HOUSE OF ASSEMBLY

Friday 29 June 2007

ESTIMATES COMMITTEE B

Acting Chair:
Mr J.R. Rau

Members:
Ms F.E. Bedford
Ms V.A. Chapman
Ms C.C. Fox
The Hon. G.M. Gunn
The Hon. R.G. Kerin
Ms L.A. Simmons

The Committee met at 11 a.m.

Department of Health, $1 825 482 000

Witness:
The Hon. J.D. Hill, Minister for Health, Minister for the Southern Suburbs, Minister Assisting the Premier in the Arts.

Departmental Advisers:
Dr T. Sherbon, Chief Executive, Department of Health.
Ms N. Dantalis, Executive Director, Office of the Chief Executive, Department of Health.
Mr C. Bernardi, Deputy Director, Financial Services, Department of Health.
Mr D. Exton, Director, Asset Services, Department of Health.

The ACTING CHAIR: Welcome to what has become known as the 'friendly committee', Committee B, where everyone is nice to everybody. The estimates committees are a relatively informal procedure and, as such, there is no need to stand to ask or answer questions. The committee will determine an appropriate time for consideration of proposed payments to facilitate the change over of departmental advisers. I ask the minister and the lead speaker for the opposition to indicate whether they have agreed on a timetable for today's proceedings and, if so, to provide the chair with a copy. Is there any broad agreement?

The Hon. J.D. HILL: I understand so.

The ACTING CHAIR: Changes to committee membership will be notified as they occur. Members should ensure that the chair is provided with a completed request to be discharged form. If the minister undertakes to supply information at a later date, it must be submitted to the committee secretary by no later than Friday 7 September.

I propose to allow both the minister and the lead speaker for the opposition to make opening statements of about 10 minutes each. There will be a flexible approach to giving the call for asking questions, based on about three questions per member, alternating each side, subject to agreement to the contrary. Supplementary questions will be the exception rather than the rule. A member who is not a member of the committee may at the discretion of the chair ask a question. Questions must be based on lines of expenditure in the budget papers and must be identifiable or referenced. Members unable to complete their questions during the proceedings may submit them as questions on notice for inclusion in the House of Assembly *Notice Paper*.

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

I declare the proposed payment open for examination and refer members to the Budget Statement, in particular pages 2.16 to 2.18 and Appendix C, and the Portfolio Statement Volume 2, pages 7.1 to 7.53. Does the minister wish to make a statement?

The Hon. J.D. HILL: Yes, Mr Chair. The 2007-08 budget represents a new direction for South Australian health care. The Rann government has unveiled reforms for a future health care system which is cost effective, sustainable and which delivers world class medical services to South Australians. In other words, a safe affordable and complete health care system. We are now preparing for the future demands of an ageing population, an ageing health workforce and an expected rise in the incidence of chronic disease. Solutions to these challenges are outlined in South Australia's Health Care Plan, which the Premier, the Treasurer and I released on 6 June 2007. The SA Health Care Plan is a detailed system-wide strategy. The SA Health Care Plan includes the most significant, single capital investment ever made in health care in South Australia.

In the 2007-08 budget, an additional $2.1 billion over 10 years has been committed to capital works projects to build modern facilities and place them in areas of most need, as outlined in the plan. To anticipate future demands and keep patients out of acute and emergency care where possible, the SA Health Care Plan introduces a stepped care approach to health service delivery. The stepped care involves five tiers of service delivery, as follows:

1. Information and support for families, individuals and communities to take responsibility for their own well-being, particularly addressing obesity and physical fitness.

2. Better integration and support in the community across GPs, private practitioners, non-government organisations, the commonwealth and the community sector to assist patients, particularly those with chronic health conditions.

3. Better primary health care resources close to where people live, such as the out of hours GP Plus Health Care Centres.

4. General hospitals which focus on elective surgery, aged care, palliative care and rehabilitation, as well as general medical services and general surgery. There will be four general hospitals in Adelaide: Modbury, Noarlunga, the Queen Elizabeth and the Repatriation General Hospital; and four general hospitals in the country at Port Lincoln, Whyalla, Berri and Mount Gambier. In addition, the Port Augusta Hospital will expand its focus as a centre for Aboriginal and Torres Strait Islander health.

5. Three major hospitals in Adelaide providing acute and specialist care: one in the north, one in the centre and one in the south. These hospitals are the Lyell McEwin Hospital, the Flinders Medical Centre, and the new Marjorie Jackson-

Nelson hospital in the Adelaide CBD. The Women's and Children's Hospital will continue to be the main provider of maternity and paediatric health care to the parents and children of South Australia, and it will develop closer links with the other major and general hospitals.

Clinical networks will provide leadership and strategic planning for health services and involve health professionals in areas including workforce planning and clinical standards. The SA Health Care Plan has carefully mapped the current and future needs of our local communities. For country people, this means delivering complex health services closer to where they live, and this will reduce the number of visits patients make to Adelaide hospitals.

The centrepiece of the SA Health Care Plan is the planned construction of our new hospital to be named in honour of the former governor, Marjorie Jackson-Nelson. The $1.7 billion hospital will be a centre of excellence for medical experts in South Australia and will attract experts from right around the world. The hospital, which merges the Royal Adelaide Hospital and some specialist Queen Elizabeth Hospital services, will offer world-class best practice medical services to all South Australians. The specific design of the hospital will involve input from staff at the Royal Adelaide Hospital, the Queen Elizabeth Hospital and the clinical networks and will take into account safety and quality issues, as well as patient care and comfort.

A new state-of-the-art hospital is needed because parts of the Royal Adelaide Hospital are now over 100 years old. Many of the current hospital's facilities do not match the expectations health professionals and patients have for modern-day medicine. Despite recent capital upgrades, the original design of the site hampers growth to meet future health care needs and does not meet current earthquake standards. Redeveloping the Royal Adelaide Hospital would take 15 years at least and would cost about $1.4 billion. However, more importantly, a new building minimises disruption to staff, avoids compromises to patient care and, in the longer term, will be cheaper to run.

The new and upgraded hospitals and changes to the roles of hospitals are a pivotal part of the reform of our health care services. However, another key element is better primary health care. The GP Plus health care strategy has been created to offer out-of-hours health care services closer to where people live and as an alternative to patients calling on hospital emergency services. The GP Plus health care centres also provide a back-up to general practice doctors to care for people with chronic diseases. Each centre offers services most appropriate for the population in that area and takes into account the services already provided at community health care centres. The GP Plus health care centre model is one that can be easily adopted and adapted in country communities. Many country community hospitals and health units already have a very strong primary health care focus. Port Pirie will have the first GP Plus health care centre in country South Australia, while the Ceduna health service redevelopment will also include a GP Plus health care centre.

In addition to South Australia's health care plan, this budget also represents a huge increase in recurrent health spending. Over the next four years, net health spending will increase by $523 million. Included in this is $250 million to manage increased hospital activity levels. This will allow for an extra 60 000 people to be admitted to hospital over the next four years. This is on top of an increase in spending of $640 million over four years that was contained in last year's budget.

In 2007-08, $3 billion will be spent on public hospital and health services. This means that an extra $1.1 billion will be spent on public health services compared with the last year of the previous government's term. The total operating expenditure budget for the health portfolio in 2007-08 is $3.366 billion, which represents an increase of $309 million or 10 per cent compared with the 2006-07 budget.

In closing, I am confident that the SA Health Care Plan will not only meet the state's future health care needs but create community assets that will make staff and patients proud. As I said earlier, the budget commits an additional $2.1 billion over 10 years for future capital works projects to support the SA Health Care Plan. This money will cover $1.677 billion for the new Marjorie Jackson-Nelson hospital; $215 million for IT upgrades and infrastructure, including the replacement of the nursing administration system; $202 million for the Lyell McEwin stage C redevelopment; and $51.5 million for country health, including the Ceduna Hospital redevelopment and the Port Pirie GP Plus health care centre.

For 2007-08, $181.4 million has been allocated under the capital program. This includes $52.8 million to continue redevelopment works in metropolitan hospitals which will complement the health care strategy which includes $22 million for the QEH stage 2; $21.3 million for the Lyell McEwin Hospital stage B; and $9.5 million for the Flinders Medical Centre redevelopment; $25 million to replace and upgrade medical equipment; $15.5 million for GP Plus health care centres, including $9.5 million at Marion and $6 million at Elizabeth; $7.3 million to replace and upgrade ambulance stations, including $2.3 million for projects in rural areas and $5 million towards the stations, including Prospect, Adelaide and McLaren Vale.

For South Australians, the results of this visionary health care plan are: Australia's most integrated, and efficient health system; Australia's most comprehensive primary health care system; the most advanced hospital practice in Australia; improved emergency department waiting times; more timely delivery of elective surgery; more health services closer to home; improved staff recruitment and retention; and a new era in cooperation and leadership among clinicians.

In conclusion, I take this opportunity to thank and praise the doctors, nurses and allied health care workers and others who work in our hospitals. We know they are very busy at the moment, and we appreciate the great effort they put in on a daily basis in our hospital system. I also thank and praise Department of Health staff and those who work in the regions who run our system and who have been responsible for the development of the health care plan. I also thank the staff who work in my office for their dedication and assistance to me all of the time.

The ACTING CHAIR: Does the member for Bragg wish to make an opening statement?

Ms CHAPMAN: No, Mr Acting Chairman, but I do have eight what is commonly known as omnibus questions, as follows:

1. Will the minister provide a detailed background of the baseline data that was provided to the Shared Services Reform Office by each department or agency reporting to the minister, including the current total cost of the provision of payroll, finance, human resources, procurement records management, and information technology services in each department or agency reporting to the minister, as well as the full-time equivalent staffing numbers involved?

2. Will the minister provide a detailed breakdown of expenditure on consultants and contractors in 2006-07 for all departments and agencies reporting to the minister, listing the name of the consultant, contractor, cost, work undertaken, and method of appointment?

3. For each department or agency reporting to the minister, how many surplus employees are there at 30 June 2007? For each surplus employee, what is the title or classification of the employee and the total employment cost of the employee?

4. In the financial year 2005-06, for all departments and agencies reporting to the minister, what underspending on projects and programs was not approved by cabinet for carryover expenditure in 2006-07?

5. For all departments and agencies reporting to the minister, what is the estimated or actual level of the under-expenditure for 2006-07? Has cabinet already approved any carryover expenditure into 2007-08; if so, how much?

6.1. What is the total number of employees with a total employment cost of $100 000 or more per employee and, as a subcategory, what is the total number of employees with a total employment cost of $200 000 or more per employee, for all departments and agencies reporting to the minister as at 30 June 2007?

6.2. Between 30 June 2006 and 30 June 2007, will the minister list job title and total employment costs for each position (with a total estimated cost of $100 000 or more) (a) which has been abolished and (b) which has been created?

7. For the years 2005-06 and 2006-07, will the minister provide a breakdown of expenditure on all grants administered by all departments and agencies reporting to the minister, listing the name of the grant recipient, the amount of the grant, the purpose of the grant and whether it was subject to a grant agreement, as required by Treasurer's Instruction No. 15?

8. For capital works projects listed in Budget Paper 5 that are the responsibility of the minister, list the total amount spent to date on each project.

The ACTING CHAIR: Is that the end of the omnibus questions?

Ms CHAPMAN: Correct.

The ACTING CHAIR: I assume that the minister will not answer all those immediately. Before I go any further, lest I be told off by the Speaker, I mention to our friends from the media that I have to draw to their attention the fact that they are supposed now to move with their cameras to the other end of the chamber. Member for Bragg, will you begin your non-omnibus questions.

Ms CHAPMAN: When Treasurer Foley announced in April last year that the May budget would be delayed to enable him to find 4 per cent savings across portfolios needed to improve and prepare South Australia's health system to meet future demand (subsequently, it was delivered in September 2006), had the minister had any discussions with the Premier about the proposed new Marjorie Jackson-Nelson hospital for $1.7 million or any other cost at that time?

The Hon. J.D. HILL: Can I clarify the question so that I am totally sure about it: you are asking me whether, prior to the last state budget, I had talked to the Premier about a potential new hospital.

Ms CHAPMAN: Prior to the announcement by Treasurer Foley in April 2006 that there would be a delay because of health pressures (and I have summarised that) in the health budget, had you had any discussions with the Premier? His announcement was made on 6 April 2006.

The Hon. J.D. HILL: To be honest, I cannot recall. I do not think at that stage there was any proposition to converse with the Premier about it, but I would not want to be categorical about that. The proposition on the hospital was brought to cabinet at a much later date than that. I believe that I had some preliminary discussions (but I think that is probably a bit early) about the need to reform the health system along the general lines we are now going. However, to the best of my knowledge, it was certainly not in any detail at that early stage.

Ms CHAPMAN: As a supplementary question, on what date was it first presented to cabinet for approval?

The Hon. J.D. HILL: I am not too sure of the relevance of this to the budget lines, Mr Acting Chairman, when cabinet considered issues. I spoke to cabinet on a number of occasions about the plans as they were being developed.

The ACTING CHAIR: Member for Bragg, I certainly do not want to break up your momentum or rhythm, but it would be helpful if things were kept tied in as much as possible to the budget papers. I think that the minister probably had a point in his last remark, although he did answer the question.

Ms CHAPMAN: I am not sure that he did answer the question but, nevertheless, I am happy to do that. I refer to Budget Paper 3, page 2.17. Of the $212.8 million that it is proposed you will start with as the preliminary cost over the next four years in respect of the new hospital on North Terrace, can you identify what that is actually for and, in particular, how much is to be spent and what has been spent on the television and radio advertising campaign to promote the hospital by you and the Premier—that is, the full-page advertisements in the daily newspapers; the production of the document, entitled South Australia's Health Care Plan; and the glossy brochures issued in daily newspapers, including the *Sunday Mail*? If all that cost has not been incorporated in your budget, whose budget allocation is it in?

The Hon. J.D. HILL: The $1.2 million, which is in the 2007-08 year, will enable finalisation of the project briefing completion and master planning and conceptual planning. My understanding is that, over the next couple of years, the majority of the works on the site will be site works, removing the railway track and the like. I think that most of that money is, in fact, in the budget of the transport minister, as the member would be aware. The railway reallocation will be 157; the new hospital, of course, is 1.677. In relation to the publicity—

Ms CHAPMAN: I have a point of order. I may not have been clear, minister, but I was asking not about the $157 million which is in transport: I was asking about the $212.8 million in your budget.

The Hon. J.D. HILL: I understand, yes. We are getting that for you and, while I get that, I will give you the answer to the other part of your question, which was about the advertising and promotional material. The Premier referred to the new hospital in his post-budget advertising; that was part of the Premier's normal budget advertisements and information and that would be contained within his budget. I have some budget to explain to the community and to let people know about the South Australian Health Care Plan. I make absolutely no apologies for doing that: I think it is important that people know what we are trying to do. It is a major change in the way we are delivering health care, and we really need to get the information out. It does not promote me: I do not appear in any of the television or press ads. It is just pure information and explanation about what is going on.

We have an allocation of $920 000 for the development of creative concepts, for the running of those concepts in the media, and other supporting information. Also, $370 000 has been made available for activities that are more by way of internal expenditure, including: health service planning; development of the activity projection model; hospital planning advice; architectural and urban planning advice; cost consultants; and development of the hospital model and other schematic pictures. I think that is the best I can give you in terms of how much we are spending, but we need to get the information out to people about how the health care plan will affect them. I will find out whether I have the other information that you require.

As I understand it, in relation to the money in the budget over the next few years, it will be planning and site preparation, but really detailed planning and that kind of thing. But, if I can give you any further information, I will certainly take that on notice and provide you with that additional information.

Ms CHAPMAN: Again at page 7.9, in announcing the new hospital to replace the Royal Adelaide Hospital and the state health plan with that, there is no identification on page 31 as to any maintenance or improvement to the Hampstead Rehabilitation Centre. In fact, it is a complete blank across the whole schedule. Will the minister rule out whether any part or all of that property will be sold alongside the government's announcement to sell the Ross Smith High School next door?

The Hon. J.D. HILL: I cannot answer about the education facilities. In regard to Hampstead, there will be normal maintenance that will be applied. We have no intention of closing down the centre. I would say there are many sites in South Australia that require development and Hampstead, I guess, would be one of those. I am talking about the hospital part of it, not the land. We just cannot do every bit of upgrading in every hospital in the state that requires it, and we just have to manage that over time. But the $2.1 billion we have in this budget I think shows a very deep and sincere commitment to upgrading our infrastructure.

There is a huge amount of open space at Hampstead which is not necessary for the delivery of health services, and at some stage government will have to turn its mind to what is the best use of that land. We have not done that at this stage, but it is certainly not needed, at least in the short term and the medium term, for health services. So it would be prudent, as part of any master planning that might occur in that district, to think about how that land would be used.

Ms CHAPMAN: I have a supplementary question. What is the value in the balance sheet of the assets of the health department on that site?

The Hon. J.D. HILL: I will have to take that on notice. I cannot tell you.

Ms SIMMONS: Staying on the same subject, page 34 of the portfolio statement states that the Marjorie Jackson-Nelson hospital announced by the government is planned to be the largest in the state at a cost of $1.68 billion to build. Can the minister explain what the new hospital will have to offer and how South Australians will benefit from its construction?

The Hon. J.D. HILL: I thank the member for that question. As I said in my opening remarks, the new hospital will bring together two hospitals, or at least part of one hospital and another hospital. It is not just a rebuilding of one hospital, and I think that point needs to be made. The hospital will be South Australia's major state-of-the-art adult hospital, providing services for its local area but also, importantly, state-wide services for people with complex illnesses. In fact, all of the state-wide services for which there is only one deliverer, as I understand it, will be run through that hospital.

It will have links with the university sector for teaching and research and will provide services in conjunction with general practitioners as part of the continuum of health care. It will be the largest hospital in South Australia. It will care for in excess of 80 000 inpatients each year. It will be designed to include the latest medical technology and will have 800 beds, an ambulatory care centre, operating theatre suite, and all clinical and non-clinical support services necessary for the provision of high quality and safe patient care.

The new hospital will provide a modern working environment for staff that will help South Australia attract and maintain medical professions—and that is one of the key and most important aspects of this new hospital, I think, attracting people into our state. The hospital cost, as we know, will be just under $1.7 billion, and it will be completed by 2016. Being a more efficient hospital, we expect that the new hospital's running costs will be $50 million less per annum (and I think that is a fairly conservative figure) than the Royal Adelaide Hospital.

As I have already explained to the parliament, independently verified costings have shown that the redevelopment of the RAH site would have cost about $1.4 billion and taken at least 15 years and would have, of course, resulted in continued disruption over that time. The Marjorie Jackson-Nelson hospital will be designed to exceed current environmental standards and will be the greenest hospital in Australia.

We estimate that the new hospital will be 45 per cent more energy efficient and 33 per cent more water efficient than the RAH. Up to 90 per cent of the waste product produced from the construction of the new hospital will be recycled, and we estimate that at least 15 per cent of the energy will be from renewable resources, including the possibilities of wind, solar and co-generation.

The new hospital will produce about half the greenhouse emissions of the Royal Adelaide Hospital, which will save 24 000 tonnes of greenhouse gas emissions every year. It will be attractive to the retention of staff, and its parkland setting will provide a healing environment for all who use the facility. I am keen to see us work with the Botanic Gardens around there to develop some sort of healing garden, perhaps using Aboriginal plantings to facilitate that kind of ethic. It will also increase access to the River Torrens.

It will be located at the current railyard in the Adelaide CBD, linking with a major transport hub of road, rail and tram. This will make access to the hospital easy for all people travelling from the central, western, northern and southern suburbs and all country regions. Preliminary planning has been undertaken this year and $1.2 million has been allocated in 2007-08 to finalise a project brief and complete the master planning and conceptual planning. A clinical consultation steering group will be appointed to oversee the consultations that need to happen with clinicians to achieve the best detail plan for the hospital.

Ms SIMMONS: Following on in the same vein of capital works, I refer to pages 7.12 and 7.13 of the Portfolio Statement and pages 34 to 38 in the Capital Investment Statement. The Portfolio and Capital Investment Statements list redevelopment of hospitals that are planned or currently underway. Can the minister detail what capital works

upgrades are planned as part of the budget and how they relate to South Australia's health care plan?

The Hon. J.D. HILL: An amount of $2.9 billion has been committed by the government for health-related capital works since 2002, and this includes the $2.1 billion package of capital works projects as part of the South Australian Health Care Plan. The Marjorie Jackson-Nelson hospital, the Flinders Medical Centre and the Lyell McEwin Hospital will become South Australia's three major adult hospitals, with capital investment and service changes. These hospitals will form the backbone of the state's high level critical and complex hospital services. Flinders and the Lyell McEwin will be upgraded and expanded to meet the needs of our fast growing southern and northern suburbs.

The Health Care Plan commits to the $200 million stage C redevelopment of Lyell McEwin, giving the hospital extra capacity and high complexity services. The government already announced a $145 million redevelopment of the Flinders Medical Centre, and as part of South Australia's health care plan an additional $7 million has been budgeted for more bed capacity. These three hospitals will provide a full range of major complex surgical, diagnostic and support services for the south, the north and the central suburbs and be the referral hospitals for all other hospitals and health facilities. Improved links and greater collaboration between health services will occur to benefit patients and their carers. At the moment, Lyell McEwin Hospital provides less than 50 per cent of hospital services for the local community. With its expansion the number will increase, meaning more people will be able to be treated locally. That is important because that is where the growth is around that area.

There will be three general hospitals in metropolitan Adelaide: the QEH, Modbury and Noarlunga. These hospitals will provide services to their local communities, with an emphasis on general medicine and general surgery but with a specific focus on rehabilitation, aged care and palliative care services. The Queen Elizabeth and Modbury Hospitals will also become high volume elective surgery sites, with the aim of people getting their surgery in a more timely way and reducing the chance of surgery being cancelled when there is peak demand in emergency departments. The QEH stage 2 redevelopment is continuing, and the government is committed to an additional $12 million infrastructure upgrade at Modbury.

Noarlunga Hospital will undergo a $30 million redevelopment to provide for more capacity for the growing southern region. The 2006-07 capital works program is $118.1 million, and construction works will proceed for the $43.5 million Lyell McEwin Health Service redevelopment, stage B, the $120 million stage 2 redevelopment of the QEH, with completion of the inpatient building, childcare centre and a multi-level car park. Planning has commenced for new capital works, including the $145 million Flinders Medical Centre redevelopment, the $3.8 million radiation therapy facility at Lyell McEwin, and $5.56 million towards improving care for older patients in public hospitals.

In 2007-08, $181.4 million is being invested, including $22 million for the QEH stage 2, $21.3 million for the Lyell McEwin stage B, $9.5 million for Flinders, $1.2 million associated with the Marjorie Jackson-Nelson, $3.8 million for the Lyell McEwin stage C redevelopment to provide new inpatient accommodation expansion of support facilities to meet increased demand—a total project cost of $201.7 million. An amount of $790 000 will go to refurbishing existing wards at the Royal Adelaide Hospital to increase ward capacity after completion of the Marjorie Jackson-Nelson hospital—a total project cost of $15 million.

Ms SIMMONS: I refer to the Portfolio Statement at page 7.9. The implementation of practice nurses within general practice will be a key initiative within the GP Plus health care strategy. What role do these nurses have and how does this initiative contribute to improving health care?

The Hon. J.D. HILL: The government is providing $7.9 million over four years for the GP Plus practice nurse initiative. It commenced on 1 January 2007 as a key health reform initiative for local GPs and state-funded health services to collaborate and respond to the needs of the local population. This was a suggestion made to me by the AMA, and it was an outstanding suggestion which we were very pleased to pick up, because it is now delivering great benefits to our community. The initiative aims to reduce workforce pressure on general practice in the outer northern and southern suburbs.

Practice nurses are registered or enrolled nurses employed by general practices to provide general nursing services. The role of the practice nurse compliments that of the GP by providing a variety of services, ranging from clinical care and service coordination to health screening, health promotion and education for individuals and the community. Practice nurses recruited to this initiative are placed in general practices to demonstrate the benefits to the GP of employing their own nurse at the completion of the trial period. The initiative will result in up to 50 practice nurses per year being employed across the Adelaide metropolitan area. From 1 January this year until now a total of 39 practice nurses have been employed within the program.

In addition, seven of the practices that have received a practice nurse through this initiative are in the process of employing nurses in their practice. Some 22 of these are in the Central Northern Adelaide Health Service region and 17 are in the Southern Adelaide Health Service region. Five practice nurses from the SAHS program have already been employed by general practice following their placement. The first full year of operation for this initiative will be 2007-08, and $2.1 million will be provided to increase the recruitment and placement of practice nurses within the initiative.

Ms CHAPMAN: I refer to Budget Paper 4, Volume 2, page 7.9. appendix 2, page 30 and, in particular, page 31. With respect to St Margaret's Rehabilitation Centre, the government's health plan (appendix 2, page 30 and, in particular, page 31), under the heading 'Service movements and capital developments', refers to a transfer of services to the Queen Elizabeth Hospital: 'site used for alternative service'. That service currently accommodates 38 rehabilitation patients. How long can they expect to stay there, and what is the proposal of the government in relation to the sale of whole or part of this site, or what are the services proposed?

The Hon. J.D. HILL: The government has made no decisions in relation to transferring beds out of that site. It is interesting that, when you announce a new plan and provide leadership (and you are criticised for whatever you do), you are attacked for not consulting. When you identify a potential option and say, 'Let's think about it,' and, in fact, effectively offer consultation, you are attacked because you are not being clear about what you are trying to do. The reality is that our Health Care Plan was worked on in great detail. It provides for a sustainable future of health care in South Australia.

We have a number of facilities, of which St Margaret's is one, which are providing a very good service to a range of

people. I have certainly visited St Margaret's. However, it is a relatively old site (it was not purpose-built), and there is the potential in the longer term for those beds to transfer to the QEH. We are being open and transparent about that, but no decision has been made. If any decision were to be contemplated in the future (and it is certainly not on my radar at the moment), we would consult with those people, and the outcome would be an improvement in service delivery for them. You do things like this only if you can improve the outcomes, and that would be the basis on which to do it.

An alternative service could include a range of things. An aged care facility would be one option; rehabilitation beds for people coming out of surgery might be another option. There is a whole range of things. However, we have not made any decision, despite the purple prose in the deputy leader's press release today about this. Before we do, we would certainly talk to the people there.

Ms CHAPMAN: I have a supplementary question. What is the value of this asset at Military Road, Semaphore, in the budget balance sheet?

The Hon. J.D. HILL: I certainly do not have that information on me. I am happy to obtain it. All our sites would be valued from time to time.

Ms CHAPMAN: According to the budget papers, they have just been revalued. I am happy for the minister to take that question on notice. I refer to page 7.13. Redevelopment stage 2 of the Queen Elizabeth Hospital includes a new research centre. When a clinician asked someone from the minister's department at a 6 June briefing what would happen to this property if the researchers elected to go to the new hospital in 2016, the answer given was, 'It would be sold'. Can the minister confirm this?

The Hon. J.D. HILL: I can confirm that we are building a research centre on the site. I can also confirm that, if there were no researchers in it, the logical thing to do would be to sell it. What I cannot confirm is that it would be sold. I can confirm that I am in discussions with the foundation at the QEH about its interest in that site. These are things, once again, with respect to which there will be consultation. Every time there is uncertainty, you are accused of creating fear and panic, and when there is certainty you are accused of not consulting. You just have to live with those ambiguities in life, I guess.

I can provide some information to an earlier question that the member asked about the $212 million for the Marjorie Jackson-Nelson hospital. In 2007-08, the money will be spent on site investigation, detailed service planning, development of the detailed brief, resolution of the procurement approach and development approval. In 2009, documentation for tender, start of site clearance, railway ceasing operation by December 2009, some of the site clearance budgeted with DTI and some with DH (the site contamination issues, for example, with the Department of Health, I understand). In 2010, decontamination of the site and commencement of construction.

Ms CHAPMAN: I have a supplementary question on the research centre at the Queen Elizabeth Hospital, about which the minister is going to consult and consider (again, I am happy for this to be taken on notice). What is the value of that site in the balance sheet at present?

The Hon. J.D. HILL: The construction cost for that is about $7 million. We are out to tender at the moment. I understand it is a separate title, so we should be able to obtain that site cost.

Ms CHAPMAN: Modbury Hospital comes under the supervision of the government as of Monday 1 July. Is the minister aware that 50 nurses from the Modbury Hospital have contacted a nurses agency in South Australia to inquire about a transfer of employment to it as an agency nurse. Their claims are that they do not have a contract, they do not know where they are going to go to work on Monday, and they do not even know what uniform they will wear. Can the minister provide some information in relation to the 426 nurses who are employed by Healthscope—at least, as at the time he answered the question in May this year?

The Hon. J.D. HILL: I am not sure from where the member received the advice about the number of people contacting private agencies, because individual nurses would make individual decisions. Who would know that I am not sure.

Ms CHAPMAN: The agency.

The Hon. J.D. HILL: What the agency says and what is actually happening might be two different things. I can advise the member that, from 1 July, all but 10 of the current staff, including the nurses, at the site will continue working for the Department of Health or the Central Northern area.

Ms CHAPMAN: I have a supplementary question: have the 10 who are not continuing been identified by your department as not being necessary, or have they elected to leave that employment—that is, not take up the government's contract?

The Hon. J.D. HILL: A number have elected not to come over. I am not sure what their reasons are: they may wish to retire, they may wish to stay with Healthscope, or they may wish to do something else. That is obviously their choice. A couple of managers, I think, were the only ones that we elected not to have because they were not required. They were Healthscope managers, not departmental managers.

Ms FOX: I refer to the Portfolio Statement, page 7.24. The Portfolio Statement provides performance data in relation to elective surgery—for example, the Central Northern Adelaide Health Service performance data on page 7.24. South Australia's Health Care Plan details a new direction for the management of elective surgery within this state. What is the government doing to streamline the provision of elective surgery?

The Hon. J.D. HILL: I thank the member for her question. It is an apposite question, given the report that was published in *The Advertiser* today. South Australia's Health Care Plan aims to streamline elective surgery and achieve the long-term goal of reducing demand on our emergency departments by designating some of our state's hospitals to be specialist elective surgery sites.

The capacity for surgery will be increased by creating high volume elective surgery sites at the Queen Elizabeth and Modbury Hospitals. These general hospitals will specialise in the areas of orthopaedics, gastro-intestinal endoscopy, general surgery, ear, nose and throat, ophthalmology and urology. The three major hospitals (the Marjorie Jackson-Nelson, Flinders and Lyell McEwin) will provide specialist care for all South Australians. They will form the backbone of the state's high-level, critical and complex hospital services, and will provide a full range of major complex surgical, diagnostic and support services. Noarlunga and the four country general hospitals will be enhanced to provide more general surgical procedures closer to where people live. The Repatriation Hospital will also increase its services in orthopaedic surgery. I think I told the house last week that we believe that we will be able to operate those hospitals with 20

per cent more elective surgical procedures in the QEH and Modbury.

Members will recall that in the last budget the government boosted its elective surgery strategy with an additional $38 million over four years. That strategy will continue within the Health Care Plan's framework, with the aim of ensuring that people needing surgery in the public health system receive their surgery within clinically acceptable waiting times. Other initiatives under elective surgery include implementation of the Checklist computer software package at metro hospitals to improve the scheduling of surgery and management of waiting lists.

This will allow for better planning of surgical activity; development of guidelines that will clarify the types of surgery (such as surgery for purely cosmetic purposes which will not be supported in the public hospital system); identifying country residents on metropolitan waiting lists who can be provided with their surgery locally; and providing funding to health services regions for the implementation of local initiatives to improve the management of regional waiting lists. These include the introduction of the role of elective surgery managers; increasing post-acute discharge packages; implementation of a new model of care, including a day rehabilitation program; and support for an ophthalmology network in the north.

As we know, demand for elective surgery continues at very high levels. The strategy was allocated $12.9 million in 2006-07 to fund additional activity and continue the initiatives to improve the management of surgical waiting lists. Hospitals are on track to achieve the target of 37 500 procedures for this financial year; that is 1 362 more procedures than performed in the previous year and it is also 2 358 more than the number of operations performed in the last year of the previous government. During April 2007 improvements were seen in the timeliness of semi-urgent and non-urgent patients with 78.8 per cent of semi-urgent patients being seen within the clinically acceptable time frame of 90 days (compared with 67.5 per cent during March). In the non-urgent patient category, 90.5 per cent were seen within the clinically acceptable time frame of 12 months (compared with 87.7 per cent during March).

There was a slight decrease in the timeliness of category 1 patients (going down from 77.2 to 74.8 per cent) which was due, of course, to treating overdue category 2 and 3 patients. However, the important thing to note is that 96 per cent of all elective surgery operations are given within 12 months, and that is above the national average. For 2007-08, $13.6 million has been allocated for the elective surgery strategy to increase the amount of elective surgery performed in metro public hospitals to a target of 38 000 procedures and to continue working on strategies to assist hospitals to improve their waiting time performance. Elective surgery strategy funding for reform initiatives will target strategies to improve scheduling practices and better management of elective surgery booking lists.

As I think I told the house a little while ago, we will be putting information online in the near future so that patients and their doctors can judge how long they have to wait at particular hospitals. Those who are able to move around will be able to pick and choose the hospital which is able to provide the surgery with the least waiting time. I hope, in the future, when we are able to provide more surgical procedures in the country, that in some areas there will be very short waits for surgery. There may well be people from Adelaide who will go to rural settings to have their surgery done—a sort of medical tourism, if you like, which I know is operating in some countries at the moment. That will obviously be the patient's choice but, for some procedures, that would be an option for some people.

Ms FOX: Thank you, minister, for that very thorough answer. My next question refers to Portfolio Statement, page 7.9, where GP Plus centres are mentioned as being an integral part of the government's Health Clare Plan. What is the government's plan for these centres?

The Hon. J.D. HILL: I thank the member for Bright for her question. Over the next 10 years the health care system will increasingly focus on primary health care as well as care received in hospitals. I was interested to note that the federal Leader of the Opposition today came out and made the point that that is what is needed. He made the point in reference to the economic—

Ms Chapman: What did he say about the new hospital?

The Hon. J.D. HILL: He made the point in relation to the economic development of our state. I am not sure what that rather idiotic remark by the deputy leader meant, but he was certainly talking about primary health care today. That was obviously a key recommendation of the Generational Health Review. This change reflects the changing health care needs of the South Australian population and the need to consolidate services to ensure maintenance of a high quality, cost effective health care system. Primary health care is about helping South Australians to stay healthy and lead healthier lives, and about keeping them out of hospital.

General practice has always been the focus of health care within communities, and this will continue to be the case. To complement the services offered by general practice, GP Plus Health Care centres will help individuals to take control of their health care, stay healthy and stay out of hospital. These centres will be the foundation of increased support to manage chronic disease, provision of support for more in-home care and help for those who want to stay healthy. Up to 10 GP Plus Health Care centres are being planned across Adelaide. The first metro GP Plus Health Care centre has opened at Aldinga, a second centre is not officially opened but is operating at Woodville, and planning has started on two larger centres at Elizabeth and Marion.

The services offered at each of these centres will be designed to meet the needs of their local communities. The services will work closely with general practitioners, and that is absolutely key to it. We do not want to establish primary health care centres that see themselves as being in competition with general practitioners in the community. I think perhaps a bit of that occurred in the past. We want to work with GPs to provide a broad range of additional health care services, and that might include (I think it always would include) chronic disease management programs; after-hours GP services (that is certainly what is happening at Aldinga); nursing and midwifery services; minor medical procedures (that is really important; if we can do things in the GP Plus Health Care centre rather than in a hospital it takes pressure off the hospital and gets people treated more quickly); and allied health, particularly in podiatry, dental, physiotherapy and occupational therapy. Health care services will be available for extended hours each day through the GP Plus Health Care centres and, with a focus on avoiding hospital visits or stays, they will play an important role in early intervention and prevention.

In the rural and remote areas some hospitals already function in that way. In fact, earlier this week I visited the Port Pirie Hospital, which is really pleased about the Port

Pirie GP Plus Health Care centre, and they and the local doctors were telling me how they already work closely together to deliver those kinds of services. So this is an example where the city is learning from country practice. They also provide emergency treatment, acute inpatient services and GP services in country settings. As I have mentioned, we are also building GP Plus Health Care centres at Port Pirie and Ceduna.

Ms FOX: Page 34 of the Capital Investment Statement shows that the Ceduna Health Service will be redeveloped. Will the minister please outline the capital infrastructure upgrades the government has budgeted for country hospitals?

The Hon. J.D. HILL: Before I do, I will make a correction to a statement I made in answer to a question asked by the deputy leader. I am advised that, of the 433 nurses who were asked to express interest in working at Modbury, 17 declined, leaving 416 nurses. Of these, 12 have not yet responded. I am told that these are likely to be casual nurses who have not worked there for some time, but they have certainly been offered a job, and only one nurse has declined an offer.

In answer to the question from the member for Bright, as part of SA's health care plan, the government has committed over $100 million to country health care services in the future. The largest of these projects is a major redevelopment of the Ceduna Health Service, which has been budgeted at $36 million. This redevelopment will provide an integrated facility involving GP Plus Health Care services, overnight stay and same-day hospital services and aged care accommodation. Upgrading the Ceduna Hospital is the government's top country health priority, as there are fundamental operational and physical constraints with the current building. These issues are contributing to constraining the efficient operation of the unit and desired improvements to the quality of patient care. The redeveloped facility will result in higher quality and better coordinated services, more efficient and effective primary health services, an increase in the provision of day surgery procedures, and culturally appropriate physical facilities from which to deliver services to the local Aboriginal population. In 2007-08 a project team will be engaged to develop the project concept in detail.

Elsewhere in the country, the government has announced a $12.5 million GP Plus Health Care centre at Port Pirie. This will enable the coordination of primary health care services and will aim to improve the recruitment and retention of staff. This project will commence in 2009-10. A total of $36 million has also been allocated in country capital programs over the next four years. This represents an increase of $10.8 million over four years and will go to country initiatives, including capital works and biomedical equipment. These allocations will be made on the basis of need, determined with advice from the Country Health South Australia board.

Other projects in country health include $1.5 million for an infrastructure upgrade at Naracoorte; $1.5 million for solar hot water installations at Gawler, Kangaroo Island, Kapunda, Port Pirie, Wallaroo, Meningie, Maitland, Minlaton, Eudunda, Lameroo and Woomera, and this will reduce greenhouse emissions by about 570 tonnes a year; $5.2 million over two years for the SA Ambulance Service; $2.1 million for country intermediate care facilities; $4 million for the national Improving Care for Older Patients in Public Hospitals program; and $1.5 million for the Port Augusta renal dialysis program, which I visited early this week. That is obviously a very busy service, so expansion there is very much needed.

I will clarify one thing I mentioned before, namely, that 17 nurses declined in the Modbury Hospital, and one nurse was declined an offer.

The Hon. G.M. GUNN: My question concerns the ability of the Ambulance Service to pick up any change in the status of country hospitals. It was put to me yesterday that, with your new health plan, if services are removed from some country hospitals (I hope they are not, but if they are) that will probably put a greater degree of pressure on the Ambulance Service, because it will have to transport patients further.

There is a real problem getting volunteer ambulance drivers in rural areas now, unfortunately, because it is a demanding role. Can the minister assure us that, with the new country health plan, if any services are consolidated or removed then consideration will be given to the effect that will have on the Ambulance Service? It is important to make sure that you have people available. If people have to be transferred from, say, Cleve, Cowell, Orroroo, or anywhere else to other centres, then you must have some ability to get them safely there.

The Hon. J.D. HILL: I agree absolutely with the member. We have not finalised any health care plan for the country, other than to say we want to build up services, particularly around some key regional centres, but we have not yet determined any plan. We will be working through future arrangements with people in rural settings. I met yesterday with representatives of country doctors and assured them that we would certainly involve them. I think the point the member makes is an incredibly valid one, that when you are dealing with country health you are really dealing with country transport as well, and you cannot look at one part without the other.

I outlined in Port Augusta the other day, as the member would know, some of the potential changes—the Passenger Assisted Transport scheme (PAT), which we hope will provide a better network of transport for people in the country. These are for those people who are capable of travelling, perhaps with the assistance of a relative, not under emergency conditions, but any system which would require transport in an emergency system has to be properly integrated with any plan. I would point out to the member that already urgent procedures cannot occur in many rural settings. There may be an emergency department—well, in every hospital there is an emergency department and we would not see that as going—where a patient could be and would be stabilised and then transferred to a bigger setting. Usually it is a city, I have to say, when it is an urgent situation.

We have also announced the establishment of an integrated state retrieval system, and that will be very much part of the planning process. I do give you my assurance that, in any consideration of the development of a country health service—an integrated service—transport issues, whether it is by volunteer ambulance, the PAT scheme or the state retrieval scheme or any other service, will be very much part of the thinking.

The Hon. G.M. GUNN: The next question also concerns transport. The minister would be aware that the Royal Flying Doctor Service, with the support of governments, is upgrading its facilities at Port Augusta, and it is going to be an excellent facility. One of the difficulties that are brought to my attention on a regular basis is that in the Far North of

South Australia there is an urgent need to upgrade some of the air strips; for example, William Creek, Marla and other places. As to whether or not the minister, through his department, is involved in supporting the upgrading of some of these air strips, I would point out to the minister that the one at Marree has been sealed, as have those at Hawker and Balcanoona. More people travelling in the north, and that is a good thing, but if you get a few points of rain in some of these areas, the air strips will be out and the Flying Doctor will not be able to get in.

It is put to me every time I go to the north, which is pretty regularly, that there is an urgent need in this regard, not only for tourism but also for the Royal Flying Doctor Service. They have these sophisticated aeroplanes, which are excellent—for someone who is rather keen on aeroplanes and has had a little bit of practice with them—but, as I say, after a few points of rain you cannot put them down. So, I wonder whether there is any facility in this budget for the government to upgrade some of these air strips.

The Hon. J.D. HILL: I thank the member. I agree with you, and every time I go to the north it is raised with me. I am going up north to the APY lands next month. I have been up there several times and they have raised the issue in relation to the strips in the APY lands and also in other sites in the north, so I am aware of that. I have done a tour with the Royal Flying Doctor Service last year some time and saw some of the sites where they land. It is not a budget issue for us. We do not have a budget line for building air strips, as the member would probably appreciate. The commonwealth has just increased the amount of money that it provides to the Flying Doctor Service, which was a good thing, but as I understand it the responsibility for the air strip lies between the commonwealth and local authorities.

I am not aware of the process that has to be gone through but I am happy to try and get some information from whatever state government agency is involved—I assume it is the Department for Transport, Energy and Infrastructure—about what is the status of any of those strips and whether or not there are funding arrangements in place to upgrade them.

Ms CHAPMAN: I have a question supplementary to that, if I may. As you are going to be visiting the APY lands shortly, minister, perhaps you could also follow up the air strips there, particularly at Fregon, where those people are looking for the upgrade of their strip to enable them to land at night. I am informed that the cost of even delivering samples for assessment to Alice Springs is quite significant, as well as cost and the delay in getting those samples back. We are talking here about assessments for sexually transmitted diseases, sometimes in children, including chlamydia, syphilis and these sorts of tests, concerning which results coming back are being delayed and which leads to other complications. Getting access in and out of Fregon, and/or Ernabella, involves significant health costs which currently your department and the commonwealth are having to meet. I would join with the member for Stuart in looking at that exercise, because it has a direct cost and service implication for the people in question, so perhaps that matter might be taken on notice in conjunction with your trip as well.

The Hon. J.D. HILL: I certainly am aware of the issues around the strips in the APY lands; I mentioned it myself, and I have made representations subsequent to visits there in the past. I understand the Department of the Premier and Cabinet, which hosts the Office of Aboriginal Affairs and Reconciliation, is negotiating over this with the commonwealth. I would not have thought there would be too many occasions where samples could not get through because of not being able to fly at night. There might be the odd occasion, I guess, but it is really more emergency situations that would be a worry. There is a routine kind of trip that allows those things to get through, but it is really for emergencies where it becomes a problem.

The Hon. G.M. GUNN: I am interested in health generally, but my real focus is on country health. The minister would be aware that I have drawn to his attention previously the unfortunate experience at the Leigh Creek Hospital, where parts of the ceiling collapsed and nearly hit a couple of the people working there. Can the minister give an assurance that steps will be taken to bring the hospital back on line? People are sometimes cynical about the government and about politicians being hail-well-met people, although I do not know why. Concerns have been expressed that this could be an excuse to close the hospital. I wonder whether the minister can give an assurance that that will not happen, because the hospital plays a very important role in providing services to the people involved in mining the coal that ensures the lights stay on in this place, although to the wider community it is merely a base hospital. So, I wonder whether the minister can allay any fears in this regard.

The Hon. J.D. HILL: I have bits of advice here that I can give the member. I understand that, generally, there is a study of the status of roofs right across the country at the moment, because it is not just a Leigh Creek issue. I have also been advised (and I can get further information for the member) that repair work is being planned at Leigh Creek at the moment. In relation to the status of individual hospitals, as I have said, we will go through a comprehensive health care process with country people. So, we are not going to use a few tiles falling off a roof as an excuse to close down a hospital. However, we will think through the issues about where we need services and what the level of services ought to be.

Ms CHAPMAN: I have a supplementary question in relation to the Leigh Creek Hospital. The health service at Ernabella, minister, has also closed as a result of the facility being burnt down. I think the minister is aware that, currently, they are offering that health service out of a house that has been temporarily converted to provide the service. The opposition has been informed that, although the facility was built by the commonwealth, your department is responsible for the insurance and replacement of these facilities. However, your department has rejected the rebuilding of this facility at a cost of some $2 million, insisting on a rebuild of the current structure at a cost of $1.4 million.

Having inspected what structure remains, minister (and I hope the minister will visit the site), I can say that it is really quite unsafe because all of the interior of the building has been burnt out. Will the minister assure the committee that the department will ensure that this service is re-established in Ernabella as soon as possible because it is their only health service? The current operation has broken down, and they are working out of temporary accommodation, and there seems to be this fight going on about how much funding will be provided to get the service back in operation.

The Hon. J.D. HILL: I am aware of the service. In fact, I visited it only a short time before it was burnt down.

Ms CHAPMAN: So, you know how good it was.

The Hon. J.D. HILL: I do know how good it was. There are also quite interesting questions being asked about the circumstances under which the facility was burnt down. I will not go into that now, but I have my own suspicions. There is

an issue to do with insurance. The state insurance authority (SAICORP) manages that for us, and SAICORP has the matter under discussion (I will put it that way) at the moment. However, I will ask Dr Sherbon to provide some further information if he can.

Dr SHERBON: The Department of Health is not the insurer; SAICORP is the insurer. Although it does not come under the Department of Health portfolio, the department is nevertheless assisting in facilitating discussions between SAICORP and Nganampa. The dispute is not over the need to meet the claim; the dispute is over the ability of the builder selected by SAICORP to deliver the product in a remote setting. So, I am facilitating discussions between Nganampa and SAICORP to try to reach a mutually acceptable outcome such that we can proceed. As the member has suggested, the minister has certainly instructed the department to assist in the early and expedient restoration of the clinic.

Ms BEDFORD: I refer to Portfolio Statement, Volume 2, page 7.9, which mentions the development of clinical networks in South Australia. What role will the clinical networks play in improving health service provision?

The Hon. J.D. HILL: I thank the member for Florey for her important question. It is something I am very proud to be associated with. We have worked really hard to improve the input of clinicians into the delivery of health services. I think it is fair to say that, when I first became minister, I was struck by how excluded clinicians felt from the decision-making process, as well as somewhat alienated on occasions. So, we are working really hard to make sure they do have a very strong way of being involved, and the clinical network is the tool we are using. These networks will give clinicians direct input into health service planning, which will improve the coordination of delivery of the services in their area, ensure better health outcomes for all South Australians, and ensure a strong and sustainable health workforce.

We have established eight clinical networks initially, but others will be developed in time. The eight clinical networks are: renal, cancer, mental health, maternal and neonatal health, child health, cardiology, rehabilitation and orthopaedics. The chairs of these networks have been appointed, and they all bring vast experience and enthusiasm to the job. These networks will link doctors, nurses, allied health professions, general practitioners, and community representatives, improving their ability to work together to provide fully integrated health services across hospital sites and GP Plus health care services. For example, the cancer clinical network will explore ways in which country people can receive the majority of their cancer care closer to their homes. Options to explore could be patients receiving chemotherapy at home or more cancer services at the four country general hospitals. The orthopaedic clinical network will work to identify ways to prevent falls amongst the elderly and ways in which increased access to elective orthopaedic surgery can be achieved.

Each network will have a steering committee, comprising doctors, nurses, allied health workers, community reps, consumers, and carers. We have invited people to be associated with all those. The first meetings of the networks are expected to occur shortly, if they have not already done so. Clinical networks will also have a key role in improving the performance of our hospitals. This will include improving safety and quality, reducing the length of hospital stay, reducing emergency department times, and improving out of hospital care.

Over the next 12 months, each network will develop a clinician-led service development plan for its area within the context of the recently published South Australian Health Care Plan. These plans will address issues relating to service distribution, quality and safety, access, workforce, teaching and research. In other words, the clinicians will be very much involved in developing the strategies that the administration of the health system will then adopt. I hope that this will give clinicians a very strong role in decision making. In addition to the other things I have just said, we have also changed the nature of the Clinical Senate. All the chairs of the clinical networks are members of that body so that we can bring together that level of expertise. I meet with it every time it has a meeting.

Ms CHAPMAN: I have a supplementary question, Mr Acting Chairman, if I may, because it is a very important service. I am pleased to hear you say, minister, how important it is to consult with them. How often and when were the Clinical Senate and/or the networks consulted on the government's proposal to build a new hospital on North Terrace?

The Hon. J.D. HILL: I say to the deputy leader that point-scoring is obviously part of the estimates process. However, if she had listened to what I said, she would have heard that I said that we had just set these things up.

Ms CHAPMAN: Is the Senate four years old?

Ms Bedford interjecting:

The Hon. J.D. HILL: Hang on.

The ACTING CHAIR: Let us have one at a time and, at the moment, the minister is talking.

The Hon. J.D. HILL: At every meeting I have had with the Clinical Senate I foreshadowed changes we are undertaking and sought its advice. The strong message I felt that I got from it was to do it. I did not go into the detail because, obviously, the detail was subject to budget and cabinet considerations.

The ACTING CHAIR: Without identifying anyone in particular in the chamber—because that is the way we do it here: we are a very friendly mob—certain rules apply, which I did not make. I am just here to enforce them. I did not think them up; had I done so, I think that estimates would be very different. However, that is not what happened.

Members interjecting:

The ACTING CHAIR: Perhaps more interesting.

Ms Chapman interjecting:

The ACTING CHAIR: Perhaps, but who knows? I did not make up the rules; I am just here to enforce them. One of the rules I would like to cite, as a matter of interest, is rule No. 6 and, from hereon, if necessary, we will refer to it in a shorthand way as rule No. 6. It states:

> That there will be a flexible approach—

I think we have all seen that so far—

> to giving the call for asking questions based on about three questions per member, alternating with each side.

We have more or less been doing that, which is nice. This is the interesting part of rule 6:

> Supplementary questions will be the exception, rather than the rule.

That is not said with any intention to direct attention to anybody. As I said, I do not make the rules. I have been reasonably flexible.

The Hon. G.M. GUNN: As is your wont.

The ACTING CHAIR: That is right. I like to be a flexible person. Minister, I am worried I might get into trouble with the Speaker.

The Hon. J.D. HILL: You are a yogi of a politician.

The ACTING CHAIR: I think I will get into trouble if I do not enforce the rules. I say this to everyone in the nicest possible way: if you feel a supplementary question coming on, ask yourself, 'Is this really a supplementary I have to have, or is it one I can put off until we have tea and biscuits at one o'clock, when I can saunter up to the minister and ask him the question quietly?'

Ms CHAPMAN: And take Hansard in with us to record the answer?

The ACTING CHAIR: Why not? As I said, if I had made the rules, it would be different; however, I am just here to enforce them.

Ms BEDFORD: I do not wish to prolong things, but I ask your ruling on this issue: who can ask the supplementary—the person who has asked the question or anybody else in the chamber?

The ACTING CHAIR: As I understand it, anybody can ask a supplementary question, provided that the question is indeed supplementary to the preceding question and answer. As I said before, rule 6, which, unfortunately binds all of us, provides that they are to be the exception, rather than the rule. There have been a few of them. So, if you feel one coming on, just ask yourself, 'Is this one I have to have, or is it one I can put off until a little later?'

Ms BEDFORD: My next question refers to Volume 2, page 7.9, where there is reference to the implementation of the SA Safety and Quality Program 2007-2011 as one of the targets for 2007-08. Will the minister inform the committee about initiatives to be implemented to enhance patient care and safety?

The Hon. J.D. HILL: I thank the member for her question but, before I answer, I will give a couple of answers to previous questions asked by the deputy leader. I need to inform the committee that the tender for the QEH research building is $12.6 million, not the $7 million I reported; I apologise for that. I can also let the committee know that the value of St Margaret's, grossed up, is $6.7 million. Its written down value (that is, net of depreciation) is $3.2 million. Hampstead Rehab's gross value is $71.2 million; written down value (that is, net of depreciation) is $41.8 million. Neither includes plant and equipment. Both valuations include land, site improvements, site infrastructure and buildings.

In answer to the question asked by the member for Florey, South Australians expect and deserve the highest standards of safety and quality in the public health care system. I think we can take that as a given. The safety and quality program sets out the priorities for continuing to improve our performance in this area. The new Safety and Quality Council, chaired by the extraordinary Mr Hans Ohff, who is independent of the public health sector, has started developing its work plan based on the priorities identified in the SA Safety and Quality Program. Mr Ohff has a wealth of experience in the private sector, including as the Chief Executive of the Australian Submarine Corporation.

All areas of the Safety and Quality Program will be tackled by the council over the next 12 months—clinical governance, workforce, information management and technology, consumer participation, and safety and quality initiatives. Of these, the safety and quality initiatives, and especially the patient safety initiatives, will receive close attention.

There are five priority areas in patient safety, for which there is good evidence for the value of examining and, where necessary, making changes to clinical practice. These are: patient falls, medication management, pressure ulcer prevention, control of infections and blood transfusion. Activity is already occurring in each of these areas. South Australia is also following the national patient safety agenda and participating in projects as diverse as open disclosure of adverse events to patients, accurate patient identification at the point of care, improved clinical handover, and credentialling of medical staff. Numerous patient safety activities are being undertaken in our public health sector every day, and the momentum to continue this effort is building.

The new council has also been charged with overseeing patient safety and quality activities in the private health sector and in aged community and other sectors. I am very pleased to say that we have already had very effective cooperation with the private sector. This is an ambitious program, but one which South Australians really deserve. The quality and safety of our health services is already very good, but the work of the council will continue to improve our effectiveness.

Ms BEDFORD: My last question refers to the establishment of the patient journey initiative as listed again on page 7.9 of the Portfolio Statement as a highlight for 2006-07. What is this government doing to improve the transport of country patients to and from hospitals?

The Hon. J.D. HILL: I thank the member for Florey for this question, because in one sense it follows on from what the member for Stuart asked. The government has established a patient journey initiative which aims to improve the outcomes for people living in country South Australia needing to access health services away from home, either from Adelaide-based services or visiting local services. As well as making the journey easier for patients, this initiative will help our aim to increase the number of procedures conducted in major country hospitals and decrease the length of time country residents spend in Adelaide hospitals. A major aspect of the initiative will be better coordination between hospitals and smarter planning of each patient's transport needs.

As part of the initiative, a new transport and patient support service has been trialled, including a health bus network and two new patient support services. The health bus network is modelled on similar community passenger networks and will be tested on the Yorke Peninsula. Should the trial be successful, the implemented network could more than double the number of rural residents eligible to apply for transport assistance, and give access to dental, dialysis and essential allied health services at a relatively low cost. Existing community passenger networks could then link with the health bus, and air travel will be expanded for people too sick to travel by road.

Two new services run by non-government agencies will also be trialled to provide additional support services for people who do need to travel to Adelaide. These are an expansion of the transit lounges in existing cancer council motels and a new meet-and-assist program. These services will provide a personalised service for patients receiving treatment in Adelaide.

For patients in the country who need highly specialised treatment, particularly trauma services, it will always of course be necessary to rely on air retrieval. To improve these

services, a new state-wide retrieval service will commence operation later this year. Three retrieval teams will be established, with a medical retrieval consultant and a clinical team on standby 24 hours a day, seven days a week. One contact telephone number will make it easier to reach the service in emergency situations, and protocols will be established to ensure uniform standards and best practice. Initially, the new state-wide retrieval service will focus on adult services, which account for 1 200 retrievals each year, and obstetric, paediatric and neonatal services will be phased in at a later date.

I would be remiss not to acknowledge the great work that the Port Augusta community has undertaken in the development of a volunteer-led travel service which operates between Port Augusta and Adelaide, and Port Augusta and Whyalla.

The Hon. G.M. GUNN: They were very persistent.

The Hon. J.D. HILL: That is right, and I was very happy to provide the $10 000, which is a relatively small amount, to make this service work, and they are now ferrying patients from Port Augusta to those two centres. They are picked up at their home, delivered to the hospital or medical site that they require, then collected after the procedure and dropped back at their home, using a volunteer service. It is a fantastic service, and they are very passionate people in Port Augusta who are running it. I think there is a lot that the general PATS service can learn from the work that they are doing. So I commend them for their efforts.

The Hon. G.M. GUNN: Mr Acting Chair, I know you do not like the word 'supplementary', so will the minister add to his answer?

The ACTING CHAIR: The member for Stuart has not been abusing rule 6, so he can go ahead and call it whatever he likes.

The Hon. G.M. GUNN: My question is this: the minister has indicated that there will be an expansion of the retrieval system, and obviously a lot of that is going to be done by the Flying Doctor, I take it. Does the government have plans to upgrade the helicopter service which will be used in the closer areas? Obviously, a lot of these retrievals are at night. I am aware of the extra helicopter facilities that have been put in at the Kapunda hospital, but are there any plans to upgrade some of these landing facilities at rural hospitals? Obviously you want the helicopters to be able to land as close to the hospital as possible.

The Hon. J.D. HILL: I thank the member for his question. I guess there are two or three things that I would want to say in response. Firstly, we are just establishing this retrieval service and we have a director who has just been appointed and, through the process of thinking through how it will operate, I guess those issues will come to the fore and will be subject to the appropriate budget bids and negotiations and so on. Secondly, the point I would make is that, as we work through the country health plan, and picking up the earlier point I made, we need to think through how that relates to those kinds of transport issues as well. And, of course, thirdly, we have a maintenance budget, so there is capacity to deal with some of those issues as they arrive. I do not think I can say much more at this stage because we really need to get these processes moving before we can think them through any better.

I can give just a little more information. A steering committee was established to develop a strategy for the development of the state-wide service, and that comprises representatives from rural general practice, the RFDS, state ambulance service, health regions and the department, so we have a good working body.

Ms CHAPMAN: I also want to ask some questions about country health. We have heard the good news and the assurances the minister has given us in relation to transport and fixing up the hospitals where roofs have fallen in. How many full-time equivalent persons are currently employed by Country Health, and of the $5.05 million savings in administrative efficiencies, and the $30.658 million to be saved in service delivery charges, how many employees will be transferred or dismissed with or without redundancy to achieve those efficiencies from Country Health SA?

The Hon. J.D. HILL: First, nobody will be dismissed without redundancy—the government does not operate on that basis. However, we expect to make administrative savings in Country Health and we are looking at $5.1 million over four years and $1 million in the coming year. We want to reduce the number of middle management administrative positions by 25 in 2007-08. I would be surprised if anybody objected to our doing that. We do not need all the managers we have currently running our Country Health service. We have been doing similar things in the city and it makes more sense to use that money to provide clinical services.

As to the exact number, we have 42 country health units managed by 28 chief executive officers, and they will be structured on a management basis into about 13 clusters, which will result in savings of about $1.44 million in a full year, which is where the $5.1 million comes from.

Ms CHAPMAN: By way of clarification, is that 28 CEOs down to 13 CEOs in a cluster arrangement?

The Hon. J.D. HILL: No. We want to manage the health units in an integrated way, so we will not necessarily be getting rid of 25 CEOs, but middle management generally. I cannot tell you exactly where they fit in the hierarchy, but it would be wrong to say we are getting rid of a particular number of CEs. However, 13 clusters will become management units and that will do what has been happening by default anyway. There are something like 60 hospitals now run through 42 units, so we will run them through 13 administrative units.

Ms CHAPMAN: Does that cover the $30.658 million as well, or is that the total?

The Hon. J.D. HILL: They are the savings targets for future years? No. It will go through this approach, which will save about $5 million over four years. We also want to make additional savings so that we are not spending money on things we do not need. We will work through the Country Health plan. One of the potential savings is that we currently have a whole range of age beds in country South Australia that are state funded and we believe they ought to be federally funded, as they are in every other state. We have 137 residential care beds currently funded by the state and we would expect that that would save something like $5.2 million revenue a year if the commonwealth agreed to fund them, so that would be over $20 million in those savings. The commonwealth has agreed to that level, so we will make those savings; it is a relatively benign saving for the state and gives us, of the $30-odd million, something like $5.2 million a year through residential care beds being transferred to commonwealth funding, which is $20 million or so over four years, plus the $5 million which we will get from the administrative savings. We want to do better and will work through some of those processes in the development of the Country Health plan.

Ms CHAPMAN: I refer to Country Health on page 7.35. The target for non-grant funded country hospitals is to go down by 1 052 outputs in 2007-08 and up in grant funded hospitals by 209. Not only is this an overall reduction in the number of outputs from country hospitals but how does the minister reconcile this with his promise to transfer procedures currently undertaken on country people in city hospitals back out into the regions?

The Hon. J.D. HILL: This year is a transition year and over the course of this year we are working with country people about the arrangements that will be put in place, so we need to work it through in a detailed way. The transfer of effort to country will have to take place after the Country Health plan has been developed. We are saying that this is the direction we intend to go. In relation to the specific detail, we will try to do some work before the end of the day and, if not, I will take that part of the question on notice.

Ms CHAPMAN: My third question is to do with Ross River and arbovirus transmission, page 7.10. The minister indicated that he will develop a predictive risk assessment model for arbovirus transmission mosquito nuisance problems in South Australia. As the Ross River and Barmah Forest disease have increased four-fold over the past year—up from 126 cases in 2005 to 566 cases last year and already 99 cases this year for Ross River virus alone—what is the minister doing about that situation now and why has there been a failure to warn the public and issue any public warning on this issue to avoid mosquito bites, in particular for the benefit of people who may be visiting a rain affected area of the state?

The Hon. J.D. HILL: A little while ago (I cannot remember exactly when), I launched a public awareness campaign in the Riverland in relation to mosquito bites. I can obtain a detailed briefing for the member about how that is going. There was some sort of snappy slogan—and I cannot remember what it was; something about a bite. When I was there, someone provided me with a miniature mosquito trap that could be used to capture mosquitoes. I think it was a novelty item that was available through one of the stores. I cannot tell the member the detail of that plan. However, we did launch a plan, and advertising and public awareness processes are in place in that area.

Ms CHAPMAN: My next question relates to the South Australian Ambulance Service, Budget Paper 4, Volume 2, page 7.39. Will the minister explain why the government has a policy that SA Ambulance is not required to recover unpaid ambulance fees for services, even when the patient has a clear financial capacity to pay the same, resulting in a $6 million write-off and loss of revenue every year? I am not talking about those who would clearly be in the homeless category, which this service picks up—and perhaps one could ask the question as to whether it would even be necessary to issue them a bill for the cost of the service? The policy of not even following up the recovery of those moneys with any enforcement agency is a massive loss of revenue. My question is: why does the government have that policy, or why does it permit SA Ambulance to not recover this sort of money?

The Hon. J.D. HILL: I am not aware of such a policy. I am aware that a number of people do not pay their ambulance bill. Cases are brought to my attention from time to time when people who are uninsured are taken by ambulance to hospital and then given a bill, and they object mightily, particularly when they are taken under the Mental Health Act against their will and are given an ambulance bill at the end of it. I would be surprised if that were a policy. I will certainly check it out. We always have default payers in any service, whether it is a government or a private service, and it becomes a matter of whether it is worth the cost of pursuing something when the chances of success are so low. I am happy to obtain a report for the member (I would be interested in seeing it myself) as to what the current arrangements are. If we are being too generous to those who can pay, we will certainly review it.

Ms CHAPMAN: Obviously, the government is at the negotiation stage with ambulance workers in relation to their enterprise bargain. There has been publicity about the very significant number of overtime hours—some 118 000, I believe—with $5.1 million spent in the past year. I think it has been pointed out publicly that this could be dealt with by an increase in the number of employees. The opposition understands that, in the future, training for our volunteers in SA Ambulance, which is currently undertaken in-house, is proposed to be outsourced. Is there any funding in this budget line, with respect to SA Ambulance training costs, for these people to undertake their training at a TAFE college? If not, is it the government's policy that they will have to pay their own training fees at TAFE to become qualified to provide a volunteer service for this organisation?

The Hon. J.D. HILL: The deputy leader has raised a range of issues. In relation to the industrial negotiations involving the ambulance drivers, the government has made an offer. I am advised that the union will recommend that that offer be accepted. So, that is a good thing. As the member said, there is an issue generally within the Ambulance Service in relation to overtime. I know that every year we have been in government extra officers have been recruited to satisfy the demand. What is happening in the Ambulance Service, I guess, is similar to what is happening generally in health. There is increasing demand, which requires additional staff, and we recruit to that demand. However, by the time we have done that, the demand has raced ahead again and we need even more people. Sometimes the only way in which that can be handled is by having people work overtime, because there is a gap between recruitment and people being capable of providing the service.

In relation to voluntary ambulance officers, we are very reliant on those people in country South Australia. I think they do an extraordinary job. I have met many of them over the past year and a half at various ceremonies and the opening of stations, and they are dedicated people. Some of them put virtually all their waking hours into providing services in country South Australia. There is, of course, an increasing demand even for voluntary ambulance officers to have a whole range of skills, because they are trusted: they are the first people to provide emergency care in country settings, and they are required to have a whole range of skills so that they can save people's lives (not only are they required, but they also want to have those skills). So, there are increasing expectations with respect to levels of skill.

In relation to the detail of the question about who pays for what and what the training arrangements are, I do not have that information with me, but I would be happy to obtain it for the member. So, I will take that part of the question on notice.

Ms CHAPMAN: My next question relates to Budget Paper 3, page 2.17: health reform. It is indicated that $89.9 million is to be saved from service delivery changes, and there is $48.689 million for operational savings over the next four years. Can the minister explain what these changes

are to be, how much for each category has been allocated for this reform, or saving, and how many employees will be transferred or dismissed with redundancy?

The Hon. J.D. HILL: I am happy to go through the saving strategy. May I say, as a minister who came from a very small budget area (the environment department, which had to make savings every year), when I became Minister for Health I said that health should be going through this process, too. Even though there is a net increase every year in the amount of money that is spent, it seemed to me to be absolutely appropriate that savings initiatives were placed on the health system as well.

I suppose it is untrue to refer to them as savings because they are just redirections within the health budget and, in fact, it is about doing the job more efficiently. I note that both the deputy leader and the Leader of the Opposition, on various occasions, have said they do not think health needs more money; it just needs to be more efficient. To a certain extent I support that philosophy, although it is not the complete answer. Because of the growth in demand we still need more budget, and that is the great elephant in the room that we are facing in health. The growth in demand for health services is so great that we continually have to put more resources in, but it is also incumbent on us, I think, as a system, to provide those services in the most efficient way that we can. I am very pleased to be able to go through that process in my agency, and I think the agency generally is pleased to go through it, although obviously there is always a bit of pain with these things.

The savings target for 2007-08 includes 89.9 to be achieved over three years from 2008-09 as part of the health reform process, and that will relate to the reform service delivery changes commencing in 2008-09. The savings requirement in 2010-11 is 47.1, which represents 1.3 per cent of the total portfolio expenditure budget for that year. These efficiencies are part of the overall budget, as I have said, and all of those savings get re-invested in health.

Those efficiencies will occur from the consolidation of services and avoidance of more duplication. We are seeing that as part of our clinical plan to have three major hospitals and three tertiary hospitals supported by general hospitals. Clinical networks and some specialities have been established to assist in fully integrating the provision of services across hospital sites and GP Plus health care centres. The plan will also address the clinical skills shortage and further enhance teaching opportunities to build our future networks.

We know, for example, by building the Marjorie Jackson-Nelson Hospital rather than upgrading the Royal Adelaide Hospital, that we will eventually be saving $50 million plus a year, just in the running costs of the hospital. That is $50 million that can be put into the provision of health services. We also need to make sure all of our existing hospitals work as closely as possible to the national benchmarks in terms of how they provide their services. Some people are staying in hospital longer than is clinically necessary. We need to make sure that that does not happen and that we have a good support service so that people are able to get health care in their homes.

It makes no sense for somebody to spend a long time in hospital when they could spend a short amount of time in hospital but have really good back-up ambulatory services. That is certainly the clinical model that we are directing. That is better for people because, from a clinical point of view, they are more likely to get better quicker if they are in their own home environment and, of course, it is a most cost-effective model. We are moving very much in that direction. I know a lot of work will be happening across all of our city hospitals in the short term to work out ways of achieving these goals.

Ms CHAPMAN: Just for clarification, there is a consolidation of services (and I think you have expanded on that in other answers as to how that will be achieved over the acute hospital structure), less time in hospital with support at home and so on. Are they only two features of the $89.9 million and the $48.689 million?

The Hon. J.D. HILL: I can give another example: we have a cogeneration project going at Flinders Medical Centre which will make some savings at that site.

Ms CHAPMAN: I am happy for the question to be taken on notice as to how that is calculated.

The Hon. J.D. HILL: I am just trying to give you a sense of the direction in which we are going. It seems to me that it applies to any kind of government institution where, if you have a light on in a room and nobody is in the room (just as a metaphor), you are wasting money and you are wasting power. What we have to do is work out a system whereby lights are not on when people do not need them, and transfer that through the system.

We have to make sure that beds are not being staffed when we do not need those beds. We have to make sure that equipment is not being purchased when it is not required. All of those things make a system more efficient; it does not diminish one iota the quality of the service. We need to work through that in a detailed way in each of the hospitals, and that is certainly our plan over the next three years.

This is a target over the next three years, and I have already given examples of the obvious things. By concentrating services in key locations it means you are not wasting resources by having them spread out with services being underutilised. It also means that you are not paying people overtime or to be on-call when they are not needed. Those kinds of consolidations are fairly obvious, but it is the more subtle administrative decisions (which we all make day to day) which, if they are done in a different way, can result in a whole lot of savings. Some of them are as a result of using capital in a better way. I just gave an example of that by building a new hospital compared to refurbishing an existing hospital. We will need to work through how to do this at individual sites. The commitment I give is that we will do this in a way that will strengthen rather than diminish service to the public.

There is some talk in the media about mothers having only short stays in hospitals these days. I know one of my colleagues, whose wife had a baby just recently, was out of the hospital in one day because she chose to be. I think when my mother produced me, blessed day that it was in 1949—

Members interjecting:

The Hon. J.D. HILL: It was a long time ago! She still remembers it, though, with great affection. I think she probably spent two weeks in hospital.

Members interjecting:

The Hon. J.D. HILL: Yes, it was the shock of the new. That was the clinical standard of the day (it may have been five days; I do not know), but it was a long time. I was an exceptional birth, but a normal one, I think, in the circumstances. I gather that forceps were used, which meant that my head was shaped in a particular way, and that caused my grandfather to think a mistake had been made. The clinical standard of the day was to leave women in hospitals. When people had operations for a new knee they would lie down for

a while; now they get them walking and jumping around quickly. Different processes are now applied which mean you can do things in a different way. If do you this and people do not stay in hospital, you need to provide good ambulance care. That is certainly what we are moving to do. With all of those things it is very hard to say this or that will happen, but it is that process working through the system that will make the savings.

Ms CHAPMAN: While we deviated to what occurred in 1949, and while I have not questioned the merits of how efficient this would be, it is very specific. It is not about $50 million or $90 million: it is quite specific as to the anticipated savings. Really, what I am asking—whoever has done the calculation for this—is what each category comprises and how much. That is the data I am seeking. I appreciate that if you or your advisers do not have it we can take it on notice.

The Hon. J.D. HILL: I will certainly look at the question and what I have said again and, if there is anything I can add, I am prepared to take it on notice. It is about running our system so there are fewer admissions and so we run our primary health care sector more strongly. We are doing a lot in that area, so if we have better primary health care we will have fewer people going into hospitals and therefore lower costs. As I have indicated before with respect to the Aldinga GP Plus Health Care centre, we know there was a reduction in attendances at the Noarlunga Hospital of people who were serviced by that centre by about 16 per cent after just a few weeks. So, we know that will work.

In the budget these are obviously targets and we need to deliver on them, but I think they are reasonable. Because this is something we need to work on over the next year in particular and over the next two or three years in general, I cannot give you how much will be saved by each of those initiatives, but I can give you a flavour of the initiatives which we would seek to pursue and which we believe will make those savings.

Ms CHAPMAN: If the minister cannot identify here how those amounts are calculated for the purposes of giving them to the Treasurer each year to put in the budget, are these amounts just plucked out of the air, or has someone in the department prepared a list of the areas that are added up to reach these efficiencies? They are targets, and they are published here as targets. They may or may not be achieved and might even be better than what has been achieved, but it seems to me that someone in the department has been asked to provide this information to the Treasurer to put into the budget, and it may be that consolidation of services into the tertiary hospitals is one of the items for which there is an estimate of $X million. Has someone in the department just plucked the amount out of the air, or are there some actual categories? If there are categories—and that is what we are asking—how have you calculated that?

The Hon. J.D. HILL: I will look to see whether there is anything further that I can add. The advice I have is that the figures were identified based on modelling using the categories of areas where we could make some savings that I have already indicated. There will still be an increasing demand—but not increasing as much as it currently is, so it will be suppressed demand—and greater efficiency in the use of existing resources and so on. I am happy to get some further information for the member that perhaps amplifies that.

Ms CHAPMAN: Thank you, Minister. This is a question that will be effective tomorrow, so you may wish to take it on notice. I refer to Budget Paper 4, Volume 2, pages 7.4 and 7.9 regarding the workforce issues. What is the total number of doctors and nurses in the public health system in both number and full-time equivalents respectively as at 30 June 2007 (which, of course, is tomorrow)? The minister will see that I have asked these questions in previous estimates and that that information has been taken on notice and provided in due course.

The Hon. J.D. HILL: I can give you at least some of that information now. What I cannot provide I will get for the honourable member. I am advised that the total number of doctors in the wider public health system—which excludes central office, where there are doctors who are not working as doctors—in terms of head count increased by 466 or 21.5 per cent from 2 170 at June 2002 to 2 636 at June 2006. Those are the latest figures.

Ms CHAPMAN: I have all those figures; the minister gave them to me in answer to estimates questions from last year. I am asking what they are as of 30 June 2007, which is tomorrow.

The Hon. J.D. HILL: I will get back to you.

The ACTING CHAIR: This is probably a convenient time to adjourn for lunch. I think the minister has generously put on a very nice lunch for us.

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

Ms CHAPMAN: I refer to Budget Paper 4, Volume 2, page 7.4, involving the workforce. The Australian Nurses Federation has announced that it is now in stage 2 of strike action, including the cancellation of elective surgery. As you know, on a daily basis we continue to hear of your colleague minister Wright's negotiating on this matter. My question is: why has it taken over seven months to negotiate this matter, with the resultant strike action, when the same party, namely the Australian Nurses Federation, also negotiates with the private sector (Ashford Hospital, Healthscope and the like) in relation to nurses' entitlements and their enterprise bargaining agreement and this is successfully concluded without strike action or any interference with clinical operations and usually within a matter of weeks?

The Hon. J.D. HILL: I thank the member for that question. Before I address that, there are just a couple of things that came from before, if I could get them on the record. In relation to ambulance volunteers, I am advised that the Ambulance Service is discussing a partnership with TAFE to provide better educational resources to ambulance volunteers. SAAS will still deliver the training but the volunteers will be able to use the library and computing resources so that they can receive their training in a more flexible manner.

The shape of this partnership is yet to be determined. However, SAAS is keen to improve training for volunteers. SAAS will not charge volunteers for their training. They have a longstanding policy of ensuring that volunteers are not out of pocket for the contribution they make to SAAS and the community. In relation to their collection policy, I am advised that they take all reasonable action to recover all outstanding revenues and other amounts which are receivable as a result of providing an ambulance service.

In relation to the Ross River virus and other viruses, I am told that the communicable disease control branch has been notified of 135 other viral infections this year, compared to 418 at the same time last year. Recent rains, I have been told, have led to a small increase in notifications, but with the onset of cold weather this is unlikely to continue. The

campaign, whose name I could not remember, was called 'Fight the Bite', which we have been running. The director of the control branch has done a number of media interviews about how to protect yourself from mosquito-borne illnesses, and we have distributed material to councils throughout the state. We also have, as a department, a joint research project with the University of South Australia, which has produced a computer modelling program for predicting mosquito numbers. So, I guess you could say that that campaign has been reasonably successful if the number of notifications has reduced from 418 to 135 but, no doubt, weather conditions have impacted on that to some degree as well.

In relation to the nurses and midwives dispute, the enterprise agreement provides for a nominal expiry date of 30 June 2007, so we are still operating within the 2004 agreement, at least for a few more days. The nurses union lodged a claim for a new agreement with the Department of Health on 1 March, so that is only three or so months ago. An offer with respect to that agreement was made on 29 June. Key features of that offer include a new salary structure operating from the first pay period on or after 1 October, with two further increases of 3.5 per cent from the first pay period on or after 1 October 2008 and 1 October 2009, an increase in paid maternity/adoption leave from eight to 14 weeks and an introduction of voluntary flexible working arrangements. The ANF advised on 31 May that it considered the offer to be unacceptable and commenced industrial action from the beginning of June, and that has escalated on a weekly basis since then.

The Industrial Relations Commission has recommended that the ANF lift the bans on elective surgery, and I am not entirely sure of what their response was but I thought it was reasonably positive. It is expected, though, that the postponement of non-urgent elective surgery will continue until 25 May. I am not aware of the state of any enterprise agreements that the nurses union has with the private sector. I imagine that those agreements now operate under the commonwealth legislation which is based around AWAs. I am absolutely certain of one thing, though: that the nurses union prefers to deal with government through an enterprise bargaining arrangement rather than the commonwealth government's industrial relations process, WorkChoices.

We know, through long experience in dealing with the nurses union, that these processes are always fairly vigorous and I am absolutely certain we will reach a good arrangement with it in due course, hopefully through negotiation, but if not, of course, there is an arbitration system that will make the decision. That is in stark contrast, of course, to the industrial relations arrangements that the Liberal Party supports, whereby nurses would have very little bargaining power and would be treated, really, as individuals.

Ms CHAPMAN: Thank you for that gratuitous extra, minister, in that contribution. I expect that is why they do so well when they negotiate with the private sector.

The Hon. J.D. HILL: You would want to have a look at the details of any agreements reached with the private sector, I would have thought.

Ms CHAPMAN: I have. They are very good, and the Australian Nurses Federation negotiate them very well. Budget Paper 4, Volume 2, page 7.4: it is proposed that metropolitan domiciliary care be transferred to Families SA. The budget paper discloses that there were 593 full-time equivalents in 2005-06. What is the number currently there in 2006-07, which will transfer next Monday, in full-time equivalents?

The Hon. J.D. HILL: As the member has indicated, the MDC Service will transfer from the Health portfolio to the Department for Families and Communities on 1 July but, in practical terms, it has already been transferred. From 1 July, it will be known as Domiciliary Care SA, and it will be a key part of the DFC's new integrated community service structure. As I understand it, essentially, anyone who works for MDC, other than through the Tregenza Aged Care Service, will be transferred into Families and Communities, as well as the budget that goes along with that. The transfer of the metro domiciliary staff to the Department for Families and Communities is 590 full-time equivalents.

Ms SIMMONS: Minister, I refer to the Portfolio Statement, page 7.19, which indicates that the waiting times for public dental services are decreasing. Can the minister please advise the committee how this is being achieved?

The Hon. J.D. HILL: The state government has invested over $36 million in additional funding into public dental services since it came to government. As a result, restorative dentistry waiting lists have been reduced from 49 months in mid-2002 to 23 months in June this year, involving a fall of 53 per cent, which is a very good outcome. During the same period, the number of people on waiting lists has been reduced by 39 per cent. In the 2006-07 budget we provided a $12.9 million package over four years to provide restorative dental care for adult concession card holders on the waiting list. The major treatment needs of people on this waiting list are fillings, extractions, and preventative services, such as cleaning and fluoride applications.

As a result of this investment, in the past year alone the number of people waiting for public dental care reduced by 7 800, or 13 per cent. Waiting times for restorative dental care will fall further to 18 months by June 2008 and are expected to fall to 10 months by June 2010. That is a key time because, if we can get the waiting list down to 10 months, we can obviously build in a program of regular checks. Waiting times have not been as short as this since 1966, when the federal government withdrew all funding from the commonwealth dental health program. We have had to put in an enormous amount of resources, but we will get back to where we were by the end of this term.

Ms CHAPMAN: Minister, I have some questions on the SA Dental Service as well. It is encouraging to hear of the reduction in waiting times. However, as an example of the people who write to me, I refer to a letter from Mr Stan Batten, which was sent to the member for Florey only a few days ago (16 June). He wrote to complain that, notwithstanding all these promises of reduced waiting lists, he has been waiting for two years for partial dentures from the Gilles Plains Dental Clinic. Mr Batten, who is 69 years old, has received a letter confirming that it will be another two years before he can expect to receive any treatment (that is, by June 2008). He has been waiting since April 2005, which indicates a four years and two months waiting time. So, whilst we have the data, minister, there are real people out there on these waiting lists. I ask the minister: how can you be assured that the information you are giving this committee is accurate?

The Hon. J.D. HILL: I am absolutely certain that the advice I get from my officers is the best advice they can give me; they are honest people who do not make up things. I was referring to restorative dentistry and you are referring to dentures, which is a different category of work. It is true that the system in place for dentures is a different system, and people can wait for a reasonable period of time because the production of dentures is a very expensive process and, as I

understand it, we do not have the capacity to do a lot of those procedures. The problem we have is that this is a service that used to be jointly funded by the commonwealth and the state. The commonwealth government's Constitution has a specific reference, as I understand it, to the commonwealth's role in providing funding for dental health care—and it is a role the commonwealth has walked away from in the 11 years John Howard has been Prime Minister. The commonwealth government has dipped its toe a little into the water just recently with the Medicare arrangements so that medical practitioners can refer people with complex diseases to a private dentist for medical funded dental treatment. However, that is obviously a limited scheme.

We do the best we can, and we are trying to deal with the broad population of people who require public dental care. I have already gone through the numbers, and we will get those numbers down. It is not possible to do everything for everyone as quickly as they want. We do manage these cases in the best way we possibly can.

Ms CHAPMAN: While we are on the subject of SA Dental Services, I refer to Budget Paper 4, Volume 2, page 7.25. I thank the minister for his excellent record in getting back with answers to questions taken on notice during last year's estimates committee. From our records, the only question that remains unanswered in relation to the 2006-07 budget is a question I asked about dental care funding to help reduce the waiting times for dental treatment and the proposal to sell $518 000 worth of assets in 2006-07. In answer to my question about where the assets were located and what assets were to be sold, you said:

> I am relying on my memory here so I will get a proper report for the member in relation to that.

That was on 19 October 2006. If that information has not been located, I ask the minister to take the question on notice again and, if possible, for us to have that detail.

The Hon. J.D. HILL: Given the good spirit in which the member asks the question, and her kindness in referring to the fact that we have answered every other question, I can only apologise if we were not able to get that information. My memory is that we have provided that information, but maybe there is more to be had. I will take it on notice, and I will certainly respond in a detailed way in this estimates committee. I think that we had a number of houses that were no longer needed. We sold those in order to invest in better management systems. I will have to get the detail for the honourable member, but there is no secret about it; it was a pretty straightforward deal.

Ms CHAPMAN: I appreciate that, minister. I have a further question on dental health, and I refer to Budget Paper 4, Volume 2, page 7.25. Since the government's introduction of a fee of $35 charged to primary school children for treatment by the SA Dental Service (which was announced in last year's budget), from its target, 5 700 fewer dental hours were provided to primary school students in the state in 2006-07. The budget reports suggest in footnote (k) that this results from parents having to provide informed consent. As parents have always had to provide consent for their children to have treatment, what additional imposition is being placed on parents that your department states in this report has caused them not to access this service? What inquiry, if any, has been made to identify whether, in fact, it is now that they have to pay, whereas previously this service was free of charge?

The Hon. J.D. HILL: I thank the deputy leader for her question, but I have to say to her that she is heading into dangerous waters, because the precedent for charging schoolchildren for dental services was, of course, established by the Liberal Party when it was in government.

Ms Chapman interjecting:

The Hon. J.D. HILL: Well, prior to that it was always free for secondary students as well. We have learnt from the charging of secondary students. We have now had 10 years or so of this system's being in place. From memory, I think that something like 96 per cent of secondary students actually have regular dental check-up, a proportion of which are through the School Dental Service, for which people pay, unless they are on a School Card or some sort of health care card. I think up to about half of the kids do not have to pay. However, the reality is that parents, particularly those who have private health care, can now take their children to a private dentist to have dental care provided in that way, and a lot of people do so, because I suppose it ends up being much the same cost or, in fact, cheaper.

The advice I have had is that we would expect a similar kind of arrangement to occur in the case of primary health care. In other words, families are in one of three categories, one of which is families who will continue to use the public dental service and get it free of charge because, for some reason or other, they are disadvantaged. The percentage of people in this category is very large, and we are very generous about that. In fact, I think we have extended those provisions into secondary school; I will check on that, but I believe it to be the case. There is a class of families who pays $35 and gets the service through the school, and then there is a class of parents who decide, for whatever reason, that they will use the private sector, and they do so.

The research indicates that the percentage of kids who are getting dental care on a regular basis is much the same, whether it be under a completely free system or a partially charged system. We know that because of the experience we have had through the $35 charge the Liberal Party introduced for secondary school children when it was in office. Of course, we have amended that scheme, which required secondary school families to pay $35 a year whether or not their child actually got a course of treatment during the year. Under the secondary scheme, not everybody was dealt with every year, but they still had to pay the $35. We have amended that so that they only pay $35 for a course of treatment. If you do not have a course of treatment in a particular year, you do not pay anything. A course of treatment is not just one visit (although it may be one visit); it could be a whole series of visits to fix up whatever dental health problems a child has.

In addition, we provide a free check-up as kids go into and leave school. This is certainly a different system, but it spreads the burden across families who can afford it. As a result of people's using private dentistry, as some do now in primary school and as they have for many years in secondary school, it means that the State Dental Service can deal with more children or, at least, it can deal with the kids in the state school system who use the state dental scheme more quickly because fewer children are using the service. So, everybody really wins as a result of this change.

Ms CHAPMAN: So, minister, why then is there what appears to be this nonsense about having to fill out an informed consent form as the excuse for the reduced numbers?

The Hon. J.D. HILL: I will take that part of your question on notice. I am not sure exactly why that is there.

Ms CHAPMAN: I am advised that another member of the committee has joined us who would like to ask some questions. **The ACTING CHAIR:** I think that the member for Mitchell might be interested.

Ms CHAPMAN: Yes, so I will just ask two more questions. I refer to Budget Paper 4, Volume 2, pages 7.24 to 7.33. In the major public hospitals, comprising the Central Northern Adelaide Health Service, the Southern Adelaide Health Service, the Repatriation General Hospital, and the Children's, Youth and Women's Health Service, there is a massive increase in the targeted private patient numbers in these public hospitals—namely, those who elect to come to a public hospital and use their private health insurance. In the budget papers, it is Central Northern, 7.8 per cent (and you are now targeting 10.4 per cent); Southern Adelaide, 6.2 per cent (up to 8.3 per cent); Repatriation General, 5.7 per cent (7.6 per cent); and the Children's is up from 14.6 per cent to 19.5 per cent. Is there an active policy of the government to encourage the use of public beds by filling them with private patients to recover the insurance income?

The Hon. J.D. HILL: I would not characterise it in that way. What I would say is that under the Medicare arrangements anyone who turns up to a public hospital is entitled to free treatment. Equally, under the Medicare arrangements, if a person has private health insurance they are entitled to claim private health insurance for their stay in a public hospital. In South Australia, a number of our patients who are privately insured indicate that they are privately insured and the private insurer pays the fixed amount for whatever that particular service is. That means the state pays less money for the provision of services, and this is a good thing. Other states are much more active in arranging and managing that than we have been, and we would like to reach whatever the national benchmark is in the provision of those services. It is exactly the same people, so, as your question might have suggested to someone just listening casually, we are not kicking out patients so we can have private patients. We are treating the same people but charging for them (or, accounting for the costs) in a different way, which is beneficial to the state budget.

Ms CHAPMAN: I think that is fair comment, except that we have a huge number of people who are waiting to get into these public hospitals within the four sectors that I have referred to and, as you might appreciate, if there is a policy (which I think you have confirmed) to maximise that for the benefit of the health budget, of course it has a direct reflection on access to those public hospitals for some people who do not have the choice of going to the private sector.

The Hon. J.D. HILL: I think the member misunderstands, and I will try to clarify it. We are not talking about trying to compete with the private sector and trying to get more patients in. God forbid! We are very happy for the private sector to provide services, but the reality is that the private sector does not provide all of the services that a public hospital provides. By and large, the services that private sector hospitals ply are in the elective surgery category, and many of them are in the less complex elective surgery category, as I think the member would understand. However, patients with private insurance also require services in public hospitals, particularly around emergencies, or particularly around more complex care, or because of geography there is no private hospital around, or because their doctor wants them to go there. For a whole range of complex reasons, they come to public hospitals.

What happens at the moment is that these privately insured people get the service free of charge and the insurance company pays nothing. What we want to do, when they use the public hospitals, is get the insurance payment that they are paying a premium for. It is not a matter of bringing more people into our hospitals; it is a matter of charging those who have private insurance—or charging the insurer for whatever the standard cost is. That is just beneficial to the bottom line of the health service.

Ms CHAPMAN: So, what is the practice that is proposed to encourage them to disclose that they are insured and to put in a claim?

The Hon. J.D. HILL: The member makes a good point. No-one will be forced to do it: it will be encouraged. We will develop protocols so that at an appropriate time in the admission process that information will be sought. I will ask Dr Sherbon, who is better able to answer this, to comment.

Dr SHERBON: The protocol adopted by our clerical staff is to ask patients upon admission whether they wish to use their private insurance. If they do not have private insurance it is a moot question. If they do, it is their decision as to whether or not they use it. We do actively ask people, and we point out that the revenue raised goes back into the health system. You can see the numbers here are very small. In New South Wales the figure for private insurance rates within public hospitals is up around 20 per cent, depending on where in the state you are. Here we are talking about 5, 6 or 7 per cent.

Ms CHAPMAN: It is 19 per cent proposed for the Women's and Children's.

Dr SHERBON: That would be obstetric women who want to choose their obstetrician. It is often the case, where women want a particular obstetrician, that they come in privately. So, as the minister outlines, it is not a process by which people are encouraged. They are simply informed of their options and informed that the accommodation fee that the fund pays will contribute to hospital revenue. They will then need to discuss with their doctor the fee that their doctor may charge.

Ms CHAPMAN: The second part of this question relates to a practice that is occurring at the Royal Adelaide Hospital whereby private patients are receiving the benefit of a facility which is a direct cost to the public health system and is not recovered. I was interested to note the minister's announcement of a piece of equipment at the Royal Adelaide Hospital yesterday to help improve the cancer diagnosis or treatment, I am not sure which, and that is to be commended. But the Royal Adelaide Hospital currently operates a multimillion dollar robot for prostate cancer patients (as a result of donations principally from Gordon Pickard and Robert Gerard) which now services 160 private patients out of 200 cases a year at the Royal Adelaide Hospital and, instead of being a revenue stream for the hospital, it has a cost of over $1 million a year, particularly to dispose of the scopes (that is, the arms used on the robot), which are radioactive, after a certain number of procedures. That is a cost of $4 000 to $6 000 per arm to dispose of them. So, apart from driving up the revenue from private patients in a public hospital, is there any explanation why this service is being provided to private patients when there is no access to insurance funds for the cost of the use of this equipment used in the procedure? Is any action proposed to be taken by the government either to

sublet this to the private sector so that it can be a recovered cost to other hospitals or, indeed, sell the piece of equipment?

The Hon. J.D. HILL: I was not the minister at the time this was arranged, but I understand that the unit is placed in the hospital as a service that can be provided to the entire community and not just public patients. That was the understanding of part of the nature of the gift. Often people give things to health services with these strings attached. I will get a more detailed response for the honourable member. Generally we share equipment with the private sector and the private sector shares equipment with us. As you would expect, we have unique pieces of equipment in a hospital and they are shared around. All the patients using the equipment are South Australians and they are all entitled to access to services in our public hospitals, as I previously explained. However, if there is a potential for cost recovery, we will certainly look at it.

Mr HANNA: My questions to the minister all relate to the target that says:

> . . . plan and develop the GP Plus Health Care Centre at Marion and the governance structures for the GP Plus Health Care Networks.

I refer to item 7.9 of the budget papers. The first question I have is about the Aldinga GP Plus centre, because I heard that only GPs will be available at the Aldinga centre when local private sector GPs are not operating. Will the minister clarify that? Consequently, what does that mean for the Marion GP Plus centre, which is next to a 24/7 general medical practice?

The Hon. J.D. HILL: I acknowledge the honourable member's ongoing interest in this centre and his campaigning for it over a number of elections. I will talk about GP Plus health care generally, and then about Aldinga and Marion in particular. I wanted to call it GP Plus to indicate partnership with general practice. It would be fair to say that there was a 1970s model of what was then called 'community health', which was really a set-up of institutions in competition with general practice as alternative models of care that were non-medical models of care. Some elements of that model are still around. That was not the model of care I wanted to see us develop in South Australia through these new primary health care centres, and I wanted to make plain that the model of care we are looking at is one that worked on the basis of partnership with general practice.

In essence, general practitioners are the main providers of primary health care to our community and we wanted to build these centres in collaboration with them and have them involved in the planning. We have been intimately involved with the southern division of general practice in the planning for the Aldinga GP Plus health care centre. The circumstances in Aldinga and Marion are different, as are the circumstances at Elizabeth and Woodville. Each GP Plus health care centre will have a different range of services, depending on the differences in that community, namely, population, geography and the provision of services through other providers.

At Aldinga there is a real shortage of general practice and relatively long waiting times to get into GPs, and the main practice in Aldinga and the southern division of general practice made plain to me that they thought the priority in that area was to have after-hours GP services and not GP services during the daytime as they were coping relatively well. Because they were busy they found it difficult to run an after-hours service and wanted some relief.

In the construction of the GP Plus health care centre we provided a whole range of allied health and nursing services which would support the local GPs during their daytime work so that chronic disease management could be jointly managed through the local GP services and the GP Plus health care centres. So nutritionists, dietitians and other health workers can help on a population basis and work with GPs on chronic disease management. However, at night time we have entered into an arrangement with a company called GP Solutions—a private company owned by GPs—and they provide locum services to other GPs. They are providing GP services after hours from 6 p.m. to 10 p.m. or thereabouts and for extended periods over the weekends. They also bulk bill. This has been fantastic for the local community because it is not a matter of using that service to do normal GP functions but using it when there is an emergency. People are able to go there at night and on the weekend when they have a problem—they do not have to book, just turn up—and there has been a reduction in the number of people in the area going to the Noarlunga Hospital, which is terrific. It is working well: the community likes it and the GPs like it.

Marion is a different arrangement because adjacent to where we will build it there is a 24-hour a day GP service and it bulk bills, so it would be silly for us to replicate that, and we will not. The Marion centre will be much bigger than the Aldinga centre—possibly 10 times—and will have a broader range of services. I am also told that the division of general practice is looking at putting its headquarters in there, and through the facility there will be the range of services available elsewhere but also the potential for specialist clinics run by GPs or even for day procedures. The GPs from the adjacent building or GPs working in the Marion area may have a particular interest in working with mental health patients or people with depression, and might run a clinic for people with depression issues, eating disorders or sleeping disorders. It will allow the GPs to specialise and we will provide services to help them do that. All this will be worked out in collaboration with the local service providers. It is an adaptive model.

Elizabeth will be different, because there is a shortage of GPs there. So, we are likely to have an after-hours GP service there, and it might be provided by a group such as GP Solutions. The alternative (and this is what I would prefer, if possible) is that we get the local division of GPs to provide the after-hours services and share the load amongst them, so that we do not have 14 or 15 GPs providing after-hours services in an unorganised way; they could all agree to a timetable. That is all to be worked out. However, that is the kind of model.

Mr HANNA: I hope the minister has forgiven me for asking him (in the corridors of Parliament House): who came up with the stupid name GP Plus?

The Hon. J.D. HILL: I hope the member agrees that it is a sensible name, now that I have explained the basis of it. It is really sending a signal to the general practitioners, who I think might be suspicious that this is something that will compete with them, and also to say to the health department that this is a model of care that connects general practice to the other primary health providers. So, it is about bringing those groups together. I think having a name like that keeps reminding everyone that that is what it is about—it is not the Marion Primary Health Care Centre, which has nothing to do with GPs.

Mr HANNA: Yes, it was a very good and thorough explanation, thank you.

The Hon. J.D. HILL: I am happy to elaborate further.

Mr HANNA: I am hoping that the budget allows for a continuation of an outreach service at the current Inner

Southern Community Health Centre on South Road, even after the Marion GP Plus health care centre has been established. Is that the case?

The Hon. J.D. HILL: I am not aware of outreach services. I can certainly obtain some advice. I have inspected that site, and I think most of the buildings are pretty ordinary—in fact, I believe that the workers were looking for a new site. You do not need a building to have an outreach service: it can be provided in a whole range of facilities. It is probably too early, in fact, to be able to answer that directly, because we are still in the process of working through how we will provide these services. I will certainly obtain more information for the member if I can.

Mr HANNA: What is the minister's current thinking on the governance structures for the GP Plus health care centres? Will it be, for example, a board with community representatives?

The Hon. J.D. HILL: We are still thinking through exactly how we will do it. It will not be through a board arrangement. I will not get rid of boards in hospitals and establish them in GP Plus health care centres. It will be part of the departmental structure, but we will need some sort of local consultative process that involves consumers and the service providers. We are certainly working very closely with the service providers. For example, when we established the Aldinga centre there was a very good, I think, public consultation process—public meetings—where local community members had an input and helped to design the structure. I do not think we need a group like that to manage the place: the department is quite capable of doing so. However, we need a system in place so that we can regularly talk to the community and the service providers about the changing needs.

It is that kind of capacity to make the thing adaptive in its role that I think is important. How we do that is one of the issues that I am contemplating generally through health. I have foreshadowed a new health care bill, which will establish a health performance council. One of the roles of that council will be to monitor and give advice about how we best do that. One of the things the Generational Health Review argued was that consumers needed to be involved in these kinds of processes. The typical way for governments to involve consumers is to appoint a panel of activists and say, 'That is the advisory body, and that is the community views being taken into account.' However, in my view, that is not a way of taking community views into account. You need to go out and talk to a whole range of people in their own locations. I guess it would be fair to say that it is a work in progress at this stage.

Ms CHAPMAN: While we are on the topic of GP Plus centres, the only feedback I had on the name was from the other allied health people, who were a bit miffed that it was going to be 'GP' in the name but not them. I do not know whether or not that is helpful. The minister might find that it is the allied health service people who are a bit miffed at their not being recognised in the name. My question relates to the number of client services providing for a full year of operation of the Aldinga GP Plus Health Care Centre (page 7.28).

The minister has explained what that is doing, and it sounds very good. However, no reference has been made to the second centre that has been established in the past year at Woodville. As we know, that is effectively a transfer of the SHine headquarters out of my electorate in Kensington Gardens to Woodville. The government has sold off its headquarters, and that has all been budgeted for. My question is: at the new health centre operating at Woodville, which does not have any client service numbers attached to it, how many client services, in addition to their consultations for advice on sexual health, are budgeted for in the 2007-08 year and how many medical, nursing and allied health professionals have been employed to provide services other than sexual health advice or treatment?

The Hon. J.D. HILL: In relation to the allied health workers, of course, they work for us, anyway: they are in the primary health care system.

Ms Chapman interjecting:

The Hon. J.D. HILL: That is very good. This is demonstrating that it is a partnership between the public sector and the private sector. I guess we could call it 'GP nurse allied health worker plus', but I do not think it would roll off the tongue quite as well. I previously mentioned the Woodville centre in passing. I said that it has started working, but we have yet to open it: I think I am opening it in about a month. Building was completed in April this year, and SHine SA started providing services to the public from 30 April 2007. The services to be provided from the new facility include sexual health medical clinics; counselling; information and pregnancy-related drop-in services; youth medical clinics and counselling; drug and alcohol and mental health counselling; pregnancy counselling; antenatal services and medical deputising services.

Ms CHAPMAN: What was the last one?

The Hon. J.D. HILL: Deputising services, which means GPs, apparently. That is obviously a bit of medical jargon; it is after-hours GPs, apparently. The main focus of this centre, as the member knows, is SHine. There was some controversy about its movement, I acknowledge, but its main focus will be providing health services to young people across a whole range of areas. I have visited the centre and I recommend that the member visits to have a look at it. That after-hours GP service will be available from 6 o'clock to 10 o'clock, Monday to Friday, 1 to 10 o'clock on Saturday, and 9 a.m. to 10 p.m. on Sundays and public holidays. The remaining services are available during normal office hours, so I guess it will have similar after-hours GP services to the one at Aldinga.

The Hon. G.M. GUNN: Minister, one of the great difficulties in providing services is the availability of GPS across country areas and being able to maintain and keep them. Does the department have a strategy in relation to ensuring that general practitioners are available to rural communities on an ongoing basis? As an example, recently some concern was expressed about this in Kapunda. There was something in the local paper and the local council wrote to me in relation to this matter. Does the government have any strategy to make life easier for people who are giving excellent service at the present time and to be able to attract GPs to country areas?

The Hon. J.D. HILL: I thank the member for his question and acknowledge that it is a real issue in country South Australia. In fact, I think a huge number of the GPs who are operating in country South Australia, and particularly those in sole practice, are overseas-trained doctors and, while we welcome them and bless them and thank them very much for coming here, it is an absolute tragedy of our system that they are not produced in our universities.

As the member would know, some 10 years or so ago the training of doctors and others in the medical workforce was dramatically reduced because there was a view that there was

too much over-claiming (amongst other things) on the Medicare system, so they reduced the supply and made it harder to get a provider number. We are now suffering the consequences of that. The consequences are that we cannot provide enough GPs to service our own needs, particularly in difficult areas like country South Australia and, so, we are bringing in people from overseas.

The federal government acknowledged this error last year when it increased the amount of training but, of course, it will take a number of years before that flows through. That is the background to this. The provision of GPs, of course, is not something the state government is generally responsible for, although we obviously have a keen interest in ensuring that GPs are there. In May 2005, a $27.2 million four-year program was announced to support the recruitment and retention of medical practitioners residing in rural South Australia.

The Rural Doctors Workforce Agency has been funded $15 million for the next three years to support rural doctors, which includes rural local services and continuing education, counselling and services over the phone—doctors for doctors. Doctors sometimes try to heal themselves but they often need other help as well.

The SA Rural Medical Engagement Schedule 2007 has been developed to foster and support relationships between country medical practitioners and country health units. I launched that schedule on 8 June 2007 with Richard Mackinnon, who is the head of the Rural Doctors Workforce Agency and who does a great job for us. Approximately two-thirds of projects announced in the program were completed in the first two years, including on-call arrangements, country clinical governance, the appointment of six chief consultants, enhanced locum services through Rural Doctors Workforce Agency, university medical scholarships and a real emergency services training program. In fact, we now provide 25 scholarships a year not only for GPs but for other health workers to go back and work in rural settings. The current vacancy rate for GPs remains stable at approximately 4 per cent.

I understand there are about 20 locums from the Rural Doctors Workforce Agency supporting country GPs. The average weeks of locum services provided by each locum has significantly increased due to improved employment arrangements. Nine first-year medical students have accepted bonded full-paying scholarships to the University of Adelaide and Flinders Medical School for 2007, and there is a commencement of 10 first-year bonded medical students in 2008. There is increased activity to recruit Australian and international medical graduates to maintain the vacancy rate of less than 4 per cent. This year, for the second time, we had an expo for graduates from the various medical schools around Australia promoting South Australian hospitals, including rural hospitals. The universities are now conducting training, at least for part of their terms of undergraduate years, in a number of rural settings. I think that is something which is of great merit and worth encouraging.

Certainly, through the development of four general hospitals in country South Australia we would want to see more training and training for longer periods of time in rural settings, because I think that is one way of increasing the potential for doctors to stay in country settings. There are a whole range of other things as well which are going on. It is something that we just need to keep focused on and I think through all these strategies we are demonstrating that we are.

Ms CHAPMAN: I refer to Budget Paper 4, Volume 2, pages 7.24, 7.25 and 7.26, under 'Central Northern Adelaide Health Service'. This section provides for the Royal Adelaide Hospital service, which is ultimately to be closed down at its current site under the government's proposal. The minister claims this is consistent with the Generational Health Review. Has the minister yet ascertained why the 2003 report by John Menadue was removed from the website, about which I recently asked a question in parliament and, furthermore, why the page of information on the number of beds at the Royal Adelaide Hospital at the North Terrace and Hampstead campuses has been removed from the website altogether?

The Hon. J.D. HILL: The advice I have in answer to the first question—and you did ask me the question in the house and I will get you a formal answer to it—is that somebody had been sabotaging the website. There had been a problem with the website, a potential hacking or something or other, which had caused that particular website section to have to be re-established. It was just coincidentally the section which had the Generational Health Review information on it. The intention was to put it back up but when somebody raised the question we made sure it was put up straight away. So, it certainly was not the intention to deprive the public of the benefit of that report.

In relation to Hampstead and the RAH, I understand there was an ambiguity in the expression of how many beds there were. I think the Hampstead beds were counted in the RAH bed count and so there was confusion about the number of beds at the RAH. The reality is that there are 680 beds, or thereabouts, at the RAH, but I think since the RAH manages Hampstead there was another figure going around that said there were a greater number of beds. So, there were two figures out describing the number of beds, which was confusing. It was technically right but it just confused people, and we are sorting that out so that there is clarity about how many beds are at which location. That is as I understand it.

Ms CHAPMAN: In relation to the hacking into the website, has that been reported to the police?

The Hon. J.D. HILL: I am not sure what procedures are in place but I gather they are being dealt with.

Ms CHAPMAN: Has there been any other occasion of hacking of the website while you have been minister?

The Hon. J.D. HILL: I will get Dr Sherbon to comment.

Dr SHERBON: Our information services department maintains a very vigilant gaze over the security of our information. We are aware of two episodes, since I have been here, in the past 10 months. One was at Flinders, where there was disruption to email capacity and internet capacity as a result of a hacking incident from overseas, and another one recently with one of our central systems, not the clinical system but a central system, where there was an attempted hacking episode and the site was vandalised but not to the point where it could not be used. We do test our systems. Our information services branch have a system whereby they attempt to hack into our own system so that we can check whether they are accessible. The security of our clinical systems has not been breached but some of our web systems have been breached and we are correcting those.

Ms CHAPMAN: Minister, of the two episodes to which Dr Sherbon has referred I understand that one was an email hacking at Flinders.

Dr SHERBON: It was not hacking into emails; it disrupted the email traffic.

Ms CHAPMAN: In relation to the attempted hacking of the central system referred to by Dr Sherbon, was that incident referred to the police?

Dr SHERBON: No, neither matter has been referred to the police. It is impossible to track where they came from. As you know, most hacking is coming out of Eastern Europe and Russia, and I understand the latest wave is coming out of Turkey. There has been no patient or staff damage, so we merely maintain vigilance on ensuring that our security of information is intact. So, no, we have not reported it to the police.

Ms CHAPMAN: You lost the Generational Health Review at the time of this hacking. What other documents or records were lost at the time of this hacking?

The Hon. J.D. HILL: I do not think it is fair to say that documents were lost. It is just that the site was interfered with, and it was closed down so that it could be reformatted or technically refreshed, or whatever the technical language is. I gather that has happened, and it has been put up.

Ms CHAPMAN: Well, what other documents were lost during that time?

The Hon. J.D. HILL: I do not know whether any documents were lost, but that particular part of the site was closed down. I can certainly find out what was on that site for you.

Ms CHAPMAN: I ask the minister to take that question on notice. I refer to Budget Paper 4, Volume 2, page 7.30: Repatriation General Hospital. At the time of preparing the health portfolio statement, it is claimed in this budget paper that the health service agreement between RGH and the minister had not been completed. Can the minister advise whether the health service agreement has now been completed and, if so, are there any changes to the targets published in the budget papers?

The Hon. J.D. HILL: The advice I have is that none of the health service agreements has been finalised for 2007-08 because we are finalising the individual budgets with the various regions. Of course, the way in which the health system operates is that we have the three metropolitan regions and country health, and the Repat Hospital is a discrete organisation.

Ms CHAPMAN: Minister, you have previously indicated and, in fact, given a commitment to the parliament, as has the Premier, that this hospital would retain its board, 'unless the diggers wanted it', to use the Premier's words. My question is: has any consultation with returned servicemen and women been undertaken to seek approval for such action?

The Hon. J.D. HILL: I have had a couple of conversations with representations from the various returned service organisations. The advice I have given to them is that they should wait. I an anticipating that the legislation will go through the parliament and that, once that has happened, there will be a mechanism in the legislation that will allow them to integrate into the southern region if they so choose—and they seem happy enough to do that. I am not sure that I am allowed to do this, but let's say the legislation is introduced to the house, there will be a mechanism in that legislation that allows the Repat to stay as it is and a mechanism to transit it afterwards. I have said to them, 'Look, just wait until the whole thing has gone through the parliament and then we can go through it without any rush. You can be comfortable about whatever arrangements you want to enter into'—and I think they are pretty relaxed with that.

The reality is that over half of the returned soldiers use hospitals other than the Repat, so the thinking I have, which I have expressed to them, is that we could establish a statewide returned services advisory committee that would give guidance and advice to the health system generally about the needs of returned servicemen and women, not just those at the Repat.

Ms CHAPMAN: In relation to that process, is it proposed that you will in some way conduct some survey of returned servicemen and women or are you just going to negotiate with the RSL?

The Hon. J.D. HILL: Not with the RSL as such, but certainly with the RSL directly, because it is a key organisation. There are a number of organisations. I am sure that you know Laurie Lewis, who chairs a committee of organisations that represents returned servicemen and women. I would see both the RSL and that organisation, which I am sure includes the RSL, as the key bodies. I think that it would be appropriate for them to consult with their own members on how to proceed. However, they are not being rushed and, if they choose to stay as they are, I am happy to live with that.

Can I also say that, in relation to the issue of dental assets, I am advised that we sold houses at Naracoorte, Kadina and Renmark for $546 146. Funds were used for addressing school dental issues and needs related to increasing dental students. Last year, I said:

> I am advised that that includes four houses at Loxton, Renmark, Millicent and Naracoorte. I am advised that SADS has not used them for a long time, and they have been kept until now as a reserve. The houses have, in fact, been rented to the public.

I hope that gives you sufficient information this time.

Ms Chapman interjecting:

The Hon. J.D. HILL: That's good.

Ms CHAPMAN: Did I understand your response correctly, that is, that those funds were put back into the SA Dental Service for a service delivery?

The Hon. J.D. HILL: Yes.

Ms CHAPMAN: I refer to Budget Paper 4, Volume 2, page 7.38. The performance indicators will now report episodes of care for the Royal District Nursing Service instead of the number of payer visits in the targeted 10 000 for 2007-08. What make-up of these 10 000 will be telephone consultations?

The Hon. J.D. HILL: I cannot answer directly, but I will happily take that part of the question on notice. However, I can say that I understand that we have had very good negotiations with the Royal District Nursing Service for a much clearer and more strategic set of arrangements so that the health system knows much more accurately what it is getting for the money it pays. A variety of categories of patients is cared for: some have disabilities, some have HIV AIDS and others are just coming out of hospital. There is a whole range of categories. I am not aware that any of them are actually telephone services, but I will certainly get that information for the member.

Ms CHAPMAN: I refer to page 7.34, the IMVS. One of the reasons for the increase in expenditure is claimed to be associated with 'non South Australian government appropriation revenue sources'. Often, this is just the commonwealth, but I ask: what are these, and what is the budgeted expenditure and revenue respectively? What is the nature of the work to be undertaken with those funds?

The Hon. J.D. HILL: I will certainly take part of that question on notice. Some of those services are private pathology. The IMVS does more than 50 per cent of the private pathology in South Australia. It also provides services

in the Northern Territory and commercial trials for drugs. It deals with a whole range of clients.

Ms CHAPMAN: That is a given, but, in the explanation, one of the reasons for the increase in expenditure is this item. It is assumed that the IMVS gives those other services, but is there a particular one of those or others that—

The Hon. J.D. HILL: I will certainly take that question on notice. I think it is just that the business is becoming a better business, and it has just grown.

Ms CHAPMAN: More commercial?

The Hon. J.D. HILL: Yes. I have opened at least one and perhaps two IMVS centres in rural South Australia in the past year or so. It is expanding its business. They do provide a very good service to doctors. Information from pathology tests is sent electronically to doctors' file notes, so it is a very well managed service they provide.

Ms CHAPMAN: Minister, I think I may have asked you (or it may have been your predecessor) about the name IMVS and your government's commitment to maintain that name. Is that still the case?

The Hon. J.D. HILL: I think the IMVS name, as a trading entity, has benefit and I would like to see that maintained. Whether the service itself (in terms of its technical name) is called IMVS is yet to be finalised, but I am strongly of the view that we should maintain IMVS as a trading name because it has a certain cachet which is of commercial benefit. However, there may be something such as 'SA Pathology Services trading as IMVS' or something like that.

Ms CHAPMAN: While we are talking about commercial merit or trade benefit, has there been any consideration by the government for the Marjorie Jackson-Nelson Hospital to have a similar 'trading as Royal Adelaide Hospital' notation, or vice versa, so that we maintain the benefit of that name internationally?

The Hon. J.D. HILL: This is one of the great furphies that has been put around, that no-one would know what a Marjorie Jackson-Nelson Hospital is. Well, on that basis, I guess no-one knows what a Mayo Clinic is, either. Big entities that do a whole range of complex, interesting things and that develop research get known because of the quality of their work and not because of the recognition of their name. The Hanson Institute, in South Australia, operates with international credibility but it is not called anything that is recognisably South Australian; it obviously has a profile because of the work it does.

I am sure the new hospital will be able to do just as well in terms of its international reach as the RAH has done. I know there are some who would like to see the Royal Adelaide Hospital title remain, but we are building a new entity with a new culture on a new site, and it will combine services. While a large part of those services are currently provided through the RAH, they are not exclusively so provided, and I think this is a strong demonstration—particularly for those who work at the QEH—that this is a new entity in which they will be full partners, not a take-over by another hospital.

Ms CHAPMAN: I take that as a no.

The Hon. J.D. HILL: Fair enough.

Ms CHAPMAN: I refer to Budget Paper 3, page 7.9, and elective surgery. The minister has announced a strategy to enable patients to find and then join the shortest waiting list for elective surgery, that each speciality and hospital will be published on-line. A public announcement has been made on that—and I think you referred to that today, minister. When does the minister propose that the website servers will be on-line and available?

Given the government's initiative to place elective surgery waiting lists (which consistently remain four months in arrears) on-line, will this facilitate current information for patients to make the assessment? In particular, I point out that the elective surgery waiting list data for all hospitals on your on-line web service goes to only February 2007, yet here we are in June. If we are to have a new list, or a new lot of lists, on a website so that someone can find out whether they can get a quicker service at Modbury or at the Royal Adelaide or some other eminent public hospital, how will they deal with that if the data is four months old?

The Hon. J.D. HILL: In terms of the date for the new service, I understand it will be done very soon. It is our intention to make the information up to date; there is no point in having information which is not relevant to the consumers or to their doctors. To make it absolutely up to date will require good systems, but that is what I hope we will be able to provide. However, I am advised that we will be able to do this in a very short period of time.

Ms CHAPMAN: Will it be updated on a daily basis? How will it work?

The Hon. J.D. HILL: It think it is probably stretching it to do it on a daily basis, but it will be done on a frequent basis so that it is meaningful. We are talking about letting people know how long they will have to wait at particular hospitals for particular surgical procedures. The facts about how long you wait will not change dramatically on a day-to-day basis. They will be trend lines. If one hospital is very busy doing hips and another is not so busy, it will be pretty apparent from the service. Whether it is accurate within 24 hours I guess is another matter, but it will be very strongly indicative of where you ought to go if you want to get a service done more quickly.

Ms CHAPMAN: How will it work? Let me give an example. I know that Mrs Gertrude Zimmerman is concerned that she is on a 22-month waiting list at the Modbury public hospital for treatment at the orthopaedic outpatient clinic. Like many, she has made some complaint to local state and federal representatives about her wait. She got a referral letter in August 2006 telling her about her treatment, and then in April 2006 she was told that the orthopaedic outpatient clinic currently has a 22-month waiting list. If I were to advise Mrs Gertrude Zimmerman that under this new system she could go to the website and find out that there was still a 22-month waiting list for orthopaedic outpatient work, would she be able to access that information? Would it be up to date? Could she go to other hospitals under this new scheme and find out whether it is 21 weeks or 30 weeks? How will it work?

The Hon. J.D. HILL: I will try to explain the general principles. At the moment, patients go and see their GPs, the GPs refer them to specialists, and the specialists give them a time based on clinical considerations. Under the scheme, I think the way it will most likely work is we will certainly have on a website how long you will have to wait for a particular surgical procedure at particular institutions (whether it is at Royal Adelaide Hospital, Modbury, or whatever; and, over time, I would like to see that include the country as well, as I mentioned before), and when Mrs Zimmerman, or any other person, goes to see her GP, if the GP is tuned into this, the GP will say, 'Right, you need to see a surgeon about elective surgery. Let's look at the website to see what the waiting time is at particular institu-

tions.' They will be able to look it up and say, 'If you go here, it's a bit further away but you are likely to have to wait only so long, which is a lot shorter than the time you have wait if you go to the hospital closer to you.' Then the patient, in consultation with the GP, can make a decision about what might be in his or her best interests, and the doctor can then make a booking with the particular surgeon who will see them. That is not a guarantee that, because it said on the website you will wait 22 weeks when you go and see the GP, it will be exactly 22 weeks. It is indicative of the relative time taken between appointment and service delivery at each of those institutions.

So, I do not want to overplay the nature of this tool, but it will be a useful tool for doctors to try to get people into surgery in the best way possible. Patients, too, of course, will be able to access this and, in part, that is one of the advantages of the scheme. This is a scheme that I saw in Victoria, where it seems to be working quite well. In Victoria, they do it down to the individual doctor. We will not do that because the doctors do not operate individual lists: the hospitals operate joint lists, if you like (no pun intended). But, in Victoria, the experience was that individual GPs of course have their preferred specialists—the ones they know, the ones they went to university with, or whatever, and the ones they have contact with. GPs do tend, as I understand it, to recommend their patients to particular surgeons with whom they have an association—and that is not a bad thing but is just the way it operates—without thinking about what other service providers might be able to do it more quickly.

This is a tool which will help educate the GPs about the potential for recommending a patient to a different location for more rapid treatment. Also, it will be a tool that patients can use, because not everybody, of course, has access to or can use the internet. Patients will use this tool and then go to their doctor and say, 'Doctor, I have checked it out: I can get a hip replacement at Modbury within so many weeks whereas everywhere else it is longer. Can you send me to Modbury?' Or, in the future, there might be rule settings. For example, Berri might become a centre where particular surgical procedures are done and we would have visiting doctors there who would do these procedures. There may be only two or three people in the Berri community who want the procedure, so there is a bit of spare capacity for somebody to come up from Adelaide and have it done next month. That is the way I would anticipate it being used. It is not a guarantee that, if you go through that link, you will only have to wait for so long. It is a way of giving more information to people—the doctors and the clients—so that they can make decisions which give them services in the best possible way.

Ms CHAPMAN: Let us hope that more information is actually a useful tool for doctors and patients. Do I take it that your current elective surgery list information and data, which is on the website, will continue to be updated on a monthly or three-monthly basis, or whatever? As I say, at the moment it is effectively four to five months in arrears.

The Hon. J.D. HILL: It is updated monthly, but it is done on an aggregated basis. It needs to be extended. At the moment, we only provide information about some Adelaide hospitals. Noarlunga, for some reason—which I have never really been able to get to the bottom of—is not included, and none of the country hospitals are. As a result of that, our figures always look a little worse, because if you take into account the procedures done in the country and Noarlunga we would actually perform a lot better. We are not comparing apples with apples in South Australia with other states. Certainly, we would be continuing to provide that general information. It is updated on a monthly basis, but a checking regime is gone through to make sure that it is incredibly accurate.

Over time, as we get used to putting it up on a monthly basis, we should get faster. I am very much in favour of putting all this information out in the public arena because, the more people understand the system, the better the system will be at providing services.

Ms CHAPMAN: The opposition is informed that 6 000-odd out-patient appointments have been cancelled at the Noarlunga Hospital. Is there some explanation for that?

The Hon. J.D. HILL: Over what period of time?

Ms CHAPMAN: Just recently. Is there some new replacement program that is going to happen to—

The Hon. J.D. HILL: I am not aware of any. Certainly, as a local member, I have not been contacted about people having had out-patient procedures cancelled?

Ms CHAPMAN: Appointments.

The Hon. J.D. HILL: Appointments—$6 000 seems a lot.

Ms CHAPMAN: It does.

The Hon. J.D. HILL: It depends over what time frame. If it is over five years, I suppose it is reasonable but, if it is over five weeks, it probably is not. I will certainly get some advice, but I do not have any advice here.

Ms CHAPMAN: I refer to page 7.50, Financial Commentary. The budget papers claim an increase in the 2007-08 budget, when compared with the 2006-07 budget, of $308.8 million. Unfortunately, as is usual when I read these budget papers, only some of the factors are identified as to what the total variations are in expenditure and income disclosed. There is $59 million and $13.1 million, there is another $13.1 million and $54 million, and there is one item with no amount. The last one is unclear, at least to me when I read it, as to what the total amount is. Will the minister identify the amounts for each of these major factors in the variations, both in income and expenditure, which then add up to the net $308.8 million increase?

The Hon. J.D. HILL: I think we have that information. I will ask Mr Bernadi to explain those variations. This is my tenth year of doing estimates (four in opposition and six in government), and I have to say that no two budget papers have been the same over that entire 10-year period. I guess that will always be the case as we change, because of current thinking and better ways of doing things.

Mr BERNARDI: On page 7.51 the difference between the estimate in the 2006-07 budget and the 2006-07 estimated result is $204.5 million.

Ms CHAPMAN: I am talking about the previous page.

Mr BERNARDI: I am reconciling the amount of $308.8 million. The difference between the 2006-07 estimated result and the 2007-08 budget on page 7.50 is an additional $104 million, so those two variations are the $308 million. The reasons for the movement are on pages 7.50 and 7.51; you need to add up both causes of variation.

Ms CHAPMAN: That is why I am looking for the difference. I refer to the second to last dot point on page 7.50: Annual indexation by state government and commonwealth government. However, it gives no amount; what is it?

The Hon. J.D. HILL: I will take that reference on notice.

Ms CHAPMAN: The last one on page 7.50, which I cannot understand but it may be clear, is the savings approved as part of the 2006-07 budget, which increased in 2007-08 by $8.4 million, as well as savings of $8.1 million approved in

the 2007-08 budget. What is the net amount for that dot point? Could that be clarified also?

The Hon. J.D. HILL: They are two savings strategies. We had a savings strategy in 2006-07, which is ramping up over the years. It started off relatively low in 2006-07 and in 2007-08 we have to find $8.4 million. We have another savings strategy being implemented in the 2007-08 budget, which is $8.1 million, so you would need to take both those figures.

Ms CHAPMAN: I note Mr Bernardi will provide information on the calculations to end up with the net $308.8 million and I look forward to receiving that. That probably covers the question I have for 7.15, where the factors contributing are the $205.5 million—I see Mr Bernardi's head nodding—more than the budget for the year. There is an increase in demand of metropolitan hospitals at $59.3 million. How much was paid to the regions to cover the increased demand at each of the Royal Adelaide Hospital and Flinders Medical Centre respectively?

The Hon. J.D. HILL: Which year?

Ms CHAPMAN: For 2006-07.

The Hon. J.D. HILL: We probably have the information, but I will take the question on notice.

Ms CHAPMAN: On the same issue, the factors contributing to the variation as detailed in the schedule as published total $191.1 million, so I seek an explanation as to the factors that add up to the $13.4 million difference.

The Hon. J.D. HILL: We will take all of that on notice.

Ms CHAPMAN: Thank you very much for bringing that matter to my attention, Mr Acting Chair. I have two questions. I refer, first, to pages 7.24, 7.27, 7.30 and 7.32—Health services performance statistics. Footnote (a) in respect of each of these categories refers to acute hospitals in aggregation of performance indicators, including intensive care patients, emergency department and outpatient services. In addition to this information not being provided, it is noted that data on rehabilitation bed days, nursing home type occupied bed days or outreach services is no longer provided at all. Can the minister explain why this information is no longer published and available in the budget papers?

The Hon. J.D. HILL: The Department of Health reviewed the suite of performance indicators reported in the portfolio statement for health in 2006-07. The main objectives of this review were to further broaden and balance the dimensions of performance reported, strengthen the focus of the indicators on the government's priorities for health, improve the alignment of internal and external performance monitoring, and achieve greater consistency in reporting across health jurisdictions to facilitate service comparison.

The performance indicators reported in the 2007-08 state budget enable more informative assessment of hospital and out-of-hospital services, access, efficiency, quality and effectiveness. During 2007-08, specific emphasis will be given to identifying and reporting mental health and Aboriginal health performance indicators. Key changes to the indicators include public hospital admissions data, including intensive care unit patients and emergency department outpatient services, which has been aggregated into a single out measure known as an 'equisep equivalent'—that is, resource use weight of hospital outputs.

All those things have been brought into this one formula so that you can compare hospitals with each other and systems with systems. Measures to assess the effectiveness of out-of-hospital services in alleviating demand pressures on the hospital system include, for example, potentially preventable admissions and hospital admissions of older people resulting from a fall in the community and a greater focus on hospital efficiency measures (for example, day of surgery admission rates and a relative stay index). The department will continue to improve the utility and scope of the indicators reported in the state budget for the next year and specific emphasis will be given to identifying and reporting, as I said, mental health and Aboriginal health performance indicators that reflect the priorities for these population groups and the key reforms in the services, including those arising out of the work of the Social Inclusion Board.

Ms CHAPMAN: At page 7.9 of Budget Paper 4, Volume 2, targets in relation to the family home visiting program are detailed and the minister proposes to expand this service. On balance, I think it is a very good service, but probably it is unfortunate that it is not on the APY lands where we have a good number of our South Australian babies every year. Nevertheless, this program according to evidence given by the Australian Breastfeeding Association to a Senate inquiry is providing visits to mothers with their newborns with delays of up to four to six weeks after the baby is born.

On anyone's assessment, if that is the case, it somewhat defeats the purpose of identifying where children might be slipping through the net: where newborn babies are in a household which is either dysfunctional or under some financial pressure or where the mother has no fixed address, for example. Historically, these children who are often between zero and five years of age do not show up on any system until they get to school. The importance of this program is to ensure that they actually are identified early and support services provided where possible.

This is a rather concerning outcome from this evidence that is alleged to have been put. So, I ask: what funding or restructure of this program has the minister proposed in this year's budget to remedy this situation and ensure that new mothers actually receive a visit within the first week of their baby's life?

The Hon. J.D. HILL: I am glad the honourable member asks me this question, because I saw the comment from the breastfeeding mothers' group. I was somewhat taken aback. South Australia is the only state that undertakes a sustained universal home visiting scheme. We have an extraordinarily big investment in this in South Australia. The goal is to get a nurse to every new mother within month or so of the child being born. Obviously, that is attempted. The Family Home Visiting Scheme is, of course, a sustained scheme which we are rolling out to greater numbers of people.

That is a scheme whereby more than 30 visits occur over a couple of years to support mothers who, for particular reasons, need that extra support, whether they are young or have some sort of disability, a mental health problem, a drug problem, or whatever the issue is. That has been working remarkably well. The universal home visiting scheme is excellent and, obviously, we intend to roll out both those schemes in the APY lands. We are working on a model which fits in with the circumstances of the APY lands. There are issues to do with the governance of it in that area. Of course, Nganampa Health has its own Aboriginal health board. It would be silly to implement a secondary scheme, I guess, in competition with, or at least adjacent to, that scheme. We are working out how we can incorporate the same principles through that scheme.

The ACTING CHAIR: Thank you, minister. There being no further questions for the Minister for Health, I declare the

examination of the proposed payment to the Department of Health adjourned to Estimates Committee B to 4 July.

Department of Primary Industries and Resources, $163 061 000
Administered Items for the Department of Primary Industries and Resources, $4 886 000

Membership:
Mr Pengilly substituted for Ms Chapman.

Departmental Adviser:
Ms P. Crocker, Director, Office of the Southern Suburbs.

The ACTING CHAIR: I declare the proposed payments relating to the Minister for the Southern Suburbs open for examination and refer members to the Budget Statement, in particular, pages 2.12 to 2.13 in Appendix C and Portfolio Statements Volume 2, pages 5.18 to 5.19. These committees are relatively informal. The committee will determine the approximate time for consideration of matters and, in this particular case, the time is to be between 3.30 p.m. and 3.45 p.m. Changes in the committee membership will be noted as they occur. If the minister undertakes to supply information at a later date it must be submitted to the committee secretary by no later than Friday 7 September. Both the minister and the lead speaker can make an opening statement (although I understand from the lead speaker for the opposition that if the minister won't he won't).

There will be a flexible approach to giving the call for questions based on about three questions per member. I understand that, for the time being, it will be the member for Finniss. A member who is not part of the committee may, at the discretion of the chair, ask a question. Questions must be based on lines of expenditure. Documents cannot be tabled other than in the same way as permitted under the rules applicable in the House of Assembly. All questions are to be directed to the minister, not the ministers advisers. Does the minister wish to make an opening statement?

The Hon. J.D. HILL: I do not intend to make an opening statement.

Mr PENGILLY: I refer to Budget Paper 4, Volume 2, page 5.18, 'Summary income statement, supplies and services'. Can the minister explain why the Office for the Southern Suburbs received $216 000 in last year's budget for supplies and services but received only $112 000 this year? What has changed for this amount to be decreased by $104 000?

The Hon. J.D. HILL: As in all parts of government, we look to doing things more efficiently on an ongoing basis. The Office for the Southern Suburbs had a reduction in its revenue, which we are managing. We just had a cut in our funds. Can I clarify that: I will obtain some more advice for the member. It is essentially as I have said. We are making some savings. When we first set it up, we were not entirely sure what resources we would require, and we had three staff in the office. I think it was fair to say that it was overstaffed, and we are now down to Penny Cocker and one other staff member. We are running the office with those resources, and it seems to be working adequately.

Mr PENGILLY: I refer to Budget Paper 4, Volume 2, page 5.19, 'Program 3, performance commentary'. Can the minister explain whether the office will meet all the targets it set for itself in the 2006-07 year?

The Hon. J.D. HILL: I believe so. There are two dot points there. The first is, 'Complete an investment attraction strategy for the southern region'. That has been completed, and it is being considered. The second is, 'Provide advice to the cities of Marion and Onkaparinga in relation to the finalisation and release of Southern Adelaide—A New Economic Future'. That certainly has been achieved as well.

There is more detail on page 5.19 under the performance commentary of the particular tasks that the office has undertaken. I have said this in other estimates: it is a small office. Its main purpose is to provide good coordination across government departments in consultation and collaboration with the two councils of Onkaparinga and Marion and the broader business community. It just tries to link all those elements together in a purposeful way and I think it has been doing a splendid job.

Mr PENGILLY: I refer to Budget Paper 4, Volume 2, page 5.18, 'Summary income statement'—'2006-07 Estimated result'. Was any money left over from the graffiti program that was initiated within the southern suburbs? If so, where has the money gone and what has it been used for?

The Hon. J.D. HILL: The graffiti program was a three-year program. The amount of $250 000 was allocated to the initiative in 2006-07. Actual expenditure was estimated to be $248 000, so I guess there is a $2 000 surplus which has not been spent on anything else. The City of Marion estimates a 50 per cent reduction in the amount of graffiti and the City of Onkaparinga a 60 per cent reduction this financial year, as a result of this program. This has been truly a great program. The City of Marion has received funding assistance of approximately $120 000 to continue eradication at hot spots, improve monitoring and reporting systems of offenders and incidents, engage young people in legitimate art and education, and continue crime prevention through environmental design initiatives.

The City of Onkaparinga has received funding assistance of $128 000 now to continue rapid removal of graffiti in conjunction with utility providers, continue the volunteer area adoption program, trial antigraffiti coatings, conduct master-classes with young people and continue crime prevention through environmental initiatives. The strategy is consistent with the South Australian Strategic Plan target to reduce crime, improve learning outcomes in the arts and increase the level of voluntarism. The Office of the Southern Suburbs has initiated an evaluation of the funding program which will be completed some time in July this year.

I really want to congratulate both the councils for the outstanding work that they have done. This was a three-year program. It has now come to a conclusion and the lessons that have been learnt and the trainings that have occurred are now built into the provision of services through those two councils, so they should have ongoing benefit.

Mr PENGILLY: I refer to the same budget line, the same page. Therefore, will your office be continuing to monitor the effectiveness of the program, even though it is completed, with a view, if necessary, to trying to reinstate it in the future?

The Hon. J.D. HILL: The program has not been completed. The funding of this stage of the program has come to an end, but the program run through the two councils, as I understand it, is ongoing. The office is in regular contact

with the councils and obviously will keep an eye on it, but there is no formal role in relation to it. The office talked to the councils about extra funding and they do not require any at present. I think that they are satisfied. I think the community is pleased that there is less graffiti around. It has been a great program. It would be great to see it rolled out in the rest of the state.

Mr PENGILLY: I refer to Budget Paper 4, Volume 2, page 5.18, 'Summary income statement'—'Grants and subsidies'. Minister, can you explain why the Office for the Southern Suburbs was allocated $224 000 in last year's budget for grants and subsidies—and in fact the estimated result is $270 000—yet it has only received $20 000 in this year's budget?

The Hon. J.D. HILL: Essentially, the majority of that was the graffiti money: 132 to Marion; 128 to Onkaparinga. There was also a little bit of sponsorship, about $9 000 worth: Red Poles art trail; super science Sunday; innovation forum; and Flinders symposium. From time to time, the office is asked to sponsor individual events. If there is a little bit of money around which has not been spent on another purpose, it is directed in that way.

Mr PENGILLY: I refer to Budget Paper 4, Volume 2, page 5.18, 2007-08 'Targets'. Minister, can you explain how much money has been set aside to assist in facilitating the implementation of the southern wave investment attraction strategy?

The Hon. J.D. HILL: I understand that there is $20 000 in the next financial year budget to assist with that.

Mr PENGILLY: I refer to Budget Paper 4, Volume 2, page 5.18 regarding the summary income statement and net cost to providing services. Can the minister please explain why the Office for the Southern Suburbs received $693 000 in last year's state budget but this year it will receive only $380 000? Given the minister's previous remarks, I probably know the reason now.

The Hon. J.D. HILL: That is exactly right: savings and the end of the graffiti program. It is a lean, mean machine which does outstanding work.

Mr HANNA: My question is about the Glenthorne Farm site, which, I am sure the minister would agree, is a venue of great opportunity currently unrealised. It has been reported that in December 2004 Premier Rann warned the university, which holds the land on trust, to get off its backside and do something. We know that nothing has been done on the site for many years. Can the Office of the Southern Suburbs somehow facilitate some action on this site? There is some urgency about it, because I know that some of the historic buildings on the site from the 1850s are falling into ever greater disrepair. There is even a feral olive tree impinging on one of the buildings at the moment. Can something be done?

The Hon. J.D. HILL: I thank the member; I share his concerns about the Glenthorne site. I had a number of conversations with the university when I was environment minister, with the environment department and subsequently with other officers. When the site was brought into South Australian control, as the member would recall, the commonwealth government sold it for $7 million to the state. The Olsen government, I believe, transferred not ownership but certainly control and care to Adelaide University on the basis that it developed it. The idea at the time proposed by the late Greg Trott was for it to be a viticultural site. That seemed to provide some sort of commercialisation, which would allow it to be maintained as an open space area, and it was also something which would fit in with the university's interests.

That proposition turned out not to be feasible, because it was not an ideal site upon which to grow grapes. I am surprised that Greg Trott thought it was, but it seemed like a good idea at the time—I think that is how you would classify that. It is not a good place to grow grapes, so that was not really a feasible outcome. I think the university has been trying to come up with a model which would achieve the same kind of outcomes, that is, keep it as open space and have sufficient income from it so that you can justify it. The current arrangement, as I understand it, is that the university either agists it or uses it for its own sheep. I am not sure; I think the university fattens them up there for the market. So, that satisfies that kind of balance; that is, it is an open space and it is still pleasant in the sense of not being built up, and there is some sort of commercial return.

My view is that the site should be used for a multiplicity of purposes. The Hon. Bob Such's notion of a natural burial ground would make it a great location to do that as a commercial activity. I certainly had a conversation some years ago with Centennial Park, which seems somewhat interested in the idea. That would be a way of getting a commercial income, creating a park-like space and allowing tree planting. I would also like to see something like an urban farm based on sustainability principles so that city and rural people could come along and see a model farm based on no chemical use, natural farming methods and a whole range of stuff. I think that it would be an interesting thing for kids to see a place where new technologies in hydrology, energy, and so on, could be demonstrated. I think that we could expand the million trees program there, and an urban forest could form part of it. A range of things could be done but, as I understand it, we are waiting for the university to come back with a concrete proposal. I certainly put those suggestions to them; perhaps not a concrete proposal, but a specific, firm proposal.

The ACTING CHAIR: There being no further questions for the Minister for the Southern Suburbs, I declare the examination of the proposed payment to the Department of Primary Industries and Resources and administered items for the Department of Primary Industries and Resources adjourned to 2 July. I congratulate all concerned with today's committee. It has been a pleasure to be present throughout these delightful proceedings. Everyone has been very well behaved and, again, Committee A is just not performing at the same standard as Committee B.

Mr PENGILLY: Hear, hear! I was very pleased that the minister did not leave for five minutes so that we had to adjourn the proceedings.

The ACTING CHAIR: He was treated with courtesy and treated all people with courtesy, and he came prepared.

The Hon. J.D. HILL: Mr Chairman, I thank you, the officers at the table today, my own staff and officers for their help, and also members of the committee for the courteous way in which they have conducted themselves. It was a great pleasure and it was just a shame it only went for such a short period.

The ACTING CHAIR: Sometimes the best things do not go for long enough!

ADJOURNMENT

At 3.51 p.m. the committee adjourned until Monday 2 July at 11 a.m.