some time ago. I will ask Roxanne Ramsey to provide more details in terms of the review that has been carried out.

Ms RAMSEY: As the minister said, this is a difficult topic. There has been a review of the Aboriginal Family Support Service (AFFS). We are now working with the person who has completed that review and also with AFFS to look at how we can implement the recommendations of the review. The review has identified that this area is under significant pressure. Both families and carers are under pressure, as is the agency. We want to look at how we can work with AFFS in terms of supporting it as an agency that is able to manage the very high demands involved in the placement of Aboriginal children.

We are reviewing the Aboriginal placement principle to look at how the 1993 legislation is being implemented and, where we are not able to place an Aboriginal child within an Aboriginal family, to understand why that is (whether it is the parent's preference or whether it is about not having adequate numbers of Aboriginal carers) and what we then need to do about it.

The other area that we are looking at is family support services in this area and how we can enhance those services so that we do not get to the stage of needing to move through court processes around removal. Within the alternative care review that we are currently completing, services for Aboriginal children and families have a high priority and it is a matter that we are particularly focusing on. It is quite early in that stage in terms of coming to solutions, and we need to be working very closely with the Aboriginal agencies and our own Aboriginal Services Division in doing that.

Ms STEVENS: Minister, what specific resources are going to be attached to those strategies?

The Hon. DEAN BROWN: I think I covered that just a moment ago, where I said there is a 7 per cent increase in funding, and I said we have not yet allocated that money to all the different programs. We are in the process of doing that now.

The ACTING CHAIRMAN: Yesterday the minister was at Port Augusta, and yesterday morning I was taken by a constituent who was most concerned to view the scout hall at Port Augusta and also down Derwent Crescent, which I took the minister to on one occasion to look at some problems. My constituent pointed out to me that the children that were causing the difficulties were probably between 6 and 8 years old. The minister is aware of my ongoing concern about the difficulty that law enforcement agencies have in controlling young people of this age and the real problems that they create for other members of the community, particularly in Housing Trust areas. Has the minister or his department given any thought to how we could address these particular issues, particularly to ensure that these young children are not on the streets at all hours of the day and night?

The Hon. DEAN BROWN: In fact when I was previously in Port Augusta you took me to the specific street that you refer to. I understand your concerns, and particularly where you have older people in the community and those older people live in fear if stones are being thrown or children are trying to break into homes, or things like that. That causes a great deal of distress to the older people in those communities. If we can try to get information in terms of any of the individuals involved; first, if these are foster children who are under the guardianship of the minister then that gives me one set of solutions. If they are not, and they are just children under the care and guidance of their own parents then we have to try to identify who those parents are, and there are some issues there in terms of the justice system as well.

The sort of problem that the member and chair has outlined is the reason why we have set up this Port Augusta Social Vision. I have been on the working party with the other ministers and with the Mayor of Port Augusta, Joy Baluch, and the CEO of the council, and several other people as well, and certainly we are trying to work through some of those issues.

If I can give an example of what has occurred in Ceduna, because the member for Flinders is here, and one initiative we took over in Ceduna was to establish a youth centre. It is interesting because the member for Flinders has indicated to me that there has been an 80 per cent drop in youth crime since that youth centre was set up. We helped to establish that centre. We bought the house and there is no doubt that there has been a very substantial improvement in the situation in Ceduna, in an area where, traditionally, there have been a lot of problems with young Aboriginal youths and children.

So this is the most recent outcome from that. This centre was only opened in October 2000 and so we now have the benefit of nine months' operation. It shows that, by putting on alternative programs for many of these young people, giving them some specific training, it can have quite a profound impact. We will be looking at the results of that Ceduna trial when we go through this Social Vision for Port Augusta as well.

The ACTING CHAIRMAN: So is it the case that you and your officers are giving consideration to doing something similar in Port Augusta?

The Hon. DEAN BROWN: Yes, as part of this there is a proposal being considered, a joint one between the council and the state government. We do have Aboriginal families programs that are now in their third year at Port Augusta. There is the Ranger Youth Centre, where in fact whole families go out and stay in a centre in the Flinders Ranges. But we are also looking at jointly setting up—that is, between state and local government—a youth centre, very similar to the one at Ceduna, I understand, and some work has been done to identify the premises for that.

Ms STEVENS: My next question, minister, is in relation to accumulated unspent funds within the SAP system. Minister, I have been advised that, as a result of forced amalgamations and a reconfiguration of the women's sector within SAP several years ago, unspent SAP funds were forwarded into the accounts of the new organisations. These funds were provided by SAP, and so were joint state and commonwealth money. I have been advised that the Department of Human Services is now going to reclaim those funds from the non-government agencies to go back into the department's general revenue. If this is the case it is of concern, as it is certainly outside the joint state-commonwealth agreement. Can the minister confirm, or otherwise, that this is occurring? Our information is that we are looking at around half a million dollars that can be reclaimed from across the sector.

The Hon. DEAN BROWN: Well, the honourable member is correct in saying that, if the moneys are sitting out there with non-government agencies and they have been unspent, yes they are being reclaimed, because these people I think signed service agreements to spend the money and they have failed to do so, and so, quite rightly, we need to then get that money back. The honourable member is quite wrong, though, in claiming that it is going into general revenue. Those funds go back into the SAP funds and they are suitable for future use. The honourable member's claim

is wrong; they go back into SAP funds. We cannot misappropriate money from a SAP program into general revenue.

Ms Stevens interjecting:

The Hon. DEAN BROWN: Well, we are not attempting to, and no-one has suggested, except you, that we are.

Mr MEIER: I refer to the Portfolio Statements, Budget Paper 5, where I noticed information about child protection, which also makes reference to young people at risk. I believe we have come a long way in understanding the effects of child abuse. However, it is alarming that some 17 000 child abuse notifications still occur each year. How do we compare with other states and territories and what is being done by the Department of Human Services to protect children from such abuse, even though we have had some examples? What are the comparisons with other states?

The Hon. DEAN BROWN: It is an interesting comparison. I was going through the figures a couple of weeks ago. The number of child abuse and neglect notifications is very concerning and unfortunately the number of notifications continues to rise—and I stress that. It is estimated that there has been a total increase of 7 per cent since 1999-2000 and an estimated 13 per cent increase for indigenous children. Notifications meeting the criteria for reasonable suspicion increased by 4 per cent, so there has been a notification on a broader basis, which reflects the awareness of the community that there is a far greater awareness of mandatory reporting of these things.

The Australian Institute of Health and Welfare report 'Child Protection Australia 1999-2000' states that South Australia had a high number of notifications relative to its population at about five times the national average. The report shows that the rate of children subject to child protection substantiation in South Australia was five children per 1 000 children in the population, compared with 0.7 children in Tasmanian and 6.3 children in Victoria. With this increase FAYS is not able to investigate all notifications of child abuse and neglect. It has developed a risk management model to ensure that the highest risk notifications are investigated. Every one is assessed, so any claim that a notification is not assessed is incorrect. All are assessed but, in terms of more detailed investigation, only those that are high risk are investigated further.

Since implementing a centralised intake system there has been a marked improvement in accessibility for notifiers and consistency of response. There is greater accuracy and consistency in identifying and assessing the level of risk in notifications. Prior to this centralised system, approximately 70 per cent of notifications were investigated. In 2000-01 all cases involving children in current danger were investigated immediately and 91 per cent of cases where children were at risk of harm were investigated. Additional funding of $1 million in 2000-01 has certainly improved the investigation rates.

The department is also now better able to target interventions to families where the risks of re-abuse are the greatest. With regard to child abuse and neglect in Aboriginal families, a team of experienced Aboriginal staff provide consultation, response services and reports on Aboriginal children. Culturally appropriate initiatives are being trialled with a number of indigenous families in the metropolitan area. Some include the North Metropolitan Aboriginal Family Service, providing a culturally based service for Aboriginal families. There is one with the metropolitan Aboriginal youth team, which established a partnership with the Child Adolescent Mental Health Services particularly to help those families where mental health is involved, and there is the appointment of three Aboriginal family practitioners to the crisis response and child abuse service. That then allows a culturally appropriate response to those teams, particularly for after hours services.

Mr MEIER: I think it was in the film *Kindergarten Cop,* in which the beefy Arnold Schwarzenegger starred, that child abuse by one of the parents was portrayed and, if I remember correctly, appropriate roughing up of the perpetrator seemed to do a wonderful job. I know we could not advocate that here, but it is alarming to see the number of child abuse cases that are notified.

My second question is also from the same document and I notice that the Department of Human Services collaborated with other agencies to improve service delivery for young people. One area that seems to cross over a number of portfolios is young people's involvement with drugs and crime. At least four ministers would have a stake in this area and I ask what the Department of Human Services is doing on these issues, what it is doing in juvenile justice generally and how it is cooperating with other government agencies to deliver better services and outcomes for at risk youth.

The Hon. DEAN BROWN: In terms of juvenile justice, the department is working on a project to replace the old and quite inappropriate facilities at the Magill Training Centre with new facilities. They are to comprise approximately 60 beds and recreation, education and training facilities. The land has been purchased on Montacute Road for construction of the new centre. The formal concept development and evaluation phase is about to commence. Further consultation is occurring with various groups as well and that includes the people who work in the Magill centre.

With regard to the department cooperating with other agencies, the police and the department are working together on a pilot drug court and proposed police drug diversion program as part of the government's commitment to the national 'Tough on Drugs' strategy. An amount of $500 000 has been allocated to develop new services to support clients as they move through the drug court program. Other services include additional detox beds, treatment support positions for Aboriginal people, financial relief counselling, supported accommodation and recreation. The police drug diversion program will commence shortly and DHS staff will provide assessment services in the metropolitan area, with a wide range of non-government organisations providing treatments in that area. Assessment and treatment services will be provided in the country by both government agencies and non-government organisations within various health regions.

Specific services will be available for Aboriginal people and people from diverse backgrounds. The department is working with the Department of Education, Training and Employment to deter school age children and young people from using drugs through effective school-based programs. In fact, I released some figures on that on Sunday, which showed that now we have reduced the smoking incidence within the community in the school ages of 12 to 17 years. We have reduced marijuana use over the three year period from about 13.5 to 11.5 per cent. We found that heroin use was at a low level. There was a slight increase in the use of amphetamines but it was still at a low level. The one disturbing outcome was that there was an increase in the use of alcohol and up to one-third of the students had drunk in an unsafe manner in the previous fortnight. Clearly, our programs in some areas are working well and we need to refocus to deal with the alcohol problem as well.

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

Additional Departmental Advisers:

Mr G. Black, General Manager, South Australian Housing Trust.

Mr P. Davidge, Director, Operations, Metropolitan.

Mr C. Overland, Director, Ageing and Community Care.

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

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

Membership:

Ms Key substituted for Ms Stevens.

Mr Scalzi substituted for Mr Meier.

The ACTING CHAIRMAN: We are now dealing with the South Australian Housing Trust.

Ms KEY: Before I commence, I want to reflect on an article written by Lionel Orchard which appeared in the *Adelaide Review* in April 1998 and which was entitled 'The retreat from public housing', the last paragraph of which states:

> Times change. New problems require new approaches. Nevertheless, the Olsen government could do worse than remember and build on principles used by one of the most significant forebears—the Playford government. Playford never cowered in the face of the edicts of national government. Instead, his government struck out in all directions in response to local problems and needs. Playford tried to get national governments to see things his way. That thinking was largely responsible for the South Australian success with public housing. It is verging on tragedy that a government on the same political side as Playford seems content to follow rationalist edicts coming from Canberra and to abandon institutions and policies which have served the state so well for so long.

This article appeared just before the last triennial review of the South Australian Housing Trust was released. Minister, I was pleased to read your media release, which talked about 322 new homes from the budget. The South Australian government will build 277 new houses, purchase 45 homes and renovate 1 735 homes across the public community and Aboriginal housing sector. I was also interested to read the minister's announcement that the housing program includes $93.4 million from the capital budget and the provision of funding by way of loans and grants totalling $25.5 million in recurrent grants. 'Regional Country Areas' appearing in Budget Paper 8 at page 5—or, as I call it, the rural agrarian socialism program for the Liberal government—makes a number of statements about the contribution—

The ACTING CHAIRMAN: Is this a series of statements?

Ms KEY: —yes, sir, it is—with regard to money going to the nine country offices. At page 20 I note that the $42.1 million of public housing, including customer service support and property maintenance from the network for the nine country offices is listed. Could the minister break down for the committee where this $42.1 million will be spent in the rural and regional areas?

The Hon. DEAN BROWN: Could the honourable member provide specific page numbers?

Ms KEY: Certainly. I refer to Budget Paper 8 where two pages in particular refer to the nine country offices: the first appears on page 13 and the other appears at page 20.

The Hon. DEAN BROWN: It says that we are going to renovate 328 public houses and construct 12 new houses?

Ms KEY: Yes, at page 13.

The Hon. DEAN BROWN: What was the other page?

Ms KEY: The sixth dot point on page 20 states that $42.1 million is to provide public housing to regional South Australia, including customer service, support and property maintenance from the network for the nine country offices. Could the minister provide me—and you may want to take this on notice—with a breakdown of how that $42.1 million will be spent? I thought it was a significant amount when one looks at the minister's media release that talks about $93.4 million in housing. It seems that a lot of the $93 million is going into rural areas, hence my comment about the agrarian socialism program the Liberals seem to be introducing.

The Hon. DEAN BROWN: First, with respect to matters appearing at page 13, I will find out where those 328 public houses are being renovated and where the 12 new houses are to be constructed. I think that the honourable member will find that that $7.1 million relates only to the Housing Trust and does not include SACHA because, if one includes SACHA in that, one will find that there are a lot more houses than that. Clearly, page 13 understates the situation. I am glad that the honourable member has highlighted the fact that it is understated because many SACHA houses are being built in country areas.

The SACHA model suits the city but it particularly suits smaller country towns where you are able to provide support through local government, churches or some other local group. For instance, I have just opened, in the past few weeks, five houses at Strathalbyn, eight houses on Kangaroo Island—

Ms KEY: In your electorate?

The Hon. DEAN BROWN: Yes. Strathalbyn is not in my electorate but Kangaroo Island is in my electorate. However, Kangaroo Island has virtually no other public housing. In fact, these houses went to Penneshaw and American River where there is no public housing. I think that four are going over to Parndana also where there is no public housing. I know of a number of projects that are going ahead in country areas, and I think that will well and truly exceed 12 houses alone under SACHA in the next 12 months. I will provide the honourable member with full details on that, including renovations. I stress, however, that I think that the $7.1 million reflects only the Housing Trust.

In terms of the $42 million, I will provide a breakdown on that. The $42 million, of course, includes recurrent expenditure. The honourable member was quoting a capital line, but the $42 million covers recurrent. The honourable member must understand that there is capital and recurrent in the $42 million, but I will provide details on that.

Ms KEY: Page 19 of Budget Paper 8 states that supported accommodation is to remain in communities. Minister, last year in estimates you talked about the same line and, as I understand, the amount that was estimated to be expended for 2000-01 was $2.4 million. Could I have the figure that is being suggested for the next financial year?

The Hon. DEAN BROWN: Certainly, and I am willing to give the honourable member some details now on some of those projects. About two or three months ago I opened the first supported accommodation for people with mental health problems in the Salisbury area. I forget the number of houses, but I will obtain the figures for the member. I think something like 10 or 12 houses were involved. Support is also given to the people involved.

I mentioned earlier today that, in the health area (because we were dealing with this matter under mental health), we have already held a public forum on the proposed places at Victor Harbor. I think there are six individual living units there and something like 15 places in boarding accommodation; it is all supported accommodation. So, somewhere in the vicinity of 25 or 28 to about 30 people will be accommodated in that facility. I have signed off on the funds for that. Victor Harbor was chosen because of the very high percentage of people there with mental health problems. They tend to accumulate there because they like the environment—they also like the local member. In particular, a number of large boarding houses there have been bulldozed for various developments and, therefore, there is a particular accommodation problem.

I have mentioned that we are looking at one in Mount Gambier, and we mentioned a couple of others earlier today. We are looking at one at Noarlunga, one at Marion and two, I think, in the western suburbs. They are all at various stages of development. I think there already has been some expenditure on the one in the southern suburbs. I will obtain for the member the details of each of those. I think we are also looking at one in the Upper Spencer Gulf region. So, we are looking right across the state, and we are trying to do it in those areas where there is greatest demand and where there is a significant population of people with mental health problems who need support. It is really support for people with complex needs: it is not just mental health. It may be a combination of mental health and an alcohol problem, and old age certainly has also exacerbated some of those other problems.

Ms KEY: Will the minister provide a list of the titles and classifications of all employees under output classes 3.1 to 3.4?

The Hon. DEAN BROWN: Where is the member referring to?

Ms KEY: I want information with regard to outputs 3.1 to 3.4.

The Hon. DEAN BROWN: Can the member refer to a page, please?

Ms KEY: Pages 6.41 and 6.42. What I want (and this would not be in that information) is the classifications of all employees, specifying in each individual case whether the employee is a permanent public servant or contract employee and, in the case of contract employees, the term of the contract and when the contract is due to expire.

The Hon. DEAN BROWN: I am sorry, I am still having trouble in finding exactly which output the member is referring to. We are talking about output statement and performance information for output. To which page is the member referring?

Ms KEY: I basically want the run-down of all the staff under the housing portfolio. I have asked for the titles and classifications of all employees who are covered under the minister's portfolio. That might be the wrong reference, and I apologise if it is.

The Hon. DEAN BROWN: Does the member want a complete run-down of all employees for the Housing Trust, SACHA, the Aboriginal Housing Authority and the department?

Ms KEY: Yes—under the housing portfolio.

The Hon. DEAN BROWN: What does the member want in terms of that information?

Ms KEY: The minister can probably pick this up in *Hansard*: this will be the third time I have said it. I want the titles and classifications of all employees, specifying in each individual case whether the employees are permanent public servants or contract employees and, in the case of contract employees, the term of the contract and when the contract is due to expire.

The Hon. DEAN BROWN: Mr Acting Chairman, that is a ridiculous proposal.

Ms KEY: Why?

The Hon. DEAN BROWN: We are talking about hundreds and hundreds of employees.

Ms KEY: Is there not a staff profile?

The Hon. DEAN BROWN: But the member is asking for specific information about a contract for—

Ms KEY: That is right.

The Hon. DEAN BROWN: That is at least three or four lines on every employee.

The ACTING CHAIRMAN: The minister is not obliged to answer that question.

The Hon. DEAN BROWN: Thank you, sir. I will obtain some broad general information for the member, but to go into every contract for every individual employee and the basis on which they are employed and everything else—

Ms KEY: Are there that many contracts? I do not think that this is an unreasonable question. Surely the human resources section of the minister's department would be able to give me this information?

The Hon. DEAN BROWN: I will have a look and see how much information there is.

Ms KEY: I imagine that it would be fairly easy. For example, there are only 25 members of staff om SACHA, as I understand it. So, that would not be too hard.

The Hon. DEAN BROWN: No, we are talking about the whole of the Housing Trust.

Ms KEY: Yes, I know.

The Hon. DEAN BROWN: I will go through it. Certainly, if we can provide the information, we will.

Ms KEY: The other ministers have managed to do it. I would have thought that housing should be able to do that as well. I also want to know whether the minister can outline the public-private partnerships within the housing portfolio planned for the next financial year—2001-02—and, if he can do so, I would like the minister to outline the value of those partnerships, including the anticipated level of public contribution, in other words, what the government would be putting into those programs.

The Hon. DEAN BROWN: Can I clarify that? When the member talks about public-private partnerships, is she talking about joint ventures? I do not understand what the member means by a public-private partnership.

Ms KEY: I am talking about the different programs that the minister has announced, and certainly discussed in the House, where one of the ways of maximising the amount of affordable housing that is available (if I understand the minister correctly from previous speeches that he made) is to enter into joint ventures, or partnerships, with different organisations, including non-government organisations, private companies, local government and different associations. I think that when we discussed the community and co-op housing legislation, in particular, the minister outlined some of those programs in his speech. What I am asking (and maybe the term is not one that the minister uses) is whether the minister can name and outline those programs, indicate what sort of money we are talking about and say how much of that will be a requirement by the state government.

The Hon. DEAN BROWN: Certainly. I am only too happy to do that. This comes under the South Australian Community Housing Authority's programs, where a council, a church or some other group such as that provides the land and we provide the money for the housing. Now I understand what the member means by 'public-private partnership'. These are specific SACHA type projects. We will go through and list all those—there is no difficulty with that—and we will give details of how many houses are involved and the amount of government money that has been provided.

Ms KEY: I know of the minister's concern, and I certainly share it, about housing as a social policy area. In the past, the Housing Trust has played an important economic role in South Australia. Can the minister outline his reaction to the latest forecast of the nationally respected economic analyst BIS Shrapnel, which shows an expected 41 per cent decline in the number of dwelling commencements in the two calendar years to 2002?

The Hon. DEAN BROWN: Let me start by saying that I regard the South Australian Housing Trust as a very key part of the South Australian landscape and a great South Australian icon. The member appreciates that we have, if you like, diversified: some of the role that was previously carried by the Housing Trust is now carried in a slightly different model with the South Australian Community Housing Authority. Then there is the Aboriginal Housing Authority, which again carries a role that was previously carried by the trust, where the Special Aboriginal Housing Unit now comes under a separate authority. I might add that that separate authority was one that was required under the bilateral agreement and the multilateral agreement on housing with the federal government.

Our construction program is on the increase. About three or four years ago, the Housing Trust was building about 35 houses a year. The honourable member has given the figures already, which are accurate figures as shown in the budget papers, and this year we will build 277 new homes in those three agencies. We have stepped up the number very dramatically, about ninefold, compared with where we were about four years ago. There is a reason for that, and it is because we have paid off long-term debt. There was a significant commercial debt of about $350 million at commercial interest rates and that was certainly taking a significant part of the income out of the Housing Trust in having to pay the interest on that debt. We pushed hard to make sure that we could eliminate that debt, and we have eliminated the debt now.

As a consequence, the money we receive under the Commonwealth-State Housing Agreement will go into the sort of programs that we are talking about. Therefore I expect that the number will remain at least around the 277 new houses a year, and I highlight the fact that that is a significant increase this year compared with last year. About two years ago we built about 150 new houses. We have stepped that up and I think that we will maintain it. If Shrapnel is correct in its forecast that there will be a downturn, and I do not profess to be an authority in that area, and it is giving national figures, here in South Australia we will be somewhat going against that trend with those three authorities.

Ms KEY: For your information, minister, the first question I asked refers to pages 6.12, 6.13, 6.14 and 6.15 but, seeing you have agreed to give me a bigger picture than I asked for, I will accept that. That will be very helpful, thank you.

The Hon. DEAN BROWN: You are referring to employees?

Ms KEY: Yes.

The Hon. DEAN BROWN: Page 6.12 covers the Housing Trust.

Ms KEY: I still want the other information, but I thought I would refer you to the budget paper because I could not find it when you asked me earlier.

Mr McEWEN: I have a question about urban regeneration, particularly East Gambier. The local community has been championing a project there for about three years, and Greg Black, Christine Charles and others are aware of it, and to date we have not made any progress in terms of getting recognition. Is there any chance that a neighbourhood development officer, even part time, can be resourced to that project to keep the initiative going?

The Hon. DEAN BROWN: There are a couple of issues and I appreciate that the honourable member has raised this with me and I know from his enormous enthusiasm for the Mount Gambier East project that this is important to Mount Gambier, and it is an area that needs refurbishment. It includes 350 first-generation double-unit properties and I am aware that those sort of properties are now inappropriate in terms of housing and something needs to be done. First, there has been some local consultation on the issue because we want to improve the area. A steering committee has been established to develop a feasibility study and costings for an improved integrated school campus and to progress the feasibility of an integrated neighbourhood centre to deal with services for the people who live there.

The East Gambier urban regeneration committee has been established with representatives from all recognised stakeholders in the community represented by the chair and secretary of the South Australian Housing Trust's South-East Tenants Advisory Board. The Education Department, I think, has committed $500 000 to the upgrading of the school campus.

Mr McEWEN: It is putting $1 million into East Gambier.

The Hon. DEAN BROWN: My figure is out, in that case. The education department is also committed to the integration of an early education centre and indoor sports and recreation centre. I know that the member is looking for funding for a community centre and I think that we need to work with him to try to secure funding somehow. I am willing to make a commitment on behalf of the Department of Human Services that we will contribute $50 000 to establish a community development officer position, and that position might do some broader work as well in the Mount Gambier community, but I am willing to make that commitment.

In 2000-01, the trust allocated $628 450 to undertake 32 renovations including external upgrades as well as internal kitchens and bathrooms and, to date, 20 of those 32 have been completed. In this coming year, 2001-02, the trust will commence upgrading approximately 50 more houses, so the program is on the increase, at a cost of about $590 000. In 2001-02 Mount Gambier East will be one of the first areas targeted in the trust's new streetscape program. This will involve fencing and landscaping to improve amenities in the neighbourhood at a cost of about $60 000.

I know that local government members have plans to put in a skate park and plant some trees and improve the streetscape, and I would urge them to look at the youth park at Yankalilla where that has been done. It has been very effective and very cost effective. I think the entire Yankalilla park was done for $15 000. There was a lot of involvement

of community groups, and people supplied equipment, concrete, and so on, and it has worked very well. A BMX track has been put alongside it and we—the community—are about to put an aged care facility next to the youth park. We think that, by putting aged care next to a youth park, it will reinvigorate the old people, and we could well find some of the residents out on bikes. The town is delighted and I think it is a very appropriate location.

The Housing Trust will provide a monthly outreach program to residents of East Gambier for a 12-month period in partnership with the Jubilee Centre and pursue customer participation initiatives. The honourable member can see that there is a significant commitment over the next 12 months—$590 000 for renovations, another $60 000 for a streetscape and $50 000 to take on a project officer.

Mr McEWEN: Wonderful news, minister.

The Hon. DEAN BROWN: When I am in Mount Gambier with the select committee, I offer to spend some time looking at the area because it is worthy of a visit.

Ms RANKINE: I was interested to hear what is happening in the South-East particularly in relation to youth. Perhaps the minister will have a chat with the Tea Tree Gully council, which tonight is discussing whether it will fund the district sports field at Golden Grove, as 35 to 40 per cent of our population in Golden Grove are aged under 19 and we are desperate for facilities to engage our young people.

The Hon. DEAN BROWN: I would love to have in my area some of the things that you have at Golden Grove.

Ms RANKINE: What would they be?

The Hon. DEAN BROWN: Your schools, to start with.

Ms RANKINE: Yes, we have schools for our children, but I am talking about the commitments that were part of that development. I am sure that at Yankalilla you do not have 35 to 40 per cent aged under 19. I am looking forward to the Tea Tree Gully council making a sensible and positive decision tonight.

The Hon. DEAN BROWN: What is the relevance of this to this line?

Ms RANKINE: It relates to what is happening in the South-East. I would not have raised it, minister, had you not. On page 6.11, output class 3, under the heading 'Highlights for 2000-01', the budget makes the point that during 2000-01 you 'established several public housing demonstration projects focusing on early intervention and prevention; these projects assisted vulnerable customers to retain their tenancies and increased the opportunities available for greater positive community participation.'

Will the minister say whether the trust has a policy and procedures for all officers to follow in relation to disruptive tenancies; are there any early intervention procedures that can be put in place to ensure that neighbourhood or tenancy disputes do not escalate out of proportion; and are all documented policies and procedures required to be adhered to?

I raise this question because my area is covered by two different regions of the Housing Trust (the Modbury region and the Salisbury region), and I find that a different approach is taken to similar problems. There are situations where I think an approach by a housing manager could prevent a situation from gaining momentum and remove the necessity for formal action, yet this does not appear to occur in one particular set of circumstances; on the other hand, there have been situations where residents have been told that if they have a problem they should take it to the Residential Tenancies Tribunal themselves. Alternatively, I am aware that normal procedures have not been adhered to and formal action has been taken directly with the RTT by the Housing Trust.

The Hon. DEAN BROWN: I will come to that specific case in a moment. The honourable member asked about these demonstration projects.

Ms Rankine interjecting:

The Hon. DEAN BROWN: Yes. The honourable member talked about demonstration projects with early intervention and prevention and trying to help vulnerable customers to retain their home. Debt management, dysfunctional families, housing management skills, and mental health care are some of the common issues. Four projects are being implemented. There is a debt management early intervention model which addresses debt reduction for tenants with debts over $1 000 and links to relevant support services. The second one is the north-west families project which addresses longstanding issues for families with generational and extensive use of DHS agencies.

Another one is the financial management project which provides financial management support and skills development. The fourth one is the supported trust tenancies project to support trust tenants who have complex needs and are at risk of losing their tenancies. In particular, this covers people who can be disruptive or difficult tenants, people with mental health problems, and Aboriginal people.

In 1999-2000, there were 234 evictions and a further 126 tenants vacated after eviction proceedings commenced. In 2000-01, there were 141 evictions—a substantial reduction from one year to the next—and 44 vacated after eviction proceedings were commenced. So, we almost halved those figures in a 12 month period. I will ask Mr Greg Black, the CEO of the South Australian Housing Trust, to comment on the value and the benefit of that and specifically on the case that the honourable member raised.

Mr BLACK: As the minister mentioned, there are a number of demonstration projects which provide partnership arrangements between various agencies within the Department of Human Services and which are looking at early intervention and prevention. Essentially, we need to do this because, as members would be aware, we are housing more and more people every year with some form of need over and above basic housing. In some circumstances, as the minister mentioned, there is a lack of fundamental living skills and behavioural problems, etc.

There is only so much that housing managers in the field can do without situations escalating into more significant problems that become social and community problems over time. The trust and the department as a whole have a sense that if we are going to make a difference we have to deal with the whole problem and not just the housing component. Hence these projects which we would like to think in the next five years or more will become more generalised across the community—subject to resources being available. That is the overall strategy that we are endeavouring to pursue.

At a Housing Trust specific level, we have also been developing a number of training programs to ensure that our staff have a much better understanding of the background and particular issues faced by our customers. For example, we have just finished a program with the Schizophrenia Fellowship to give staff a much better understanding of and empathy for people with this form of disability. A number of these programs are ongoing.

With particular regard to neighbourhood disputes, our general experience is that it is best to intervene in these

disputes as early as possible. Because of this, 18 months ago, the minister announced a new program of housing visits so that all tenants will have regular contact with our staff not just in situations where there is a problem. The feeling is that that will improve our capacity to intervene as early as possible. A second initiative that the minister announced at that time involves a policy of probationary tenancies. The current situation is that, for the first six months, tenants are essentially on notice that there is an absolute requirement to meet all the conditions of their tenancy agreement. We try to give them as much support in that critical early period as we possibly can.

The final component of all this in terms of difficulties with neighbours comes down to the capacity and willingness of individuals to make compromises and move on and to try to understand the other person's position. When it comes to that sort of more difficult circumstance, we endeavour to look at the possibility of mediation. As members may be aware, there are a number of mediation services available, but fundamentally it is up to the individual to be willing to take that on with a positive approach. At the end of the day, if none of those things work we have little choice under the legislation other than to seek eviction.

The biggest difficulty with the actual eviction process—as the minister mentioned, we have halved the number in the past year, which I think is of great credit to the staff—is that the Residential Tenancies Tribunal requires that neighbours who are protagonists in those situations must give evidence. There have been some circumstances, involving elderly people in particular, where they have been very reticent to give evidence for fear of retribution. We are having continuing discussions with the tribunal and its registry about the question of evidence and whether it may be possible in the future for the Housing Trust to represent people on their behalf and to provide documentation such as complaints to the police. That is an issue that we are endeavouring to deal with right now.

Ms RANKINE: I want to clarify that there are actual procedures in place for housing managers to follow; and can you explain why there is a variance in adopting those?

Mr BLACK: There are internally published policies and procedures that staff should follow. I am sure the member is correct that there are circumstances when people behave at variance to that. My experience across the state is that the number of exceptions to that are relatively rare, but if there are circumstances where it is a member's view that the staff are behaving inappropriately we can certainly follow that through.

The Hon. DEAN BROWN: Can I make a point here: a number of members of parliament write to me on matters involving that. I think they are sensitive issues, and if members contact me, or Tina Lloyd in my office, we follow through and try to apply it in a commonsense way and achieve the best possible outcome for the neighbourhood.

Ms RANKINE: Can I just add that Tina is very good to deal with, excellent.

Mr SCALZI: Before I ask my question I would like to commend the Housing Trust and the staff for the way they deal with a lot of difficult neighbourly disputes in my electorate, and I have over 1 000 Housing Trust premises, and I think from time to time you will come up with difficult cases. I deal with the Modbury office, similar to the member for Wright, and I have found the staff there very helpful, and I commend the Housing Trust and the area officer, John Giradi, for the excellent work they do in a most difficult area. My question concerns the impact of GST on housing programs. Minister, we have heard a lot about the effect that the GST has had on the housing market, especially on the purchase of homes. Output 3.1 on page 6.12 of Portfolio Statements outlines the average cost of providing additional houses, but I would imagine that the GST impacts on more than just the purchase price of homes. Can the minister please detail the impact of the GST on housing programs?

The Hon. DEAN BROWN: Thank you for that question. In fact, I was one of those at a ministerial level amongst the state and territory ministers who was very concerned at the potential impact of the GST on the total program, because for the first time GST would apply, and housing of course was one sector where the cost of the end product would go up as a result of GST, rather than down.

When the state and territory housing ministers met on this I was somewhat dismayed that there did not seem to be a great deal of enthusiasm about pursuing the matter further. We had a meeting in Hobart, and I pushed it. In fact, this became almost the sole issue at the meeting. I pushed it and said that I thought there was value in us going in and arguing very strongly the case for an adjustment. They said that I would never be able to convince the commonwealth of the need for an adjustment.

In fact, we ended up with a very significant adjustment. We ended up with $27 million more over three just to adjust for the GST. South Australia has ended up with a very good outcome. We got $27 million. Some $85 million to $90 million was the total money and we ended up with $27 million, so we have ended up with just under 30 per cent of the money. So we are thrilled with the way we got the compensation. I think it highlights the value of the case put together by the officers, and argued. It was not an easy argument. We argued this for six months or nine months, but the outcome was very worthwhile indeed.

As a result of that, that is another $27 million over the three year period for the construction of housing. We were able to guarantee that tenants would not have to pay increased rent as a consequence of the GST, that component. South Australia won a significant ruling from the Australian Tax Office on what components of social housing programs were subject to the GST. This will provide an added benefit of over $1.5 million annually to the Housing Trust alone.

There is no doubt, also, that on top of that the $7 000 first home owner's grant, and now the $14 000 for new construction, have had a very positive impact on enabling home seekers to buy or build their own homes. I do not mind saying that we put a subsidy of about $2 500 into each public housing home, and that is pretty similar, whether it is SACHA or the Housing Trust. So we have encouraged those tenants, particularly in Housing Trust homes, who are able to to access that first home owner's grant scheme, the $7 000, and actually buy their home. I think that is a good outcome, particularly from the trust's perspective, and from the tenant's perspective, because it means that for the first time the tenant has now got a home, and they have been able to access $7 000 from the federal government to get the home. HomeStart has put together a purchase package with that $7 000 to help those people buy their own home.

So, first, it has the benefit of giving those people the long-term pride and joy of having their own home, of taking responsibility for that and building it up and looking after it, and they get $7 000 input into that. In addition to that, it then frees up that money for us to go off and either do more renovations, or it provides more capital to be able to go and

build more homes or renovate more homes and increase our overall program. I assure you that the money does go back into the housing program. It is required to, it has to. There was another component for compensation and that is apparently included in that $27 million. There was a component that we get in terms of the adjustment over the fact that the pension was being adjusted for GST but we then missed out on that. So we are getting that compensation as well, but apparently that is part of the $27 million.

Mrs PENFOLD: Minister, page 6.11 of Portfolio Statements refers to a review of housing policy. Could the minister tell the committee what is being reviewed and what the expected outcomes of the review will be?

The Hon. DEAN BROWN: That is correct; every three years there is an overall review of the trust, and a housing policy statement, Housing South Australians, is being prepared by the department to locate South Australia's public housing intent within a broader Human Services policy framework. Sorry, I have somewhat wound two together there. There is this broader review in terms of housing policy and then we come to the triennial review, and I will touch on that in a moment. I thought initially you were talking about the trust review. As I said, the Housing South Australians statement is being prepared by the department to locate South Australia's housing policy intent within a broader policy for the Department of Human Services.

The work will include an examination of the role of the department and the four statutory housing authorities that provide housing assistance. The project is examining housing provision and support across all tenures based on current and future need and also on demand. It will look at the impact on economic, demographic, social and policy changes in the provision of public housing assistance. One classic example is that we have an ageing population in our public housing and the need is tending towards older people and more of them living by themselves, so the demand for large family residences has dropped and the demand now is for smaller, perhaps two bedroom facilities designed specifically for older people.

I refer also to the subsidy levels in various housing assistance programs and possible impact on alternative assistance in terms of housing outcomes. The project will ensure that South Australia has a cohesive policy framework to begin negotiations with the commonwealth ready for the next commonwealth-state housing agreement. The present agreement expires in June 2003. We as a state know that the minister took a lead in negotiating the last one and we want to be able to argue the case as, after all, we have a significantly higher proportion of public housing in this state than in any other state. It is of greater interest to us than it is for other states. Currently, the project is examining demographic, social and policy trends, the needs and demand, and gathering baseline data on housing assistance programs. It is doing modelling of various financial and stock level scenarios, examining trends in home ownership and private rental supply, and encouraging debate on the role of the DHS in the provision of housing, particularly through HomeStart, the Aboriginal Housing Authority, the South Australian Housing Trust and the South Australian Community Housing Authority.

We also have the next triennial review for the Housing Trust, which we are required under legislation to do every three years. That is under way. The last triennial review was a very substantial one and did an enormous amount of financial modelling. A lot of that information is still largely relevant, so this will be a somewhat smaller review and will not go back and revisit what was already well documented in the last review.

There are a couple of other projects as well at which we are looking. If we see the demand for aged housing I am keen on looking for other ways we can start to provide that aged housing in a more suitable setting. One issue has always been having older tenants in homes next to young tenants, invariably young blokes with cars, who do their repairs and play stereos and tend to have their friends in at different hours of night than do older people. The two do not mix very well together at all.

Members interjecting:

The Hon. DEAN BROWN: No, the youth park will be fine as it is a different age group. We are looking at a couple of projects and I hope to be able to outline shortly how we might provide age groups that would go into particular housing and be together and see how it goes and see what other support we might provide. With older people you can often have them in slightly smaller houses, but they are home more than they would be if they were working. It may be that you would need to provide general community facilities in that area. We are looking at how that can be done as well. I am hoping we might be able to pilot a number of different projects. I have had the three housing authorities looking at how that can be done and they have come up with a paper that I have agreed to. I acknowledge their excellent cooperation and the work that has gone into the preparation of that paper.

Ms KEY: I refer to output class 5, page 6.20, targets for 2001-02. There are a number of points, including implementing the state homeless plan, implementing an Aboriginal homeless strategy to provide accommodation options for homeless Aboriginal women and developing an inner city youth services framework. I refer to page 6.11, highlights, dot point 7, which talks about providing boarding house accommodation to suit transient and homeless customers. There are a number of questions I would like to ask, but with five minutes left it will be difficult to do that.

What is the status of the inner city framework? Is that still part of the program that DHS is looking at, and will some of the action and strategy plans put to you be implemented, including facilitating a whole of government approach to prevent homelessness in recognition of the important contribution made by other government agencies such as Aboriginal affairs, police, corrections, justice, recreation, education and employment? Will the minister also comment on the issues that were topical recently with regard to a number of Aboriginal and other homeless people sleeping rough in the parklands and advise what sort of plans we will put in action to try to assist the many homeless people who are in the city centre itself?

The Hon. DEAN BROWN: First, the inner city framework is a joint effort between the Department of Human Services and the Adelaide City Council. The report is currently in the process of being distributed. It is finished and it has been agreed by both parties.

Ms KEY: Have you personally signed off on it?

The Hon. DEAN BROWN: Yes, and it has gone out. It is in the process of being widely distributed at present.

Ms KEY: Can I have a copy of it?

The Hon. DEAN BROWN: Certainly. In terms of other programs, a number of initiatives are being looked at. We have identified the non-government organisations and the government services involved and supported by both the

department and the council. There are 10 key outcomes—areas for services. It links homelessness with primary care, health care and other supported services. There is an Aboriginal task group that advises on Aboriginal homelessness. I will get the honourable member a copy of that. We are working on a couple of other initiatives with the Adelaide City Council and other non-government groups. We have agreed to some proposals for the upgrade of St Vincent de Paul and that is being worked through that with the Adelaide City Council. There is a development application and that is really in the hands of St Vincent de Paul and the Adelaide City Council.

Ms KEY: What about the boarding house accommodation—that was the one I was particularly interested in.

The Hon. DEAN BROWN: The boarding house accommodation project put forward was blocked by the Adelaide City Council, which rejected the planning approval.

Ms KEY: You said it was a highlight for 2000-01. What were you referring to if it was a highlight?

The Hon. DEAN BROWN: That was there for last year.

Ms KEY: It is hardly a highlight if it did not happen, unless there are other boarding houses I am not aware of.

The Hon. DEAN BROWN: I think that is historic; that has picked up what was listed last year. I am saying that I think that the one about which we are talking relates to the project that was blocked by the Adelaide City Council. The council also blocked the proposal to relocate St Vincent De Paul, and that is why we have now agreed with St Vincent De Paul to look at a redevelopment of its existing facilities. There is a plan for that and we have gone for the bigger of the options in that regard. I do not think that we are likely to have the same planning approval problems. It is largely just a building application that must be dealt with.

We also have some proposals in terms of other initiatives for the Salvation Army, and I will not take up time now going through each of those. We have a stabilisation facility proposal that is currently being considered and we are looking at another one in terms of longer-term housing.

Ms KEY: This relates to the $500 000 announced by the Premier?

The Hon. DEAN BROWN: Yes.

The ACTING CHAIRMAN: I call the member for Torrens to speak briefly.

Mrs GERAGHTY: I hope that the minister has finished answering the question from the member for Hanson.

The ACTING CHAIRMAN: That has nothing to do with it.

Mrs GERAGHTY: I will make two comments about some issues that were raised. The first issue relates to the RTT and people being concerned about being identified and, given that we have a reasonable level of violence in the community, I think that it is imperative that we look at protecting those complainants and, where possible, the trust must act to protect those people.

The Hon. DEAN BROWN: I support that view very strongly because, invariably, older people lodge the complaints. They just feel insecure if they are putting it up publicly.

Mrs GERAGHTY: Also, young people with families. I have received—and I am sure other members have, too—a growing number of complaints about maintenance that is being charged to tenants, which would appear to be normal wear and tear maintenance, such as, perhaps, faulty light switches that have simply worn out because of age—just a normal power socket—and fraying mesh on the windows or door frames. I have looked at some of the accounts that my tenants have received and I find that many of those items are items that, under a private landlord, would be accepted as normal wear and tear.

I really think that we need to look at that. I have a number of cases I could send to the minister because I think that people are being unfairly charged for what would appear to be normal wear and tear under the maintenance program. I would certainly like that matter looked at. How much has been recovered from tenants for maintenance charges in the past 12 months and how much has been paid by the trust in maintenance?

The Hon. DEAN BROWN: I will need to get that information and, to save time, I will undertake to do so. I made one point earlier and I want to make sure that the record is absolutely correct. The committee may recall that I talked about $27 million over three years—extra for GST—in answering a question from the member for Hartley. I thought that there was an additional amount over and above that, but I was advised that that was not the case. In fact, it was the case. In addition to that $27 million over three years, there is a further $14.4 million over three years which, again, was a quite separate issue that we argued some 12 months after the first argument.

Although I was surprised to have won the first argument, I had even greater surprise in winning the second argument against the commonwealth. It just highlights—and I remind members—that it is worth arguing every dollar with the commonwealth because it shows that you can get significant benefit. We get $4.7 million this year and, as I said, $14.4 million over three years out of a further adjustment. I will not go into the full details but that related to what we would have lost through not being able to charge or include the additional payments for GST adjustment in our rent. We have excluded that and we have lost income on an ongoing basis so that we would be able to get this extra money out of that.

Mrs GERAGHTY: When the minister responds to my question, could he also give me the criteria relating to maintenance?

The Hon. DEAN BROWN: Criteria for maintenance for the homes?

Mrs GERAGHTY: Yes.

The Hon. DEAN BROWN: I can indicate that, in the current year, the revised forecast is to spend about $63.1 million on maintenance in the Housing Trust.

Mrs GERAGHTY: Is the minister talking about supposed tenant damage maintenance or is he talking about general maintenance?

The Hon. DEAN BROWN: That is total maintenance.

Mrs GERAGHTY: I would like to see what tenants are paying so that I can look at what is or is not fair.

The Hon. DEAN BROWN: I will provide that information for the honourable member.

Witness:

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

Membership:

Ms Stevens substituted for Ms Key.

Additional Departmental Advisers:

Dr D. Caudrey, Director, Disability Services Office.

Mr C. Overland, Acting Director, Office for the Ageing.

The ACTING CHAIRMAN: Minister, would you like to make a brief statement?

The Hon. R.D. LAWSON: This year has seen record funding allocated to disability services in South Australia—$180 million—with an additional $6.1 million in state funds being provided in 2001-02. This government continues to give significant attention as well as funds to the needs of people with disabilities and their families. The allocation of new recurrent funds will provide further accommodation, respite, day options, early childhood intervention and equipment repairs. Additional funds will also enable further expansion of the popular Moving On program, providing recreational and other activities for school leavers. This year it is expected that 70 new school leavers will be involved in the program. State programs will be targeted to complement commonwealth funding for ageing carers. Some $4.6 million of capital funding has been allocated for the new aged care facility at Northfield to be operated by the Intellectual Disability Services Council. Tenders have been called for this new 50 bed aged care facility for older residents at Strathmont. We are not ignoring the needs of residents who will be remaining at Strathmont: $50 000 has been allocated to progress the future development plans of that centre.

The government remains committed to assisting people who wish to move out of institutional care into community living. There is now widespread acceptance that living in institutions is not the most desirable form of living for people with intellectual disability, and we have facilitated the movement into the community of a number of people from Strathmont and Julia Farr's Fullarton campus. In 2001-02, 27 community accommodation places will be created to enable Strathmont residents and 25 community accommodation places will be created for Julia Farr services residents.

This year saw the launch of the Disability Services Planning and Funding Framework, a blueprint for disability services over the next three years that has been built around the five key strategic directions of the strategic plan of the Department of Human Services. The creation of a new brain injury rehabilitation service at the Hampstead Centre is also providing essential services for people with disabilities and those who care for them.

In the field of ageing, the Home and Community Care program remains the centrepiece of the state government's commitment to older people and their carers. The increase in HACC in the 2001 financial year has been $6.3 million, and next year it is anticipated that over $7 million will be available from both state and commonwealth contributions. Younger people with a disability will also benefit from HACC. The implementation of the Moving Ahead plan to help older South Australians with rehabilitation, prevention and home support has been further progressed at a cost of $1 million. Some $7.7 million of capital funding has been allocated for the redevelopment of facilities which accommodate state funded long stay patients. This will enable our facilities to meet commonwealth standards by providing a combination of single and double rooms with ensuite and shared ensuite facilities in the place of four and six bed wards, as is the current situation. The following locations will benefit: Tumby Bay, $1.2 million; Laura, $1.4 million; Crystal Brook, $1.4 million; Quorn, $1.1 million; and Cummins, $0.9 million.

The commonwealth does have primary responsibility for the funding of aged care places and has allocated more than 2 100 new places to South Australia in the last two years. While some places will be quickly established, a number require new buildings. Some providers, especially in the community and charitable sector, do not have ready capital resources to bring the places on stream as soon as we would like, and the government is examining making HomeStart funding available for non-profit operators to establish aged care facilities.

The state government has continued its efforts to ensure that South Australian residential care facilities are not disadvantaged by the commonwealth funding formulas. As a result of government joining with industry and consumer groups to obtain a funding equalisation and assistance package, South Australia will be in line with national levels by 1 July next year. We are continuing to match commonwealth funding in line with our 10 year plan.

In conclusion, it would be remiss of me in these opening remarks if I did not acknowledge the work of a number of people. First, I should acknowledge the families and carers of the frail elderly and people with disabilities. Collectively, they provide the bulk of care and support in our community, and they always will. The maintenance of connections between people and their own families and friends is, where possible, one of the prime policy objectives in this field. I should also express thanks to the many executives and officers within the Department of Human Services who are involved in both the fields of disability services and support for older people. Nurses, care workers, options coordinators, policy people and many others within the government sector are dedicated to the support of others. Too often their efforts are unremarked, and I salute them all.

Many of the programs in these areas of activity are delivered by non-government organisations and I commend their boards, management staff and supporters. In this International Year of Volunteers, I should also acknowledge the wonderful work of volunteers across this sector in both government and non-government services. The budget papers do not tell the full story or even half the story for those with disabilities and the frail elderly. Indeed, in focusing on the macro, sometimes they obscure the individuals whose needs we seek to serve. I am sure that I express a bipartisan view when I say that good budgeting and policies are only a means to an end, and that end is the quality of life for individuals and assisting them to live the life they want to live.

Ms STEVENS: In relation to disability services, in a press release the minister announced a community home for young people with Prader-Willi Syndrome, a group home for people with disabilities in Port Lincoln, permanent accommodation places for young people with intellectual disabilities, and a service for people in the northern suburbs with physical and neurological disabilities and high support needs. Can the minister outline the amount of funding for each of those initiatives and the number of people who will be catered for in each of them?

The Hon. R.D. LAWSON: They are four very good initiatives that we are undertaking out of additional funding this year. I think it is worth mentioning that, as part of the unmet needs funding that was allocated for the first year last year, a very large number of individuals in South Australia have been assisted and are being assisted across the sector. One of the things that I made clear last year was that the additional funding not only of the $6.1 million of state funds but also the $4 million of commonwealth funding be

allocated to clients who were not receiving services rather than expand services to existing clients. That was a very important initiative because many of the people who received services for the first occasion last year from the state, as well as the commonwealth, had not previously received them.

With regard to the particular projects, first, the accommodation service for those with Prader-Willi Syndrome—as the honourable member will know, this is a disorder which is particularly distressing and which requires a great deal of support and adaptation of accommodation because of the eating disorder that comes with the disability. For quite some time, about 10 years, families of people with Prader-Willi Syndrome in South Australia have been agitating for a service, but none has been provided, and I was delighted that we were able in this year to provide that service, which is being accommodated through IDSC. I do not have the figures exactly, but it is a four-person accommodation and it is costing $394 440 per annum. That indicates the level of support that is required, approximately $100 000 per person.

With regard to the project in Port Lincoln, as a result of the efforts of a community group there, ably supported by the member for Flinders, there has been a strong agitation for the establishment on the Lower Eyre Peninsula of an accommodation service for people with disabilities. There is a current service available in Whyalla, which is of course quite a distance for people to drive. It is envisaged that that will accommodate four people but there may be provision for respite, so it may be possible for more than four to be accommodated. The precise funding has not been established because it will be necessary for us to go out to tender on that. The cost is likely to be $400 000, similar to the Prader-Willi Syndrome facility.

I mentioned earlier that, as a result of last year's funding, we established 101 new accommodation places last year, and they will continue into this year. I am advised there will be a further eight places created by IDSC in this funding year.

Ms STEVENS: Are the eight places under dot point 3 or dot point 4 of your press release?

The Hon. R.D. LAWSON: You are referring to my budget press release. I do not have a copy of that.

Ms STEVENS: As I said, dot point 3 is 'permanent accommodation places for young people with intellectual disabilities who have been in ongoing crisis respite' and dot point 4 is 'service for people in the northern suburbs with physical and neurological disabilities and high support needs'. Which one of those do the eight fit into?

The Hon. R.D. LAWSON: I will have this checked, but I believe that is to assist the Elizabeth Bowey Lodge, which is a facility within the honourable member's electorate and which we are supporting not only through disability funding but also through an additional allocation of HACC funding. There is also a property in Salisbury called Robert Street which was originally a respite house, but which, by reason of various circumstances, became more than a respite house: it became an accommodation service.

Ms STEVENS: That was for kids who were abandoned.

The Hon. R.D. LAWSON: You can use the word 'abandoned'. They are the people who have been left for the state to look after in various circumstances, I might say. I would not necessarily categorise it as 'abandoned'. However, we are funding that particular service through an additional allocation. Once again, I do not believe the precise amount of that funding has been determined, but they are usually younger people with high support needs. That will be at the higher end of the spectrum.

Ms STEVENS: How many places in that?

The Hon. R.D. LAWSON: I think that is eight, but I will have that confirmed.

Ms STEVENS: We have four in the Prader-Willi house, four at Port Lincoln and eight in Robert Street, which is changing from respite into ongoing accommodation. That totals 16.

The Hon. R.D. LAWSON: Plus 101 from last year.

Ms STEVENS: I am talking about this year.

The Hon. R.D. LAWSON: We are talking about a continuation of the program which started last year.

Ms STEVENS: I am talking about new programs, and it is 16. In relation to your statement about the state funds for 2001-02, my analysis of the budget is that the $6.1 million, about which you have talked in your press release, is made up of unspent funds from the state government new allocation last year, plus the commonwealth's extra contribution of $4 million, plus commonwealth indexation. Is that correct?

The Hon. R.D. LAWSON: Well, the press statement you are reading (and which I now have in front of me) talks about new funding—and it is new funding.

Ms STEVENS: Can you explain where it has come from?

The Hon. R.D. LAWSON: The sum of $6 million was announced first in year 2000 for 2001. It was $6 million recurrent; it was $6 million in both years so that is $12 million. The commonwealth applied $4 million for ageing carers' funding in year one and $8 million in year two. The commonwealth-state arrangement was that we would match the 12 with 12 and that is what we did. We are the first state to agree to match the commonwealth funds in that regard.

Ms STEVENS: I do not think that you have answered my question. I put to you again that the funding for new services this year comprises the balance of the $6 million of new funds from last year—obviously, you will carry on with the rest of what you put in last year, the new services, the balance—plus the new commonwealth amount of $4 million plus indexation on that amount of money.

The Hon. R.D. LAWSON: I do not have the precise make-up of it. It is $6 million from us and $4 million from the commonwealth: $10.2 million.

Ms STEVENS: I am surprised that the minister does not have that information. I would be grateful if he could provide the details of this funding.

The Hon. R.D. LAWSON: I will provide you with a full breakdown.

Ms STEVENS: I refer to Elizabeth Bowey Lodge at Salisbury, which the minister knows I was concerned about earlier in the year. I note a press release from the minister which refers to an additional $365 000 for Elizabeth Bowey Lodge at Salisbury. I was pleased to see this in the minister's press release. I contacted Elizabeth Bowey Lodge and was told that they did not think they had $365 000 but only $230 000. I looked at the HACC allocation and noted that Elizabeth Bowey Lodge got $210 000. They would be pleased to get the balance up to the $365 000. Will the minister clarify exactly what amount of additional funding is to be given to Elizabeth Bowey Lodge?

The Hon. R.D. LAWSON: There are a number of amounts on a sheet that has been handed to me, but I have a specific recollection of signing off the HACC funding round with the amount of $365 000 or whatever it was. That was signed by me and approved for funding this year, and it required the commonwealth contribution. There is no doubt

that $365 000 was provided from Home and Community Care funding.

Ms STEVENS: I am surprised at that because last night I got off the internet the HACC allocations. I have them here. I am sure that it says Elizabeth Bowey Lodge Incorporated—$210 000. However, if it is $365 000 I am very pleased.

The Hon. R.D. LAWSON: It will be that amount of money. Whether or not it is all HACC, a seed of doubt has been sown in my mind. It is suggested that some of it might be commonwealth aged carer funding.

Ms STEVENS: Will the minister clarify that?

The Hon. R.D. LAWSON: I certainly will. The total Disability Services Office and IDSC funds allocated to Elizabeth Bowey Lodge last year was $602 000, and recurrent funding was $440 000. This year, it will rise to $804 000—an additional $200 000. However, as I have said, it is my understanding from the sign-off that $365 000—or whatever that amount was—was directly from HACC.

Ms STEVENS: Will the minister clarify that also?

The Hon. R.D. LAWSON: Certainly.

Ms STEVENS: As I said, the agency would be absolutely over the moon if it got $365 000 when it thought it had received only $230 000.

The Hon. R.D. LAWSON: I am advised that it received $602 000 last year and $804 000 this year.

Ms STEVENS: I look forward to clarification of that. I refer to the level of unmet need. Will the minister provide an estimation of the level of unmet need that still exists in terms of disability services as at 1 July 2001? Recently, we did some work of our own on this and we came up with a figure of $18 million recurrent to meet that unmet need. Do you agree, and what is your figure?

The Hon. R.D. LAWSON: I do not agree; I do not have a figure. We are not regularly in the habit of compiling unmet need data. The member will be aware that about three years ago a commonwealth study was undertaken for the purpose of the commonwealth-state disability agreement seeking additional commonwealth funding, and that established unmet need across the country. As a result, extensive discussions took place. The commonwealth did agree to put in an additional $150 million over two years, although it did not commit to put it into the base of the commonwealth-state disability agreement. As I mentioned earlier, we were one of the first states to agree to match the commonwealth on that. That did not meet the amount then calculated, as I recall, of something of the order of $300 million—

Ms Stevens interjecting:

The Hon. R.D. LAWSON: About. I simply have not made that calculation. I have no reason to doubt that it is probably the same or higher.

Ms STEVENS: I am really surprised—in fact astounded—that the minister has no idea about what the level of unmet need is.

The Hon. R.D. LAWSON: We will be undertaking further studies, because we are about to embark upon a further negotiation with the commonwealth for the renewed commonwealth-state disability agreement—and this will not be until the middle of next year, when the agreement expires. We, along with the other states, once again will be compiling unmet need data to get all the material ready for the bid for the renewed agreement.

Ms STEVENS: In other words, you do not have any forward plans in terms of meeting any such unmet need because you do not know what it is.

The Hon. R.D. LAWSON: No, there is no shortage of forward plans, I can assure the member.

Ms STEVENS: The forward plans, though, do not link to any particular numbers?

The Hon. R.D. LAWSON: We are addressing programs that are established. We identify needs on a case by case basis across the state, not on the basis of some statistical exercise to establish by some world standard or any other statistical data what the unmet need is.

Ms STEVENS: The minister is telling me that the disability services office manages its disability program on a case by case basis rather than a population basis, in terms of projected statistics and other mechanisms of determining population demographics?

The Hon. R.D. LAWSON: Of course we are aware of all the demographics, but when we establish a service, let us say the Prader-Willi service, do we say, 'We will look in some statistical book to say how many Prader-Willi people there might be in South Australia and how many require a service'? We actually identify real individuals who want a service and make sure that we provide it.

Ms STEVENS: That is patently ridiculous, if the minister is determining and managing the disability services in this state on a case by case basis. In other words, he is wanting every person with a disability to ring up or write to him before he determines whether they have a need; that is just ridiculous.

The Hon. R.D. LAWSON: We have provided a good deal more for disability services than the opposition ever provided.

Ms STEVENS: I am asking the minister about forward planning and the basis on which the minister makes his forward plans.

The ACTING CHAIRMAN: The member should ask her question and then we will hear the answer. In that way we will not have too much cross talk.

Ms STEVENS: To sum up, the minister is unable to tell me any estimation from his department about the major issue in disability services across the country and in this state, that is, the level of unmet need that exists.

The Hon. R.D. LAWSON: I do not agree that that is the major issue. The major issue is providing the services and support to the people who need it.

Ms STEVENS: I would have thought that the level of unmet need was a major issue in that.

The Hon. R.D. LAWSON: No, you need also to look at the needs you are meeting, how well you are meeting them and how better you can meet them.

Ms STEVENS: The point I am making is that the minister cannot give me any estimation of that at this point.

The Hon. R.D. LAWSON: I do not have them here. If any data has been compiled within the department, we will certainly make it available.

Ms STEVENS: I would appreciate that and I would appreciate the minister's putting his good officers to work to try to perhaps provide some information to this parliament about what they assess the level of unmet need for disability services in this state to be.

The Hon. R.D. LAWSON: If the member was really interested in it, I would have expected her to put a question on the *Notice Paper* in the last couple of years.

Ms STEVENS: If you were really interested I would have expected you to have the answer today in estimates coming out of the state budget.

The Hon. R.D. LAWSON: Ask me any time: put the question on notice and you will get the answer.

Ms STEVENS: I am asking now and would appreciate a reply. I now move to the ageing portfolio. I notice that you have talked about an additional $2.7 million of state funding for HACC. Does the $2.7 million that the state government has committed match the commonwealth offer or is it different from that and, if so, could you explain?

The Hon. R.D. LAWSON: We have matched the commonwealth offer over the past few years since we introduced the 10 year plan. Since the HACC agreement has been enforced in South Australia we are the only government to have consistently matched the commonwealth contribution on HACC.

Ms STEVENS: And that was good.

The Hon. R.D. LAWSON: Thank you.

Ms STEVENS: Can you give us some information on the review of domiciliary care services? Can you give us an indication of where that review is at? I am not sure whether it is finalised yet. Perhaps you can tell us when it will be finalised.

The Hon. R.D. LAWSON: There have been a number of reviews over the years of domiciliary care services in South Australia, but notwithstanding those reviews it is fair to say that not a great deal has happened in relation to the four metropolitan domiciliary care services. A couple of them grew out of hospital services. The Royal Adelaide had the eastern domiciliary care service; northern and western came out of the Lyell McEwin and Queen Elizabeth Hospitals. Southern domiciliary care is a separate stand alone organisation, although it has been closely tied to Flinders over the years. This review was undertaken by Mr Jeff Fiebig, previously Director of the Office for the Ageing. It was a comprehensive review that required a good deal of cooperation across the department.

Mr Fiebig proposed—and the executive of the Department of Human Services agreed—that there should be a single client assessment system and information service for the whole of metropolitan Adelaide. It proposed the development of a universal client assessment tool and a classification structure and it also proposed changes to the organisational or governance arrangements relating to the metropolitan domiciliary care services. It seems that the first thing we have to do in order to improve those services and introduce single client assessment and any improvements of that kind is to have a single system of governance in which all people in the metropolitan area receive the same sort of priority and services, the same standards being set.

Country domiciliary care services are mainly based upon regional hospitals and domiciliary care tends to work extremely well in country areas but not so well or so uniformly across the whole metropolitan area. An implementation process is still being developed and a senior executive, Mr David Meldrum, has been appointed to manage the implementation of the review. This is a complex review: $45 million is spent in all domiciliary care services across the state each year. There are a large number of employees and clients, so it is a big and complex service.

Ms STEVENS: In relation to domiciliary care fees, last year, as I am sure you would remember, domiciliary care fees were introduced. I have a number of questions in relation to that: what is the total number of fees collected; what was the total cost of collection of those fees; and what has happened to the dollars collected in fees?

The Hon. R.D. LAWSON: Can I answer the last question first? All the net fees collected through domiciliary care services have been returned to the service collecting the fees so that the services can be expanded. The imposition of fees I prefer to call client contributions because these fees, by no means, represent full cost recovery. The maximum, as you will know, for a pensioner is $5 per week for all services, irrespective of the number of services, and the average cost of most services is about $35. So this is a modest client contribution to the fees.

It was relatively complex and I am told there were quite expensive set-up costs. I think that the original estimate was $800 000 in the first year and I think it will be almost that, but not quite that, on the figures that I have seen to date. There are administration costs which I think have been running at about 20 per cent, and I would expect those to be relatively high in the first year. It is actually being managed by the Southern Domiciliary Care Service.

Ms STEVENS: Have any of the other services needed to put on extra staff to handle the collection of fees?

The Hon. R.D. LAWSON: Not so far as I am aware, because the Southern Domiciliary Care Service is doing all the collection for all the services in the metropolitan area. There is a different arrangement in the country.

Ms Stevens interjecting:

The Hon. R.D. LAWSON: I might pass that on to Roxanne Ramsey, the executive director of country and disability services.

Ms RAMSEY: Different regions are doing it in different ways. It may be best if we get the answer to you against each region. Eyre region, for example, has a different mechanism to the Hills, the mallee and the southern regions.

Ms STEVENS: I am sorry, but I was a little distracted and I missed what you said about the total collected.

The Hon. R.D. LAWSON: The original estimate was $800 000 for the year. We have not yet had a full year of the costs. I am advised that we are under estimates for that $800 000.

Ms STEVENS: You do not know by how much?

The Hon. R.D. LAWSON: I do not know precisely. I will get that figure for you. In fairness, I think it is better to wait until the service has been in place for one complete year because, as I say, there were extensive set-up costs in the first few months.

A large number of applications have been made—some 6 000 or 7 000—for fee waivers for people who spend $76 a month, I think the figure is, on other medical and health needs, and practically all the applications with fee waivers have been granted. Although 6 000 or 7 000 might sound a lot, there are many clients across domiciliary care.

Ms STEVENS: My next question relates to a letter that has been written by Nicholas Pashalis in relation to HACC funding. I will put the letter on the record. The name of the project was Home Support Services Expansion and the sum sought was $89 150. I have a letter which says that this organisation was not eligible. It has written to the Hon. Mike Rann in relation to this matter stating:

> . . . our organisation has been providing domestic help, home help, social support and transport to over 60 elderly and severely disabled people of Greek origin. The service is based on a volunteer squad of 13-15 Greek pensioners who offer their services for a small reimbursement of their petrol. The program started in 1988 with a small one-off government grant of $40 000 for two years ending on 30 June 2000.

The organisation had been encouraged to apply for a new grant according to the real needs of the Greek community. It says that the application was bluntly rejected on the grounds of limited funds. Further negotiation with the department produced a $15 000 grant and apologies from the minister's office. The letter further states:

> Again we had been encouraged to apply for a recurrent funding taking in consideration the real needs of the Greek community. The fate of the new application was the same as previously. Blunt rejections on the grounds of limited funds. Yet we repeatedly have been assured from the minister's office and the OFTA that this time $5 million more funds will be available for the current funding round.

The organisation asked the Leader of the Opposition to put in a word for them in relation to their submission. Would the minister comment on what I have just said in relation to that organisation and its unsuccessful application?

The Hon. R.D. LAWSON: Can I first say that this organisation's application was not bluntly rejected. A committee of commonwealth and state officers and other people assess all HACC applications. This organisation was in receipt of recurrent funding of $2 900 a year, I am told. Last year it received a $15 000 one-off grant from HACC. This year it again applied and it was not recommended for funding, and I do not know the precise reasons given by the committee in its recommendation. I will certainly provide the honourable member with that information. A number of ethnic aged-care services receive extensive funding from HACC. The Greek Welfare Centre, the Greek Orthodox Community of South Australia, Multicultural Aged Care, ANFE, CIC, the Jewish Community Services and Ethnic Link have received funding this year.

There are, however, some additional funds that will become available through HACC by reason of unspent funds from organisations that do not seek to continue, and I am looking to the allocation of those funds within the next couple of weeks. It is very possible that the Greek pensioners, because they were unsuccessful, may be successful in receiving some of those funds. I say nothing about the particular level or type of services offered by the organisation. We already provide over $81 million through the HACC program, and had we had enough funds in HACC I am sure we would have liked to support practically every application.

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

ADJOURNMENT

At 9.33 p.m. the committee adjourned until Wednesday 27 June at 11 a.m.