HOUSE OF ASSEMBLY

Tuesday 23 June 1998

ESTIMATES COMMITTEE B

Chairman:
The Hon. G.M. Gunn

Members:
Mr R.L. Brokenshire
Mr R.J. McEwen
The Hon. R.B. Such
Ms F.E. Bedford
Mr K. Hanna
Ms L. Stevens

The Committee met at 11 a.m.

Department of Human Services, $1 167 948 000
Minister for Human Services—Other Items, $16 050 000

Witnesses:
The Hon. Dean Brown, Minister for Human Services.
The Hon. R.D. Lawson, Minister for Disability Services, Minister for the Ageing.

Departmental Advisers:
Ms C. Charles, Chief Executive, Department of Human Services.
Mr D. Filby, Executive Director, Policy and Budget.
Ms V. Deegan, Director, Financial Risk Management.
Mr F. Turner, Director, Finance.
Ms J. Murray, Manager, Executive Services.

The CHAIRMAN: I declare the proposed payments open for examination. Does the Minister wish to make an opening statement to the Committee?

The Hon. Dean Brown: Yes, I would like briefly to outline the key strategy of the new Department of Human Services, which brings together the health, housing and community welfare programs of the Government. In addition to that it continues to pursue the disability and ageing areas of Government concern. Therefore, in a quite unique way it brings together a very broad range of community and human services. The key objective out of the bringing together of these various functions of Government is to achieve first a flow so we have seamless help for people when they are in need; whether they have housing, health, or community welfare needs, we are able to tackle those issues. It could well be an older person or a person with disabilities who needs particular help.

The second matter is that the thrust of the department is very much about working in partnership with the community. It is about encouraging the community itself to take responsibility for people within the community, but obviously with Government financial assistance and coordination. We need the Government there coordinating the services to ensure significant gaps do not occur in the services being provided, and we need Government funding because the Government is by far the major funder. But, at the same time, we recognise and appreciate that a huge number of volunteers are working to provide community services now, giving assistance in the broader community sense and helping individuals in the community. There are a lot of organisations that are either volunteer based or not for profit. Again, they are key organisations in the community that have provided many of the services, particularly in the areas of ageing and people with disabilities.

We see our role as encouraging the development of these community services and assisting organisations. It needs to be understood that the Government cannot provide all these services, particularly with the ageing of our community. The Government would be in a position such that, as the community ages, more people would be available to do volunteer work but, equally, more people would demand services. It needs to be on a community basis. One other objective of bringing together the services is to get one point of contact for people with a need and to be able to meet all their needs, if possible, through that one point of initial contact.

This merging of three large areas of Government—that is, health, housing and community services—is being done in two ways: first, within the organisation formally, from Christine Charles as the CEO down, in bringing together people responsible for areas of the State and, in some cases, for the whole of the State (and the intention is that all of those services be provided under that one person); and, secondly, at a regional level, whether it be in the metropolitan area or in the country, to get the various departments that have acted there individually in the past to now work closely together and provide that seamless service. Incidentally, a great deal is being done in that regard around Noarlunga and the Riverland, at Port Augusta and at Mount Gambier. As I have moved around the State, I have been impressed with the initiative being taken within the community by those Government agencies to make sure they provide an integrated service.

One of the key concerns I have had is the area of mental health services within the State. As a result of community decisions about 10 years ago, it was decided to move away from the large institutions and to put more facilities in the community. Some of those facilities need to be hospital based and some of them need to be community based, whilst at the same time, where necessary, still providing a broad institutional support in specialist cases. That move has now been going on for at least seven or eight years. It has been supported by Federal and State Governments. However, it was apparent that there were some gaps in the services being provided. It was timely that there be a reassessment of how that process was going and where additional services needed to be provided. As a result of that, in December, we started a mental health summit, and that finished finally in May. It was an excellent program. It brought together the community—the people involved with mental illness, from the carers, from organisations representing people with mental illness and the health providers.

In total, six major workshops were set up that looked at areas such as mental health problems for young people, accommodation problems for people with mental illness, the clinical treatment of people with mental illness and others. As a result of that, the Government has now made some significant announcements, probably the most important being that we took the one-off funding for 1997-98 and turned that into permanent funding. In addition, we have allocated another $3 million a year. So that means $8 million

per year, committed for the next four years, which will equate to $32 million for mental health in the community. It is an area which has not attracted a great deal of publicity. It is an area on which in many ways the community tends to turn its back and shun. Therefore, it is an area that needs significant support.

Another key initiative the Government has taken this year is to boost capital infrastructure in the areas that I have talked about, particularly health. There has been a significant increase in capital funds. For instance, this year across Human Services our capital budget is $191 million. Major capital works are planned for the Royal Adelaide Hospital, the Queen Elizabeth Hospital, the Flinders Medical Centre and the Lyell McEwin Health Service. Other hospitals will have capital works programs as well, including the Noarlunga Hospital, in that three year time frame. Significant redevelopments are occurring in the country. I have recently inspected the facilities, which are almost complete now, at Port Lincoln. There will be a substantial redevelopment of the South Coast Hospital at Victor Harbor and other facilities as well.

In the housing area, the main emphasis of the Government is on refurbishment of its very old stock, but we are also increasing our effort in the community housing program where, in partnership with the community, a community house is provided which is then the ongoing responsibility of the community. I believe this is a very good move because it answers the housing needs of the community at a community level and perhaps much smaller areas of housing, focused on the sort of guidelines which I have already put down in the Parliament, but particularly for people in crisis need for housing, for people on very low incomes, for people with mental illness and for people with specific disabilities. No doubt, during the day those guidelines will be discussed and I would be only too happy to talk about some of the initiatives we are taking. That broadly covers the key issues.

The other key issue that is unresolved as we enter this coming financial year is the Medicare agreement with the Federal Government. That is a problem for all States around Australia, with the exception of Queensland and the ACT. Of course, they have signed open agreements where if additional money is allocated to the other States they share in that. Incidentally, even those two States have not yet signed an agreement with the Federal Government because they have found enormous difficulty with the draft agreement that was put up for signing and have asked for very significant modification to it. I conclude my opening remarks there, but it gives at least an overview in terms of what the agency is about.

The CHAIRMAN: Ms Stevens, would you like to make a brief opening statement or raise some questions?

Ms STEVENS: Yes, Mr Chairman, I would, but, before I do so, I mention that I have some questions that I would like to table. When would you prefer that to happen?

The CHAIRMAN: I can just about guess what they will be, but I do point out that some of those questions are particularly detailed and will take a lot to answer, and it probably will not be possible to have them included in the record in the time space normally given, so you will have to be patient with the answers.

Ms STEVENS: I will do that at the end of the day, Sir.

The CHAIRMAN: Yes.

Ms STEVENS: The work of the Estimates Committees will be hampered this year due to the changeover to accrual accounting and the resultant changes in the format and presentation of the budget. These changes have also been compounded by significant changes to administrative arrangements and the regrouping of agencies following the creation of 10 super departments.

Whereas previous budget papers, and in particular Financial Information Paper No.1 (Program Estimates and Information), provided the Parliament with program information and estimates of expenditure compared with the previous year's budget and actual expenditure, this information is no longer available. For example, last year in the health portfolio, details of expenditure and performance for the previous year were given over eight programs comprising metropolitan hospitals, country health services, hospital support services, mental health services, community-based services, services to Aboriginal people, public and environmental health, and disability services. This year, the program information is reduced to just eight lines described as 'Outputs Purchased by the State Government'.

No detailed information is given on programs: for example, there are no details on how much has been budgeted for the operation of our hospitals or our community health services. Even more misleading is the fact that in many cases next year's budget figures are now only shown in comparison with last year's actual expenditure. Comparison is not made with last year's budget. This means that members are not able to compare budget changes year on year or make any judgments about overexpenditures or underexpenditures. There is no information to indicate whether programs have been wound down or overspent.

Instead of Program Estimates the new format provides us with Portfolio Statements, which attempt to quantify outputs in the delivery of services and which will create a good deal of debate. Suffice to say at this stage that most of the key performance indicators in the health area of this budget are totally meaningless. As an aside I also point out that many pages in the Portfolio Statements are not even numbered and, given the insistence by Chairs of this Committee in past years that members must refer to page and line numbers, this will obviously be very difficult.

The CHAIRMAN: That will depend on the manner in which members ask their questions.

Ms STEVENS: During briefings before the budgets the Under Treasurer and senior officials assured the Opposition that the transfer to accrual accounting would be totally transparent. Indeed, the opposite is true. Parliament is no longer being provided with the details of how taxpayers' money is to be spent in the coming year. The change is certainly a victory for the accountants. While we now have an impressive array of operating statements, abridged financial statements and cash flows—all worthy and important information for managing our financial affairs—we can no longer tell how much we are spending on our hospitals, on the Royal District Nursing Service, Domiciliary Care or Mental Health Services. These are the things we want to know and the things that this Committee wants to deal with today. These are also the things that our citizens want and deserve to know about. These are the things that make a difference to their lives and they have a right to this information.

The pall of secrecy that has fallen over the activities of the Human Services Department, both as a result of the change to accrual accounting and the lumping together of several agencies, is exacerbated by the cancellation of other performance indicators previously available to the public. These include the cancellation of the gold book, last issued in June

1997, and the cancellation of the publication of waiting times for elective surgery.

Recently an officer within the Minister's department undertook to provide my office with information previously published in the gold book. Unfortunately, this has not happened. I remind the Minister of his statement on 28 November 1993, when he said:

> A Liberal Government will be committed to open and honest Government, fully answerable to Parliament and the people.

Against that background the Minister and all Ministers should go back to Treasury and say, 'Look, this accrual accounting is fine; it sends a shiver up the spine of every accountant in the system, but it does not satisfy the Government's obligation to tell the people how their money is being spent.' The present format does not satisfy the Parliament, community groups or the work of this Committee. Departments still run programs: that is their core business. The Minister should ensure that in future years this Committee is given proper information about programs to enable it to do its work.

Will the Minister table estimates of expenditure by program, including all those programs shown in various parts of last year's estimates documents, that have now been amalgamated under the Minister's control?

The Hon. Dean Brown: The member for Elizabeth has made a statement about the previous programs that were listed. The agency is now tending to concentrate on the functions and has presented this year's budget papers on those functions. There is a clear reason for that, and that is that many of those functions cut across previous agencies and programs. For instance, if support is being provided to people in need under what might have been in the past a clearly defined program operated by the Department of Family and Community Services, that support might now be provided partly by health, community welfare and housing. To progress government and provide a seamless service, it is not possible to go back. I do not think that the honourable member would want us to go back, and neither do I think would the community. The response from the broader community is one of delight, because, at long last, if a person has a need they do not have to approach three separate Government agencies and argue their case on three separate occasions, being treated almost as if they are in three separate countries.

However, I am mindful of what the honourable member says. I want the provision of information today to be as transparent as we can possibly make it. Therefore, as the honourable member raises a question, we will try to answer that question in terms of the old program and provide her with information about the level of support that flows from that. For example, there is no doubt that the issue of the level of funding of public hospitals will be raised. I have given two commitments: first, that the funds that we put into our public hospitals will be no less than what was provided last year; and, secondly, that we will supplement those funds to provide for salary increases. When the final budgets for hospitals are worked through—and this cannot be done until we are provided with the final figures for the current year (1997-98) in July—we will make that information available.

The honourable member also raises the issue of elective surgery. That information is available and it will be provided to her when she raises that question. Therefore, I do not think any accusations ought to be made at this stage that the information is not transparent or that we are trying to hide anything. The situation is just the opposite: we have tried to be open; we have provided the honourable member with briefings; and we will continue to do so. The honourable member also referred to the functions of the department. One could have got the impression that the entire operations of the department had been condensed into eight lines. I invite members to look at pages 5.12 and 5.13 where functions such as crisis and acute care, coordinated care, community care, personal financial assistance, housing services, accommodation and care and policy development are referred to in some detail.

Ms STEVENS: In my question I asked the Minister whether he could table estimates of expenditure by program, including the programs mentioned in last year's Estimates. Is the Minister saying that he cannot?

The Hon. Dean Brown: No, we cannot, because we no longer operate according to those programs. Funds are not allocated specifically to those programs; they are now allocated in a different way. However, I have indicated that, if the honourable member raises a question regarding a specific service which was formerly provided under the old programs, we will try to relate to her what is currently happening. I gained the impression that the honourable member wants an assurance that we are not cutting back on services. If she looks at what I have said, she will see that we are talking about increasing services in areas such as mental health and others. If the honourable member requests information about a specific service, we will try to provide that information, but we might not be able to provide it in exactly the form that she wants.

Ms STEVENS: Minister, I want to ask a question about health services and it relates to community-based services for old and frail people. I want to ask you about an agreement—

The Hon. Dean Brown: I do not want to be obstructive here but, under the agreement, aged care was to be dealt with tonight, on the program that the Opposition signed off on and at its request, and aged and disability services, with my colleague the Hon. Robert Lawson, was to come on at quarter to 9 tonight.

Ms STEVENS: It is specifically a health question. I want to ask the Minister about an agreement entered into by the Government on 9 September 1997 to transfer patients from the Queen Elizabeth Hospital to a property operated by Trojan Owen Investments, called Rose Cottage. The Opposition has a copy of the contract between the Queen Elizabeth Hospital and Trojan Investments which raises serious questions about ongoing duty of care for patients and a lack of due diligence on the part of the hospital in signing a contract that was so demonstrably inadequate in terms of standards at Rose Cottage. The Opposition also has a copy of a letter dated 3 March 1998 to you, Minister, from the Advisory Committee on Supported Residential Facilities about this matter. My question is: given that an inspection of Rose Cottage by the City of Port Adelaide Enfield revealed that it failed to comply with the requirements of the Residential Facilities Act on matters of air-conditioning, lighting, hygiene, privacy, maintenance, food hygiene, lack of equipment, staffing and fire safety, why did the Queen Elizabeth Hospital enter into this contract without first consulting the licensing authority on the facilities licence status and its compliance with standards?

The Hon. Dean Brown: Of course, I was not Minister when that contract was signed and so any specific knowledge or approval for the signing of that contract was not my responsibility. I will have to take the question on notice and we will come back to you. Clearly, I was not there at the time

that the contract was signed, and Christine Charles was not there either; but we will get the information and get back to you.

Ms STEVENS: Minister, I am very concerned at your reply in relation to that because I have a number of other questions on this matter, because it is a serious matter and I believe it is more widespread than that one instance. However, I will continue to ask the questions. Did the Government conduct any investigations into the performance background, financial stability and qualifications of the management and staff of Rose Cottage? Are there now any guidelines to ensure that such checks are made in any future contracts, and what are the details?

The Hon. Dean Brown: Again, we will try to get that information, but I point out that in fact the contract was signed not by the Health Commission but by the Queen Elizabeth Hospital, from what the honourable member has said in her statement. So it is a matter for the management and the board of the Queen Elizabeth Hospital to answer those questions.

Ms STEVENS: I would have thought that as Minister you would have had a concern about what was happening in such a facility.

The Hon. Dean Brown: I would have concern, but they are very specific questions as to what actions the board took. I was not Minister at the time; I do not sit on that board and only that board can answer those questions.

Ms STEVENS: Minister, I have a copy of a letter that was written to you this year by your advisory committee, in which they outlined their concerns. They have not had a reply from you. So you have known about this. This information was given to you in March this year.

The Hon. Dean Brown: No doubt an answer to that is being followed through. The member has asked me very specific questions as to what action was taken by the board prior to the signing of that contract in September last year, and that is not my responsibility in that I was not Minister at the time. But I will get that information for the honourable member.

The Hon. R.B. SUCH: My question relates to page 5.6 of the Portfolio Statements which indicates that a specific objective for the year 1998-99 is to renegotiate agreements with the Commonwealth on health care. As we all know, the health care agreements are crucial to the future of the health systems in this and other States. Can the Minister advise how close we are to signing the next agreement?

The Hon. Dean Brown: At this stage there is still a significant stand-off between the Commonwealth Government and the State Governments, with the exception of course of Queensland and the ACT. The Health Ministers met last week and again discussed the issue. There has been a great deal of press speculation that the Federal Government is about to make a counter offer, but it is no more than press speculation: there has been no specific discussion with any of the States on a counter offer, either with the Ministers or the Premiers. Therefore, we are awaiting a final response from the Commonwealth.

If this press speculation is correct—and I hope it is—that the Commonwealth realises the need to put additional money into the public hospital system because of the dropout in private insurance, the ageing of the population and the change in medical technology then I hope it understands the need to pay the States for that increase in demand. This morning I released a report from Access Economics which is work commissioned by all the State Governments. That report highlighted that since 1984 the States have been increasing their share of public hospital expenditure, that it has risen from about 45 per cent to about 51 per cent. That is the State Governments' contribution: the Federal Government's contribution has been dropping. At the same time, more people have been dropping out of private insurance and relying on the public hospital system, so that means an even further share of hospitalised care in Australia is being covered by the State Governments.

The Federal Government has argued that it has offered the States $2.9 billion more. The State Governments dispute that and say that the real increase is in fact less than $100 million over the five years of the agreement, and I will outline reasons why. First, $300 million of that so-called $2.9 billion results from a reduction in the Commonwealth's current forward estimates. The sum of $479 million is recurrent mental health and palliative care funding, which the States are receiving now but because the Federal Government is formally bringing it under the Medicare agreement it is trying to argue that this is new money, which clearly it is not. It is only new money in the Medicare agreement: it is not new money from the Commonwealth.

There is $682 million for quality and access to be distributed amongst the States and Territories, but there is no guarantee of any share of that at all; and $500 million for the so-called one-off system restructuring/information technology, but that does not treat patients within the hospitals. Also, there is $750 million for veterans' affairs under its new package, which I welcome, but there are some States where that is of marginal or no value. It would appear that in South Australia that new package under veterans' affairs, because of historic arrangements here, is unlikely to give us any significant additional funding. There is $120 million which was the one-off package for those who signed up early—if you like, as an inducement to sign early. The share that we would have got there was so small that it would operate the hospitals for about eight days and we are arguing over a level of funding for five years. So you would have had your eight days in paradise and, frankly, five years in hell.

To return to the issue, we are trying to get this important issue resolved. My concern is that, under the offer made so far by the Commonwealth, there would be 10 000 fewer admissions in this coming year than there have been this year, yet the demand is going up by about 7 per cent a year. I believe that, as the administrators of public hospitals, we cannot afford to be sitting there, almost as if we were operating sheep drafting gates, deciding who does and who does not go into a public hospital. That is why I would argue very strongly for additional funding. I am dissatisfied with the previous Medicare agreement, which was signed under the previous Federal Labor Government, because it made no provisions at all for a drop-out in private health funding, yet we have seen 87 000 South Australians drop out of private health insurance and become reliant upon the public hospital system, and we have received no compensation for that. So, the present Medicare agreement is clearly at fault. The new agreement provides inadequate funding, and the Access Economics report released today highlights the need for a lift in the funding base for public hospitals.

Mr BROKENSHIRE: I refer to page 5.1 of the Portfolio Statements, where it gives details of the new portfolio structure. What are the benefits of the restructuring of the health, housing and welfare sectors in the Department of Human Services; and how will that integration benefit people, particularly in lower socioeconomic areas, where in the past

transport has been slow to catch up with the growth in the fast growing areas in the northern and southern regions? People have said to me on numerous occasions that they have trouble when they go to Noarlunga Centre for one thing and are referred back to Morphett Vale for another. How is the new system working, and what are the details of your plans for improving it over the next 12 months?

The Hon. Dean Brown: In my introductory remarks I talked about this in a general sense, but some particular examples are worth highlighting of where that integration of services has been very beneficial. One is in improving responses to domestic violence. In the past domestic violence was dealt with partly by Family and Community Services, but that issue involves a significant emergency housing component, and victims of domestic violence, especially women and children, fleeing the family home are extremely vulnerable and often have very complex needs. The required responses encompass emergency housing, financial assistance, medical services, counselling and mental health support and, in some cases, legal intervention. A group of officers, including service providers, are mapping the wide array of current provisions and developing an integrated framework to provide those services. This will guide decisions regarding the most timely and effective way to respond to that issue of domestic violence.

Other area is mental health, particularly for young people. Many young people in the care of the former Department of Family and Community Services suffer very severe mental health and behavioural problems. Issues of security, behaviour management and departmental and portfolio boundaries have made it extremely difficult to provide timely and appropriate responses to these young people. It was only with great effort over a number of years that the former FACS Department, the Health Commission and DECS were able jointly to establish the Behavioural Intervention Service last September at Lochiel Park. By contrast, in a few short months the new Human Services Department has been able to get resources dedicated to mental health services in secure care facilities. In other words, we have brought the health side of it together with family and community services and housing. These are operating in concert with a range of other, better focused physical and mental health services.

The third measure is local area collaboration, where regional managers of Health, FACS and Housing are now exploring ways to provide that broad response at the local level. For example, managers in the Noarlunga area (which I know is of particular interest to the member for Mawson) have developed a human services planning team to ensure that opportunities for collaboration on service improvement are maximised. They are working on a joint approach to services planning, including improving case conferencing, progressing traineeships and developing a portfolio position on community issues in Noarlunga. There have been cases in the rural sector where the same sort of response has been achieved, including the Riverland, which I will visit shortly. I notice that the member for Chaffey is here; I think she has been helping to organise my day's visit to the Riverland. Again, we will be looking at how the three former agencies in the Riverland are working together to provide one, coordinated response. I could go on, but that gives a good example of the level of integration that is now being achieved.

Mr McEWEN: Given that the Mount Gambier's hospital insists that any GP operating in Mount Gambier must be on the accident emergency roster and that this has cost the town two family focused GPs in the past couple of months, what plans exist for residential medical services allowing the hospital to deal with casualty and emergency?

The Hon. Dean Brown: I will ask Mr Filby to answer that.

Mr Filby: There have been difficulties attracting general practitioners to work in Mount Gambier and a number of country towns, not only as a result of issues around the accident and emergency roster, but generally. In the past year or so the Health Commission has been actively involved with those hospital boards to attract to work in South Australia doctors who have trained overseas and to promote their cause before the Medical Board for limited registration. There has been some success for that happening in some places, and the department will continue to support country boards trying to find doctors to work in country towns in that way.

The Hon. Dean Brown: I think there is a very specific component there, and I will follow that issue through for the honourable member. Mr Filby has given a general answer that covers all the hospitals. Incidentally, it is worth noting that I have recently signed off on trauma packs going into private hospitals at public expense. So, now hospitals such as those at Keith, Ardrossan, McLaren Vale and others all now have the appropriate traumatic pack for emergency cases. The rural enhancement package has done a great deal to help country GPs be on duty after hours and make sure they get reasonable compensation for the period for which they are on duty. It sounds as if the Mount Gambier Hospital board has put down a very specific requirement. The honourable member has asked us to look at that specific requirement, because at least two GPs in that town have not liked that requirement and he is asking for that to be reviewed. We will take that on notice.

Ms STEVENS: I return to the matter of Rose Cottage and the Queen Elizabeth Hospital. Given that the contract that was signed between Trojan Investments and the Queen Elizabeth Hospital states that the Queen Elizabeth Hospital would discharge patients, to be transferred to Rose Cottage and at that point 'the Queen Elizabeth Hospital's responsibility for the patient will cease', why did the Government attempt to contract away its duty of care while offering to pay $85 a day per patient; and was this contract cleared by the Crown Solicitor?

The Hon. Dean Brown: I cannot specifically answer that in relation to Rose Cottage, but I will check those details. The Government has a number of programs, particularly for rural people, such that, if they do not have a home and they come in from the country for routine treatment at various hospitals, they are given financial assistance.

Ms Stevens interjecting:

The Hon. Dean Brown: It may not be, because we might be treating these people through Rose Cottage, as well; they may be staying there. I know that they can stay in other facilities, and I know that we have a contract with such a place on Greenhill Road. I am not aware of the details of the contract relating to the basis in which a person would go into Rose Cottage, and I understand that that contract has been signed by the Queen Elizabeth Hospital. I will follow up the matter and investigate it.

Ms STEVENS: When did the Minister first become aware that some patients were being transferred from the Queen Elizabeth Hospital to Rose Cottage and then on to other facilities without the knowledge of or consultation with relatives or carers? When informed of this, what action did the Minister take?

The Hon. Dean Brown: That matter is under investigation by the Department of Human Services, and I am waiting for its response to it. Fairly early in the piece I was aware that the Queen Elizabeth Hospital had outside accommodation facilities. It drew this to my attention when I went to the hospital; it was talked about. The issue raised by the honourable member is, I understand, under investigation by the department.

Ms STEVENS: My question related to when you were informed?

The Hon. Dean Brown: The honourable member indicated that a letter had been sent to me, and it would relate to that time, approximately. So far this year I have 2 500 pieces of correspondence; therefore, I cannot say now when every piece of correspondence came into the Minister, and I do not think anyone would expect me to.

Ms STEVENS: I refer to a particular letter of concern from one of your advisory committees. That is why I am a little surprised that you did not know about this matter in more detail.

The Hon. Dean Brown: We regard every piece of correspondence or file that comes in as a matter of importance, and it is immediately dealt with by the appropriate people within the agency, and a response comes back.

Ms STEVENS: Have any other agreements been entered into for the transfer of patients from public hospitals to residential facilities and, if so, what are the details?

The Hon. Dean Brown: I just indicated that we have arrangements with a particular motel for country patients. That is one of which I am aware, but I will need to check and get a detailed answer to make sure that we have not excluded other arrangements for other hospitals.

Ms STEVENS: I want to be clear about this, because it is my understanding that the Queen Elizabeth Hospital is looking at other arrangements, and possibly at least one other metropolitan hospital is considering doing the same. I want to be clear that these arrangements were undertaken for people being discharged from the hospital and placed in these facilities. The point of all these questions is that obviously contracts were entered into and the facility concerned was not up to scratch, and that is of great concern when you consider that some of these people were nursing home assessed clients who required a high level of care that simply was not there. That is why there is such a concern about this matter.

The Hon. Dean Brown: We all know that there has been a move towards reduced stays in hospitals and also a significant increase in the use of day surgery. In some cases, when people have come in for day surgery but still need medical supervision or perhaps nursing supervision, some step down care may be available within the community, and that is more appropriate than putting them back into their own home, particularly if they are living by themselves with no carer at home. That is to be applauded, because it is, in effect, providing that step down care rather than no care, which is what has been done in the past. As I said, facilities are available for country hospital people, and we provide financial assistance for such people. The honourable member would be aware of that, and I will deal more specifically with that matter later. Most other hospitals are looking at how they make arrangements for some step down care. However, I will go around to the boards of the different hospitals—and I think there are 53 of them (although I would imagine that it is less likely in some of the country hospitals)—and get a comprehensive answer for the honourable member.

Ms STEVENS: Is the level of care appropriate to the needs of the people? It has been exposed that this was not the case.

The Hon. Dean Brown: We need to look at those facts. I do not wish to prejudge the matter. The honourable member has made that accusation; let us look at the facts as well.

Ms STEVENS: Your committee has made that accusation.

The Hon. Dean Brown: The step down care is at least something where there has been a void in the past. Because many of these people simply went back home, either to their family or, in many cases, to no-one.

Ms Stevens interjecting:

The Hon. Dean Brown: The honourable member has obviously made a judgment on this. I see that she has put out a press release and called a press conference for 1 o'clock today on Rose Cottage. Let us get the details. I should have thought that the honourable member, having asked a question here, would like at least to get the answer before rushing out to the press.

Ms STEVENS: I have sought the answer, Minister, but you have not been able to provide it.

The CHAIRMAN: The honourable member has been given a pretty fair go. I do not want too much back chat or we will go right back to the rigid rules; I will start asking for line and page references.

Mr McEWEN: In his opening comments, the Minister talked about the 87 000 people who dropped out of private care and who are now on the public system. How does the Commonwealth handle the fact that it is quite obvious that they are derelict in their duty in relation to the fact that we now have 87 000 unfunded places in the system? There must be some recognition at least that this has fallen between stools and that the Federal Government must be accepting responsibility for it?

The Hon. Dean Brown: That has been the argument—

Mr McEWEN: You say, 'Shame on those who signed the contract.' You would need to get the colour right when you say, 'Shame on them!'

The Hon. Dean Brown: We have had 87 000 people drop out of private health insurance under the present agreement, and the States have not had $1 of assistance to help with that. That is what the honourable member has indicated. The reason for that is that the Medicare agreement which was signed in about February or March 1993 did not contain a clause that required the States to be compensated for a further drop-out from private health insurance. The member for Gordon is quite correct in his statement.

Mr McEWEN: The Feds must recognise that; it is a deficiency in the contract. Why should the liability totally fall back onto the State?

The Hon. Dean Brown: That is exactly what we have been arguing for eight or nine months. However, the Federal Government is saying that it has no contractual obligation to compensate us. Therefore, it is not intending to do so, and it has put the pressure back onto the States. It is interesting because the Access Economics report that we released this morning has highlighted that this has occurred each time there has been a five year Medicare agreement. It is not only in this agreement but also in previous agreements where the same problem has occurred, and it is time it was corrected.

As from 1 July, under the Commonwealth's proposed agreement—which we have not signed—if there is a further drop of 1 per cent in private health insurance there would be compensation of $83 million across the whole of Australia.

Our argument is that that is fine starting from the new benchmark, but the States are being asked to fund the 87 000 people who have dropped out in South Australia from now until time immemorial because there is no recognition that we have gone from 37 per cent private health insurance down to 30 per cent. That is where the argument has been.

Mr BROKENSHIRE: Page 5.2 of the Portfolio Statements indicates that during 1998-99 the department will continue to strengthen the community directions established for the provision of mental health services to the community. Mental health services are increasingly in the spotlight in our community, and down our way I appreciate the support given to Noarlunga Health Services with respect to mental health facilities, but I am wondering overall what strategic planning is taking place in this area.

The Hon. Dean Brown: A number of key initiatives came out of the mental health summit. The first, and most important, was that a 24 hour crisis service would be provided, particularly for younger people. If someone has, or knows of someone with, a mental health problem, regardless of the time of the day, there needs to be a response. In some areas that occurs now. The ACIS line helps to provide that service. ACIS teams are very strong in some areas, particularly in the metropolitan area, and they deal largely with adults. There is not that same service in the country for adults or juveniles, and there is not that service to the same extent for juveniles or people under the age of 18 in the metropolitan area.

Another issue was the need to have better education and training for general practitioners on mental health issues. General practitioners are often the first people to identify mental illness, yet often it is not recognised—at least at a sufficiently early stage. Another issue was the need for early intervention and, again, that is very much training and education for the broader community as well as the general practitioners.

It is important for all of us in the community, if we see someone potentially in a state of depression, to understand their needs and get help for them as quickly as possible. That is very important for young people and teenagers who are studying at school and who are under enormous pressures. As a result of those pressures they may need help to overcome what might be a short-term depression, but if help is not there it may magnify into a much greater mental illness. Of course, that is the area of concern with youth suicide: often it is not identified or treated.

For those patients who require additional intensive mental care, there is the opportunity to develop supported residential accommodation on the former site of Hillcrest Hospital in association with James Nash House which is a secure mental health facility. We have recently opened new facilities at the Queen Elizabeth Hospital—a 40 bed acute facility, both secure and unsecured, for people with mental illness—and I have recently announced the allocation of $7.5 million to build a new facility at the Flinders Medical Centre. That facility is, again, both secure and unsecured and will provide a service for about half the State in terms of rural people where facilities are not available in regional hospitals as well as a service specifically for young people. There will be a specialist wing for younger people, particularly teenagers, and there is a need for that. At present, the only facility for teenagers in a hospital is at the Women's and Children's Hospital, and that covers everyone from nought to 18. Teenagers with a depression could be immediately alongside young children of four years or five years of age, and I think that is inappropriate.

I am the first to acknowledge that facilities have been inadequate in the past, but we are trying to address the situation. This Government has been trying to do that for some time, and the investment which has occurred in places such as the Queen Elizabeth Hospital shows that.

Further, I have some answers regarding Rose Cottage and I would be happy to provide that information to the member for Elizabeth. The contract was taken out with Trojan to reduce the pressure on beds at the Queen Elizabeth Hospital for patients who were awaiting placement in a nursing home. As the honourable member would realise, the number of nursing bed places in the State is dependent on the Federal Government, not the State Government, so at times there was a need for step down care for people who were discharged from hospital and who could not find a nursing bed.

As I said, these arrangements were put in place in August-September. The arrangement is between the Queen Elizabeth Hospital and its management and the manager of Rose Cottage and Trojan. At the commencement of the contract the operator was checked for both public liability and insurance coverage. The facility was an accredited nursing home—I stress 'was an accredited nursing home'. The facility was licensed by Port Adelaide and Enfield Council and was inspected on a regular and very frequent basis.

Formal meetings were held monthly between the hospital nursing staff and the operators. All issues raised were quickly addressed. Nursing staff from the Queen Elizabeth Hospital undertook regular inspections. Questionnaires were distributed to patients and issues raised in the questionnaires by those patients were addressed by the hospital. Rose Cottage was generally used for short-term stays only. The contract with Trojan ceased on 12 May.

Ms Stevens interjecting:

The Hon. Dean Brown: Well, I am surprised you did not mention that. If the honourable member knew that and did not say it, why did she give the impression that it was still ongoing?

Ms STEVENS: I did not.

The Hon. Dean Brown: You did not tell this Committee that the contract had ceased.

Ms STEVENS: It is irrelevant to the fact that it was entered into.

The Hon. Dean Brown: I am answering the question and I throw back a challenge to the honourable member. When she raised this issue and talked about the contract, why did she not reveal to the Committee the very fact that she now acknowledges—that the contract was cancelled on 12 May? It shows a deliberate attempt to hide pertinent facts from this Committee. As my colleague the Hon. Mr Lawson says, perhaps the honourable member could clarify at the press conference or even now why she did not reveal to the Committee that the contract had already been cancelled. Why did she give the impression, as I gained from the question, that patients from the Queen Elizabeth Hospital—in the present tense—are going into Rose Cottage? That is not the case at all. Perhaps she would like to explain.

Ms STEVENS: In relation to the Minister's question to me—

The CHAIRMAN: It is not question and answer time. Matters can be raised with the Minister. Members have the opportunity to give an explanation. I suggest that she ask her questions. This is not a general debate.

Ms STEVENS: I am happy to do that. The Minister himself was raising issues with me, which is why I respond-

ed. However, I am happy to go on with the next question. My next question relates to—

The Hon. Dean Brown: I highlight the fact that, if the contract is terminated, it has nothing to do with the Estimates at any rate. It is in the past: we are talking about funding for next year.

The CHAIRMAN: The member has raised an important issue and the Committee has spent some time on it with both the Minister and the honourable member asking questions and giving comment. I suggest that the honourable member ask her next question because the one following is going to the member for Fisher.

Ms STEVENS: Last Friday the Committee was presented with information from leaked documents which show that the Government required an efficiency dividend of 1 per cent for 1998-99 and a further dividend of 1 per cent for 1999-2000. This resulted in a cut to the teachers' salaries budget of $11 million. Will the Minister confirm that the Human Services Department was also required to provide this dividend of around $30 million?

The Hon. Dean Brown: I can confirm that it was the whole of Government. This is not new because it was announced by the Treasurer some months ago. The whole of Government was required to find a 1 per cent efficiency gain. The Department of Human Services is trying to achieve that efficiency gain by ultimately cutting down on administration: this is one of the reasons for bringing the three agencies together. We have met our 1 per cent efficiency, but I assure the honourable member that it does not affect the funding for public hospitals. We have maintained the funding for public hospitals without the 1 per cent efficiency gain.

The Hon. R.B. SUCH: Following the line of questioning by the member for Mawson on mental health, I was delighted to hear that extra facilities are being provided, especially for teenagers suffering from mental illnesses, as it has been a concern of mine for some time. My question relates more specifically to Glenside Hospital. Will the Minister indicate what future services will be provided to enable patients with a severe and chronic mental disorder to relocate from Glenside Hospital? I refer to page 5.20 of the Portfolio Statements.

The Hon. Dean Brown: I will ask Christine Charles to answer that question. The member for Elizabeth raised the issue in the Parliament. I will try to give additional information further to the question she raised in the Parliament about a month ago.

Ms Charles: There has been a significant amount of planning in the mental health area, and in particular strong attention has been given to the linkage between institutional care and community services. In terms of the Glenside Hospital campus, which fits within the general direction taken with health services, work is currently under way clarifying the detail of the program for the exit of that site. A number of facilities are in place. The Flinders Medical Centre will take some activity from the Glenside site. We are working to develop specialist and community mainstream options, cluster housing, specialist nursing homes and acute care in general hospitals as a back up.

The process of providing the detail of the exit plan for the Glenside campus involves and will continue to involve people working on the site as well as specialist services across the system. The mental health facilities plan being developed will include services right across Adelaide, so we are looking at a devolved service backed up by specialist acute response teams like ACIS and a range of facilities from secure care right through to support services in the home.

Ms STEVENS: I refer to Medicare funding. Given that the Opposition has a report released by the Australian Institute of Health and Welfare in 1995, which contradicts some of the findings in the report by Access Economics the Minister released today, will the Minister provide a summary of the total health funding for South Australia from 1982-83 to 1997-98 showing the expenditure by the State Government throughout those years compared with money received from Commonwealth grants and progressively showing changes in funding as a percentage? I am happy to take the question on notice.

The Hon. Dean Brown: Was it a national or State report?

Ms STEVENS: National—Australian Health Expenditure, released on 8 November 1995.

The Hon. Dean Brown: The Access Economics report is much more up to date than that and releases figures right up to 1997-98. It has used both ABS and budget figures and was a very comprehensive report. I would need to look at the other report to see where the discrepancy lay as the honourable member did not highlight that. I will try to get that sort of information together.

We gave much of that information to the Senate. The honourable member will find most of that information in our submission to the Senate. We have gone back to 1987-88. The honourable member may find that the information is there. Surely she is not particularly worried about the period 1984 to 1987, if it is not there. The submission broke it down State by State. I suggest she look at the case presented to the Senate inquiry in May as that information is already available.

Ms STEVENS: I would like the information that I asked for because we wish to cover the years covered in the Access Report. I would like you to give me what I have asked for.

The Hon. Dean Brown: We are happy to get that information.

Ms STEVENS: Given that the communique issued by the Minister and other State Health Ministers on 18 June 1988 states that the Prime Minister alone can break the deadlock that has existed for six months, what action has the Minister taken to ensure that the Premier has raised this matter directly with the Prime Minister given the failure of the Minister's negotiations with Dr Wooldridge?

The CHAIRMAN: To what section of the budget does that question relate?

Ms STEVENS: Page 135 of Budget Paper 3.

The CHAIRMAN: I did not know that the Prime Minister was mentioned there. The Minister may answer the question if he so desires.

The Hon. Dean Brown: State Premiers around Australia have had ongoing discussions with the Prime Minister stressing the need to settle the Medicare issue. Our Premier has done that since the Premiers' Conference, and I know that Premiers of other States have also done so. Fairly recently, discussions have taken place—and this has been talked about publicly—between the Premiers of Victoria, Tasmania and Western Australia during the Prime Minister's visit a couple of weeks ago. Those Premiers have stressed the need in the past few weeks—

Ms STEVENS: What about our Premier?

The Hon. Dean Brown: Our Premier has also had ongoing discussions with the Prime Minister. The Prime Minister recently visited those three States but he did not visit South Australia. I know there have been talks between the

Premiers of those States and the Prime Minister regarding this issue. So, I assure the honourable member that the issues raised by the State Health Ministers last Thursday in Adelaide are being taken up by the Premiers.

Ms STEVENS: Given the comment last week by Dr Brand, the new Federal President of the AMA, that they 'need to be making sure they are making a fair contribution to health costs and not just poking the finger at the Federal Government on this issue', and the Minister's evidence to the Senate inquiry that mistakes are now being made in our hospitals because of cost pressures, how does the Minister apportion the blame between the cuts of $230 million in real terms to health funding between 1994 and 1996 when he was Premier of this State and the $45 million increase in costs caused by people leaving private health insurance between June 1993 and December 1997?

The Hon. Dean Brown: I refer the honourable member to the Access Economics report, which I released today, because that report explains that. What happened in South Australia happened in the rest of Australia. I covered this in my earlier remarks. What the Commonwealth did was to take money out of FAGs. The State and the Commonwealth both make a contribution. The Access Economics report shows that with some fluctuations the State contribution has increased since 1984 right across Australia—and that is the case in South Australia.

Ms Stevens interjecting:

The Hon. Dean Brown: Well, it has. The Access Economics report shows that the States have gone—

Ms Stevens interjecting:

Mr BROKENSHIRE: On a point of order, Mr Chairman, I thought that the Minister had the right of reply.

The CHAIRMAN: Order! The honourable member will contain herself and allow the Minister to reply.

The Hon. Dean Brown: The State's share has increased from approximately 45 per cent in 1984 to approximately 51 per cent now, as stated in the Access Economics report. In 1993, under a Labor Government, the Commonwealth Government shifted funds away from FAGs. It would normally give money to the States and the States would then put a large chunk of that money into hospitals. However, the Commonwealth Government put the money straight into hospitals and not into FAGs. Instead of giving the money to the States and the States then putting that money into hospitals—and this was under a Labor Government—

Ms Stevens interjecting:

The Hon. Dean Brown: The honourable member is smiling, but it was a Labor Government that made that transfer. Access Economics picks up that point in its report where it states:

> A superficial examination of the Commonwealth and State Governments' efforts in financing public hospital services may invite the conclusion that, in the early years of the current five year hospital cost-sharing agreements, the State government efforts fell behind at a time when they were struggling with budgetary problems in the aftermath of the 1991-92 recession as well as the failure of large State-owned financial corporations in two States—

of course, we are talking about the State Bank in South Australia: I could go into that, but I will not—

> However, in the final years of the current agreements, the State Governments have at least equalled the Commonwealth's funding effort.

And we have certainly done that in South Australia. We have put in additional money. I will provide the honourable member with those figures, but I think we have put in about $73 million extra.

Ms Stevens interjecting:

The CHAIRMAN: Order! The Chair has been very tolerant. The Minister is answering the question. I remind the honourable member that on a previous occasion she would not tolerate insubordination.

Mr Brokenshire interjecting:

The CHAIRMAN: I do not need the help of the member for Mawson. If he is not careful, he will be off the list for the remainder of the afternoon. I suggest that the member for Elizabeth not proceed with her interjections or the Chair's tolerance will end forthwith.

The Hon. Dean Brown: I have made public statements about the exact figure, but I think it was $73 million. In December last year we took out those figures. From the beginning of the current Medicare agreement on 1 July, the South Australian Government has contributed an additional $73 million per year and the Federal Government has put in $13 million extra per year. So, at present, the State Government is substantially ahead of the Commonwealth Government. The honourable member might care to take up with her Labor colleagues in Canberra the question of why they took money for allocation to FAGs away from the States. It is interesting to note the honourable member's completely different attitude from that of her colleagues on the Senate inquiry, because they acknowledged all those things. In fact, they argued with the States. I wonder where the honourable member stands, whether she is backing South Australia and the other States or whether she is not. I think it is time for her to show her hand.

Ms STEVENS: I have done that many times.

The CHAIRMAN: Order! The Chair has just declared its hand. There will be no further interjections.

The Hon. R.B. SUCH: My question relates to page 5.3 of the Portfolio Statements—'Maximising value for money and the effectiveness of service delivery'. In particular, I wish to focus on the management of the Modbury Public Hospital. Will the Minister elaborate on the amended agreement that has been entered into and the overall benefit to the Government of that agreement, and will he say whether the amended agreement provides greater benefits than the original agreement?

The Hon. Dean Brown: The revised agreement did in fact produce a better outcome for the Government. I have already talked about some of this revised contract, but it does provide a better outcome. Let me explain why. The increased benefit to the Government mainly lies in the extension of the minimum term of the management agreement, from 10 years to 15 years. So we have a surety of the cost savings at Modbury Hospital, which must be at least 5 per cent below the Casemix price, and it could be more than that, thereby increasing the guaranteed period during which we get the discount services. I am sure the honourable member realises that instead of being over a 10 year period it is now a 15 year period. There is also a substantial increase in rental payments to the Modbury Public Hospital Board, arising from the lease of space within the existing buildings of the Torrens Valley Private Hospital. The renegotiated contract also includes increased accountability for Healthscope, and also increased safeguards for the State Government.

The member for Elizabeth has raised on the Notice Paper a series of questions about the hospital agreement. We have been preparing answers to those. I have now decided that I will release the full contract. I cannot table it here in an

Estimates Committee—you would stop me, Mr Chairman, if I tried to. So, when the Parliament next sits I will make sure that the full Modbury Hospital contract is released. The confidentiality clause of the original contract has now been removed. I took legal advice on this from Crown Law and the answer was that, now that that confidentiality clause has been removed and provided Healthscope is in agreement there is no reason why the contract could not be released. I intend to release the amended contract.

Mr BROKENSHIRE: Minister, I refer you to page 5.20 of the Portfolio Statements which indicates that during 1998-99 your department will continue to strengthen the community directions established for the provision of mental health services to the community. You were talking about the ACIS a couple of questions ago, and I note their commitment down our way. What is the purpose of the crisis and intervention teams in mental health and how are they specifically operating in the regions?

The Hon. Dean Brown: Firstly, the Access and Crisis Intervention Service (ACIS) was established in each metropolitan region on 11 November 1996. These services are promoted by the former area project and the realignment of general mental health services. The ACIS teams provide a timely response. In fact, I have been out and have had a look at the operation of the ACIS team in the northern area, at Salisbury. They provide timely and responsive 24-hour service to people over the age of 18 years within that defined geographic location. It is for people who have an urgent or intensive specialist mental health need. They maximise the number of people who have their treatment and support services met within the community during a crisis by providing a specialist mental health intervention service in the least restrictive environment.

They have access to confidential clinical information systems that provide up-to-date information about the client, so that they know the treatment that the client is on, who the doctor, general practitioner or psychiatrist has been, etc. They facilitate access to emergency respite accommodation in a non-hospital setting when a client, family or carer requires respite from an immediate situation. They provide education and also consult with other agencies. They educate and consult with the police, ambulance, accident and emergency staff in the larger hospitals, and they facilitate acute mental health in-patient admission for people whose needs for treatment and care cannot be met by community settings.

Mr HANNA: Minister, the Health Commission Annual Report for 1996-97 lists several major payments for consultants working on plans to privatise the Queen Elizabeth Hospital. What services did Fisher Jeffries provide for $479 000 and why couldn't those services be provided by Crown Law?

The Hon. Dean Brown: I am not quite sure what this has got to do with this coming year's expenditure, as that is history. I thought we were dealing with estimates for next year. Mr Chairman, do you still want me to go ahead and answer it?

The CHAIRMAN: Whether the Minister answers a question is entirely in his hands.

The Hon. Dean Brown: I am happy to get that detailed information. I was not the Minister at that stage. I will get a brief summary of what services were provided by Fisher Jeffries and why they went to Fisher Jeffries.

The Hon. R.B. SUCH: I refer to page 5.7 of the Portfolio Statements and the section covering community wellbeing, safety and support, and I refer to the issue of men's health, an issue that has been close to my heart for a long time. This is in no way to detract from the excellent programs being offered for women in regard to breast cancer awareness and treatment, and cervical cancer. Specifically, I ask the Minister in relation to men's health: what initiatives are under way and may well be under way in the next 12 months taking account of broader issues and some of the specific issues relating to men's health, including such issues as prostate cancer?

The Hon. Dean Brown: Mr Chairman, I realise that the member for Fisher has had a keen interest in this. He has raised this matter with me as Minister on a number of occasions and it has been a long-term campaign that he has promoted. Let me deal with the last point of his question, which was about prostate cancer. Prostatic cancer is the second most common cause of death amongst men, after lung cancer and in many ways should be seen in the same light as breast cancer with women, where a significant education campaign is taking place with increasing awareness of the importance of detection of breast cancer, and so there should be with prostate cancer.

There are a number of issues surrounding the detection and treatment of prostate cancer which still require significant research before effective models of screening and treatment can be developed. In fact, two weeks ago I was at the Flinders Medical Centre with its cancer research group there specifically talking about these issues and some of that research program. They are actively involved in a research program on prostate cancer and we discussed how we could help boost the funding for that research program. This research program is also occurring significantly at the Collaborative Centre for Prostate Health at the Repatriation General Hospital, as well as other centres nationally, and I mentioned Flinders.

One key concern is the methods available for early detection, with the current options for early detection for prostate cancer being either not specific enough or too evasive for screening purposes. That is one of the issues that came out of my discussion a fortnight ago, that you cannot set up a broad screening program like the breast screening program because it just is not effective enough.

This view is supported by the Royal College of Pathologists of Australia, and was also in submissions from many States and the Commonwealth's Department of Veterans Affairs to the Australian Health Technology and Advisory Committee in 1996. Prostate cancer will continue to be an important area of health research not only in terms of its treatment but also concerning the development of effective screening and identification to reduce the mortality rate for this disease.

A lot of work has been done overseas, and I guess the conclusion so far is that if an older person contracts the prostate cancer they are urging that they take perhaps drugs and a minimal approach to treatment: and if it is younger men with prostate cancer then they are urging a more dramatic interventionist form of treatment. I suppose, in a general sense, that would be the advice that I think the health specialists would currently give.

Then there are broader issues in terms of social and health policy for men within Australia. In fact, a very interesting national conference was held about two weeks ago, having been orchestrated by the Federal Attorney-General on men's policy issues, and covered some health aspects as well. Following the endorsement of the development of a men's health policy by the South Australian Health Commission—and the honourable member wrote to me on this and I asked the Health Commission to take it up—substantial work has

been completed by the Men's Health Policy Steering Committee in developing a background paper, discussion paper, brochure and framework for a consultative process involving the community and key people within the health area. Given that the development of the men's health policy was begun before the formation of Human Services it is now necessary to widen the work done to cover the whole of the portfolio and more broadly include men's health and well-being.

There is also an opportunity under health promotion, with the refocusing of Living Health, for us to look at specific programs that might help men, particularly older men, live healthier lives and to look at a range of issues including potentially issues that might reduce the incidence of prostate cancer. I guess, in a short answer, they are the sorts of issues which we are looking at and which we have been tackling. Shortly I expect a specific discussion paper to come out on men's health. It is a big issue. You may have seen my letter to the *Advertiser* recently where, following its campaign on breast cancer, I asked it to look at doing something similar in terms of prostate cancer because it does need to have public discussion and an education program.

The Hon. R.B. SUCH: In relation to an awareness/education type program and acknowledging that you said that broad-based screening techniques were not adequate at the moment, is there a specific program in mind to make men have the risk of prostate cancer checked by their GP or other medical officers?

The Hon. Dean Brown: That is part of this program that I want to get going. The important thing is to make men aware of the risk and, at an early stage, to seek medical advice. Often men are the ones who say, 'No, there's nothing wrong with me,' even though they suspect there might be something wrong, until it is too late. So it is a matter of urging men to have a regular health check-up—and I am talking in a broader sense here—with their general practitioner.

A lot of men seem to boast of the fact that they have not been near a doctor for five years or something like that; perhaps that is not good. Another area I would urge men to be regularly checked for, particularly if they have had a childhood or youth in the sun, is skin cancer and sun spots, because early intervention can remove what otherwise would become very dangerous skin cancers.

Mr BROKENSHIRE: I refer to page 5.7 of the Portfolio Statements which refers to an output class described as 'community well-being, safety and support', and pick up the issue of the importance of checking one's own health. Can you advise what is being done in your department to reduce another form of cancer—cancer of the cervix?

The Hon. Dean Brown: A very effective campaign has already been run on cervical cancer. Research shows that up to 90 per cent of cancer of the cervix could be prevented if all women had a pap smear every two years. Early detection of cervical abnormalities is the key to the successful treatment of cervical cancer. The State Government has a South Australian cervix screening program which has been promoting the message of two yearly pap smears for women in this State.

Members would probably have seen what I think is some very effective advertising—in fact, some of the best advertising I have seen—in the health prevention area that has been on television during the past few weeks. I think that it is a Federal Government initiative. That last line almost by the woman in the advertisement is, 'Look, I'm just too busy.' That is why we are trying to urge people to have that regular check-up and pap smear every two years.

The results have been encouraging in South Australia: we have now the lowest rate of cervical cancer in Australia. The figures for 1996 show that there were only 45 new cases of cervical cancer in South Australia, which is the lowest since the cancer register commenced its operation in 1977; and 17 deaths were recorded in 1996. These reductions can be largely attributed to the cervical screening program. There are gaps, however. The risk of getting cervical cancer increases with age; older women are vulnerable and yet data from the South Australian cervix screening program shows that screening decreases rapidly as women get older. In the two years 1996 and 1997 only 43 per cent of women between the ages of 65 and 69 who should have had a smear had one. Again that is picked up in that advertisement urging older women to still have that smear test. As the Health Minister, I have been urging all women to stop making excuses and to make that appointment and see the doctor.

Recently the State Government approved the purchase of a second automated screening system for pap smears at the Institute of Medical and Veterinary Science which will speed up processing and reduce the number of false negative results. Manual screening of cervical smears always results in a proportion of abnormal smears being classified as normal. We have spent about $800 000 on an Autopap 300QC which automatically re-screens pap smears previously reported as normal through the manual technique. The first Autopap machine has proved to be most effective and has identified many problems in the first year of service alone. As awareness of cervical cancer is increasing, so is the demand on the machines. The second machine will help address that increasing workload at the IMVS.

I was sitting with a group of research pathologists and public health specialists who were talking about the change in the incidence of some of these diseases. Cervical cancer is the most classic example of all, where through regular testing and early intervention they have been able dramatically to change the incidence of deaths and serious cancers.

Mr HANNA: I thank the Minister for enlightening the Committee on the necessity for pap smears. Whenever I hear about that I am always mindful of Dr Papanicolaou, who pioneered the technique. I turn to matters of economic health. On many occasions the Olsen Government has given explicit support to Mr Howard's plan to introduce a GST. Has the Minister or any of the departments or agencies under his portfolio undertaken an analysis of the impact of the introduction of the GST at the likely rate of 10 per cent or any other rate on the cost of delivering State Government goods and services?

The CHAIRMAN: The Minister is not responsible for any policy that may or may not be introduced in the future. You are really starting to test the tolerance of the Chair. I will allow the Minister to respond briefly, but I do not want any more such questions. It is really a hypothetical question and I should rule it out of order. I want no further questions along that line.

Mr HANNA: What you say is true, Sir, but the question was whether an analysis has been done.

The CHAIRMAN: The Chair has given a ruling and the honourable member will not question it. The question is hypothetical. We are here to consider the Minister's budget and therefore we will have no further hypothetical questions. As I have allowed the question I will allow the Minister to respond briefly.

The Hon. Dean Brown: It is a hypothetical question, and the answer is 'No.'

Mr HANNA: By way of clarification of your last ruling, Sir—

The CHAIRMAN: If you want to go down the track of having a debate with the Chair—

Mr HANNA: Oh, no, Sir.

The CHAIRMAN: The Chair has been very tolerant and I wish to continue to be so, but there are other forums in which the honourable member can raise those sorts of questions. I have made up my mind quite clearly that we will not go down the hypothetical road.

Mr HANNA: So, if I were to ask questions on the impact of the GST on this area of health and human services, you would rule that out of order?

The CHAIRMAN: I would rule that out of order, because the Minister has already answered 'No.'

Mr HANNA: Following your ruling, Sir, I will not persist.

The CHAIRMAN: The honourable member really has no alternative.

Mr HANNA: That is right.

An honourable member interjecting:

Mr HANNA: The member for Fisher is trying to lead me astray, but I will persist.

The CHAIRMAN: The member for Fisher is out of order.

Mr HANNA: Totally! What was the total of all consultancies paid in relation to the Queen Elizabeth privatisation in this current financial year; and what is budgeted for consultancies in the coming financial year in relation to the Queen Elizabeth privatisation?

The Hon. Dean Brown: I will take that question on notice. All that information is detailed in the Health Commission's annual report, which was put out last year. I would have thought the honourable member could sit down and read that and get the information himself; I do not see why we have to do the reading for him. However, we can pull together that information again, photocopy the pages from the annual report and send them to him.

Mr HANNA: I thought I was clear in asking about what relates specifically to the Queen Elizabeth.

The Hon. Dean Brown: I will make sure that is clarified for the honourable member. The second part of the question concerned consultancies for the Queen Elizabeth for the coming year in a general sense?

Mr HANNA: In relation to proposed privatisation.

The Hon. Dean Brown: There is no proposed privatisation.

Mr HANNA: Of any services?

The Hon. Dean Brown: I do not know specifically of services at the Queen Elizabeth Hospital that are in the process of being privatised, but I will ask that question of the board. For instance, I presume that would include Rose Cottage as a private service, but that was not proposed: that has been cancelled.

Mr HANNA: Across the board in the Human Services portfolio, what consultancies with a value exceeding $10 000 have been provided for in this coming budgetary period?

The Hon. Dean Brown: I will explain consultancies, because often they are taken out of context, particularly by Oppositions, which try to create the impression that a lot of money has been wasted on consultants. Some of the consultancies are for architectural or general legal work, all of which is put down under the name of consultancies. In other cases, the Federal Government specifically requires us to engage consultants to review Commonwealth-State programs, where a condition of signing the funding agreement with the Federal Government is that an independent consultant must carry out a review and that the report has to be available to the Commonwealth Government as well as the State Government. We will get the information as to what consultancies have already been identified. Obviously, I must take that on notice, but I stress that many of these are decided throughout the year, when the need arises.

The Hon. R.B. SUCH: I have written to the Minister regarding my concern about the more comprehensive labelling of groceries and similar products. Constituents have informed me that in Australia the ingredients in grocery lines, and so on, are not labelled as comprehensively or as accurately as they are in the United States. I appreciate that this matter would also come within the province of the Attorney-General. Is the Minister aware of any moves within Australia amongst Health Ministers to see whether we can have more comprehensive labelling of fat and sugar levels, and so on, in products so that people who wish to pursue a healthier lifestyle can do so?

The Hon. Dean Brown: I am aware of the honourable member's correspondence to me on this issue, and I share his concern. A lot of the food labels in Australia are inadequate. Recently, an argument on that has been mounted nationally to make sure that pig products coming from overseas list where the products come from. I am one of those who believe we should know exactly where the pig was reared and where the pig product has come from. We should also be able to access the same information for poultry products. We need that information because pigs and poultry are animals that could bring into Australia exotic diseases as a result of a hygiene problem, endemic diseases within certain countries or inadequate meat hygiene standards.

The more basic issue of labelling must be dealt with at a national level. State Governments cannot bring in standards that apply just in a certain State, because food is produced in factories that now go throughout Australia with no restriction. The matter comes under the national review of food legislation. A great deal of effort has been put into this by Trish Worth, the Federal member for Adelaide, who is the Minister assisting the Federal Minister for Health.

The Department of Human Services has been actively involved in assisting the Australian/New Zealand Food Authority, which is the new body that has been set up to deal with this, to develop new food hygiene legislation and nationally uniform food Acts. We still have a long way to go. This new authority arose because of the Garibaldi issue, and it was taken up by the then Minister for Health, Michael Armitage. It was one of the key initiatives that he took up. It is a credit that the authority has now been established. Involvement is by way of representation on three of the working parties of the food authority, with notification requirements, food industry guidelines and uniform food Acts.

Additionally, the Department of Human Services has been working with local stakeholders to ensure that the proposed legislation meets the needs of the South Australian community. This consultation process has been through the South Australian Food Hygiene Implementation Committee, which includes representation from local government, environmental health officers, the Business Centre, consumers and large and small food businesses.

The implementation committee is supported by a reference group of 33 members, which is primarily composed of food

businesses and other Government departments. The implementation committee, called SAFHIC, has identified key concerns with the hygiene proposals that relate to their impact on small business and how auditing systems would operate. Two of the working parties, on one of which the Department of Human Services is represented, are addressing these concerns. Also, the implementation committee has set up mirror working parties in South Australia.

I have raised the honourable member's concerns with the food authority, and I will continue to pursue those, because food labelling in Australia needs to be improved, particularly as it relates to the country of origin of the food product. It is possible to take food products from overseas, to 'manufacture' the product in Australia and simply list the manufacturer in Australia, and that is inadequate. There needs to be identification as to where the raw material came from—at least the major raw material—and in which country the manufacturing has taken place.

The Hon. R.B. SUCH: Claims are made that food products are 'hand made'—which raises some concern—or that they are 'homemade', 'fresh', 'freshly made', 'fresh daily', 'country killed', and so on. There is much ambiguity in many of these labels; for example, the label 'fresh daily' is saying not that all the fish in the shop were caught and brought in on that day and that they are fresh but that the products are fresh daily. That also encompasses salads and things that are sold in bulk. There is a lot of vagueness about how fresh some of these things are and about precisely how they were made. I shudder when I see pies and pasties that are claimed to have been 'hand made'. Will the Minister encompass my concern when he takes up this whole question of more adequate labelling of food products?

The Hon. Dean Brown: Yes, I will. A lot of concern is that supermarkets carry many readily prepared food products, and customers need to be reassured of the quality of those. Supermarkets now have large salad bars, and we must be careful that people do not come along and sneeze, cough and splutter all over them. We need to carry out more national research about the hygiene standards that apply.

The other concern is that it is a requirement of manufacturers to maintain high and rigid standards, yet those food products then go into a retail outlet which are not subject to the same legislative or regulatory requirements. For instance, the manufacturer of smoked salmon is required to put on the pack where it was manufactured and a use-by date. However, once it gets into a retail outlet, that pack is opened so that it can be put into sandwiches, and so on, or sold as a part-pack, with the result that suddenly that use-by date disappears.

It is of considerable concern that there is global evidence that food poisoning is on the increase, because of the ready-made nature of food. Certainly, the experiences of the United States of America and the recent food scare in Japan indicate that we must do much more. There have been some timely reminders. In this State, we can be grateful that we have a Public Environmental Health Section of the Health Commission which has been quite outstanding in its ability to trace food poisoning back to contaminated food. I pay a tribute to the way in which it has done that, first, with the Garibaldi issue, which was almost unique in the world in that it was like trying to find a needle in a haystack and, secondly, with the gelati experience. We got on to the matter quickly, instead of allowing what happened in Japan, where hundreds of people died without their having found the source of contamination.

[Sitting suspended from 1.2 to 2 p.m.]

Mr BROKENSHIRE: I would like to ask about the free flu vaccine. I would like to have noted by *Hansard* that a number of senior people in my electorate have been appreciative of your commitment to try to support this program. I therefore refer to page 5.7 of the Portfolio Statements, 'Output Class: Community Well-Being, Safety and Support'. The Federal Government has recently announced a free flu vaccine program for people over 65 years of age. Minister, how do you intend to implement this in South Australia and how successful do you think this program will be in South Australia?

The Hon. Dean Brown: Let us deal with this year. Prior to the State election, the State Government, through the previous Minister for Health, gave an undertaking there would be free flu vaccines for all people over the age of 70. In fact, even though that was back in September-October last year, the judgment of it has certainly borne fruit because there is now the Sydney A flu and there are alarming signs that it is on the increase very early in the season. I understand that in the last couple of weeks the reported number of cases of A-type flu has doubled each week which would suggest that a significant epidemic could be occurring. I do not wish to alarm anyone, but there are signs it is on the increase very rapidly.

Through this program, which was implemented at the beginning of the year, 142 000 doses of flu vaccine have been used. The scheme was put into place very quickly by the Department of Human Services. The vaccine was sent out to individual general practitioners who administered it and the cost was picked up by the State and Federal Governments. The Federal Government made a contribution to the cost of the vaccine. The State Government paid for the balance of the cost of the vaccine, the main part of the cost, and also administered the scheme. It seems to have gone very well.

The 142 000 doses of vaccine were dispensed in a two month period, and I acknowledge the tremendous effort put into this program over a short period of time by the department's immunisation unit in the communicable disease control branch that coordinated the whole program. The people most at risk from the flu are those who are older, particularly those with chronic debilitating diseases; children with congenital heart disease; adults and children receiving immunosuppressive therapy; and residents in chronic care facilities such as homes for the aged.

As part of the 1998-99 budget, the Federal Government recently announced it was going to make available free flu vaccines for people over the age of 65. I stress that we are talking about the vaccine being free: people are still required to pay the consultancy with the general practitioner who invariably bulk-bills the patient, so there is probably no cost to the person involved but there is no guarantee because it depends on whether the doctor practises bulk-billing.

The Federal Government's vaccine will not be available until March next year. It is expected that the packaging and distribution of all vaccines this coming year will be contracted out to an agency with relevant expertise rather than doing it within the department. This will be done to allow the department to concentrate on facilitating more effective immunisation services. An evaluation process is currently being undertaken into what has been done this year, and it is expected the contractor will be operating the package and delivery service from 1 July 1998. I am pleased that the Commonwealth Government has provided this free vaccine. Once again, I remind all people over the age of 70, at least for this year, to take up the offer and next year to ensure people

over the age of 65 take up the offer because anyone over the age of 65 is certainly in the target group.

Ms STEVENS: In previous years, the Program Estimates provided details of indicative funding for individual hospitals and in the past it has been the practice of the Health Commission to provide the Opposition with supplementary information on hospital funding prior to the budget Estimates Committee. This year we have not received that information. Recently, there has been considerable publicity about hospital budget over-runs, including a reported deficit at the Queen Elizabeth Hospital of about $7 million. Following media reports on 11 May 1998 that hospitals are running deficit budgets and cutting services, I ask the Minister to inform the Committee of the expected cost over-runs and the financial position in relation to revenue and expenditure for 1997-98 of each of the major metropolitan and country hospitals?

The Hon. Dean Brown: I do not have that information to hand. I would suggest that the honourable member be patient for a week or two and we will provide her with the figures for those hospitals. It will not be just a projection, but what appear to be probably the correct but unaudited figures. I think that is a better way of doing it. If the honourable member is willing to wait a couple of weeks, I assure her that I will provide the information to her as soon as it is available. Is the honourable member prepared to do that?

Ms STEVENS: I will wait a couple of weeks, thank you. My next question is: does the Government intend to reimburse hospitals for cost over-runs in 1997-98, or does the Government expect hospitals to carry these over-runs into next year?

The Hon. Dean Brown: Traditionally, the Health Commission has not reimbursed the hospitals for budget over-runs but that is a matter for negotiation when they work through the budget for next year. When the figures come out for hospitals, we believe there will need to be adjustment between hospitals because some areas are bigger growth areas than others. A bigger increase in funding probably will be given to some areas because there appears to be more growth in those areas. I assure the honourable member that certain parameters have been put down—and I have mentioned those earlier—and that the absolute minimum amount of money allocated this year for hospital services will be the same as last year plus the 3 per cent and any other salary increases which have been negotiated where there was additional money to be put in. That does not mean that there will not be some other increases—there will be in some areas. At the end of the current year we want to match up demand between the hospitals for different services.

Ms STEVENS: Will the Minister explain why the Government expects to be holding a total of $182 million in cash and deposits at call at 30 June 1998? Given that this amount is double the cash held at the end of 1997 of $91 million, and with changes to the department's functions, will the Minister reconcile the $182 million with last year's figures?

The Hon. Dean Brown: The portfolio cash balance comprises the operating cash balances of the South Australian Housing Trust, the Department of Human Services, the South Australian Health Commission and the health units. Projected cash balances of the Housing Trust at the end of June 1998 and 1999 are expected to be $49 million and $38 million respectively. At the end of June 1998 we expect the Housing Trust to have about $49 million in cash as there are various contracts under way, money was provided for them in the current financial year and in many cases the work has not yet been finished.

The projected cash balance of the Department of Human Services at 30 June 1998 is $43 million, which is an actual run down in cash reserves and not an increase within the human services area. The main source of funding is for the capital works program, which includes cash transfers to SACHA (South Australian Community Housing Association) in support of the capital works program of community housing. The projected cash balances of the Health Commission for this year as at 30 June is expected to be about $90 million, which it was last year. The cash balance of the Health Commission is comprised of two parts: cash held by the commission, projected at $29 million and $18 million for the two years and cash held by incorporated units. At the end of June this year we expect the cash held by the Health Commission to be $29 million and the balance is cash held by the incorporated units.

The breakdown of the health cash balance projected at 30 June 1998 is as follows: $29 million for the South Australian Health Commission deposit account held at Treasury, including $10 million for carry-over funds; $4 million held for the Flinders Medical Centre car park sinking fund arrangement; $15 million for a prudential arrangement, which enables unplanned contingencies to be met, as well as a broad provision in the event that the budget strategy cannot be contained within the annual allocations of health units and the need to be funded from contingency provisions; and $60.4 million held by incorporated health units, held in a number of banking arrangements including SAFA.

A large proportion of these funds is held by health units under private practice arrangements with medical practitioners. Traditionally this pool of funding has allowed valuable medical equipment, conference and special purpose arrangements to be funded. Previous efforts to apply these funds on a loan balance to fund the other parts of the health unit operations have been declared *ultra vires* by the Auditor-General, and Crown Law has required repayment of loan funds provided. Further cash balances held include: operating accounts for highly specialised medical equipment, established under self-financing arrangements such as MRI and radiotherapy; tied research grants provided by the National Health and Medical Research Council, drug companies and other agencies providing arrangements; self-funded operating accounts established to provide accommodation, car parking facilities, engineering and building services, recharge operations and the like; nursing home operations, particularly in the country; and, donations, bequests and other recurrent and capital amounts. Hospital CEOs approved the establishment and operation of these accounts and their audit is undertaken by prescribed auditors under the Public Finance and Audit Act. That is a very detailed account indeed in terms of what the balances are and why.

Ms STEVENS: I refer to the redevelopment of the Queen Elizabeth Hospital. After five years of confusion, it is time the Olsen Government set out its long-term plans for the Queen Elizabeth Hospital. In January 1996 Minister Armitage announced a $130 million redevelopment of the Queen Elizabeth Hospital and nothing happened. In September 1996 Dr Armitage announced that the redevelopment had moved into its next phase. This was code for 'the project had stalled'. In February 1998 the Premier said that the Government had no money to fix the Queen Elizabeth Hospital—and it needed $80 million—unless he sold ETSA. On 28 May the Treasurer announced $43 million for the redevelopment of the Queen

Elizabeth Hospital. Even this does not agree with the fine print.

The capital works Budget Paper 5 on page 123 allocates $4.3 million this year. Budget Paper 2, pages 1 to 5, shows a forward commitment of $14 million and $11 million in the year 2000-01. That gives a total of $29 million, so not even the $43 million is funded in terms of being on the forward commitments for the capital works program. What works have been identified to make up the so-called 'redevelopment' and has the Government given up on the 1996 plan for a total campus redevelopment?

The Hon. Dean Brown: I assure the honourable member that there is a commitment by me to upgrade the Queen Elizabeth Hospital: I have said that previously. The previous plans to establish a private hospital of a substantial size went out to the RFP—a natural process to go through and shows that the Government used a rational judgment. We went out to the private sector, asked for proposals and were not satisfied that the proposals that came in would give us the benefits we wanted. There was little guarantee of that based on those proposals. At that stage I indicated that we needed to look at a substantial redevelopment of the Queen Elizabeth Hospital using the Government's capital works program funds. We started work on that last year.

I met with some of the board members of the hospital and discussed it with them and with the CEO of the hospital. As a result of that a proposal came forward that is now being worked on in detail. We wanted to retain the hospital as a full teaching hospital. The design of the new hospital will provide a state of the art facility with flexibility and functional efficiency. The redevelopment will include construction of emergency and ambulatory care facilities and theatres all linked to wards of high standard.

The range of services provided for the new hospital will be appropriate for a modern teaching and referral hospital and will include: primary care, medical, surgical, diagnostic and support services. The master plan for the redevelopment of the Woodville Road site includes options for the utilisation of existing buildings for non-clinical services and the opportunity for collocation of other human services on that site.

This planning exercise has enabled a more accurate estimate of the scope of the redevelopment to be identified. We expect to spend about $43 million over the first three years of the project. Clearly, some of that work will not begin until part way through this year. We are talking about a period of about three years from the beginning of the project. Of course there is still some planning to be done in that regard. Yesterday, Cabinet agreed, subject to the approval of the Public Works Committee, to the first stage of the redevelopment: the construction of a new intensive care unit at a cost of $4 million. This is over and above the mental health facility. The proposal for the intensive care unit will go before the Public Works Committee as soon as possible, and work will then quickly commence. So, Cabinet has already signed off on the first stage of the redevelopment.

Ms STEVENS: How many years will it take the Government to carry out the works totalling $90 million?

The Hon. Dean Brown: We are uncertain whether the cost will be $90 million or $100 million, which I am sure the honourable member would understand. I expect that it will be over a five to six-year period once the program starts.

Ms STEVENS: For the first three years, the cost is estimated to be $43 million. What is the estimate for the next two years?

The Hon. Dean Brown: Over the next two to three years we expect the cost to be about $50 million to $55 million. I can provide the Committee with a little more information. The intensive care unit, to which I have just referred, is expected to cost about $4.7 million. The works will comprise the construction of a new intensive care facility on the first floor of the north wing of the main building. The location of the new intensive care unit is fully compatible with the major redevelopment work soon to be commenced and represents the unit's final location. Tenders have closed, and a preferred tenderer has been selected. Cabinet is now seeking the approval of the Public Works Standing Committee and it is anticipated that construction will be able to start later this year and hopefully it will be completed by about the middle of next year.

Mr BROKENSHIRE: Ambulatory care is an issue in which I have an interest. On page 5.3 of the Portfolio Statements it is indicated that one of the department's strategic outcomes relates to finding alternative and innovative methods for the delivery of services. Will the Minister provide an update on developments in the reform of ambulatory services provided by hospitals and recognised under the current Medicare agreement?

The Hon. Dean Brown: There have been 29 research projects looking at ambulatory care at a cost of about $4.4 million as well as a combination of demonstration projects related to substitution of acute in-patient care and descriptive studies associated with the development of information management. Examples of major South Australian achievements include alternative models of care. These were trialled and found to be very effective in terms of achieving good clinical outcomes to help contain costs with a high level of consumer satisfaction. Successful trials were conducted in a variety of settings, including: step-down facilities within acute health units; community-based models of care; day treatment centres; the emergency department (community linked management of the elderly); and home-based care.

There is increased flexibility in the range of services provided. An analysis of the opportunities of hospital-at-home services has enabled hospitals to obtain payments through case mix funding. In other words, an attempt is made to keep the patient in the home rather than take them to hospital if they require a relatively low or medium level of care. A qualified nurse would perhaps call at the home briefly two or three times a day. That is regarded as much more effective than suddenly taking a patient out of their home and putting them into a strange environment and increasing their stress level.

Many projects have contributed to the development of a better understanding of ambulatory activity and enabled the identification of appropriate reporting systems. Once they have been demonstrated to be sustainable, business cases must then be developed to get ongoing funding. Successful ambulatory models of care include: community-based, maternity and infant care programs (Northern Health Services and the Flinders Medical Centre); hospital-at-home program (Flinders Medical Centre); dermatology day unit (maintained at the Flinders Medical Centre); the home enteral nutrition program (maintained at the Women's and Children's Hospital); the nursing convalescent units (Flinders Medical Centre); and the home based rehabilitation program for stroke victims (Repatriation Hospital). Ambulatory care will play a pivotal role in the evolution of health care services in South

Australia. The number of options in this area have increased dramatically.

Ms STEVENS: With reference to the Queen Elizabeth Hospital upgrade, I listened to the answer given by the Minister, but I want to know whether the entire works will completely upgrade or replace the main building as announced by the previous Minister in January 1996 or whether it is just a series of patch-ups.

The Hon. Dean Brown: No. We are looking at bulldozing some of the facilities and installing new buildings.

Ms STEVENS: In other words, the main building will be replaced in the end. Is that so?

The Hon. Dean Brown: They are working through a model. The multi-storey building will be retained, and the former nursing home will be bulldozed. I will ask Mr Zissler, who is in charge of the capital works program of the Department of Human Services, to comment.

Additional Departmental Adviser:

Mr M Zissler, Director, Capital and Asset Management.

Mr Zissler: A range of buildings, including the former nursing home and some of the smaller buildings, will be demolished over time. The main building, which consists of nine floors, will be kept in tact. The final location of the ICU will be in the north wing.

The Hon. Dean Brown: The major new building will be erected on a cleared site.

Ms STEVENS: When you will knock down those other buildings?

Mr Zissler: Yes. There will be a site clearance over, I suggest, the next 18 months to two years. We have to relocate the research facilities, which are currently situated in the grounds of the nursing home.

The Hon. Dean Brown: I would like to clarify an answer which I gave earlier concerning cash balances, so that there is no misunderstanding. I may have indicated that the South Australian Health Commission cash balance at June 1997 and June 1998 would be at a similar level of $90 million. In fact, the cash balance for the health system has dropped from $175 million at June 1997 ($91 million in the South Australian Health Commission and $84 million in health units) to $90 million as at June 1998. So for the health system it has dropped from $175 million to $90 million as of June 1998—$29 million in the South Australian Health Commission and $61 million in health units. The $91 million I referred to for last year was for the Central Health Commission only, not for the units.

Ms STEVENS: Back to the QEH: will all of the works that we have been talking about address the 1996 findings announced by the previous Minister that all electrical, mechanical and infrastructure services are, and I quote: 'at the end of their safe and useful life'?

The Hon. Dean Brown: Yes.

Ms STEVENS: I would like to talk about the Lyell McEwin Hospital upgrade. This issue is very dear to my heart and it is actually in my electorate. There has been considerable concern over many years now by residents of the electorate about whether in fact there will ever be an upgrade of the Lyell McEwin Health Service. Last year in Estimates I asked the previous Minister what the total value of the Lyell McEwin Health Service upgrade would be and he gave me the answer that it was $48 million. As you know, Minister, I have already pin-pointed this in the House, but according to the Capital Works Statement the Lyell McEwin Hospital redevelopment is now at $40 million. My questions are: first, why have we dropped from $48 million to $40 million? What is the difference there and what things aren't we going to have for $8 million less? Secondly, is it the final figure or will this be an ongoing saga? Finally, when will we actually see it completed?

The Hon. Dean Brown: There was a strategic reassessment last year of the redevelopment of Lyell McEwin Hospital and that is the reason why it is now much more ambulatory care focused and why the figure is less than it was 12 months ago. The proposed development focuses on providing an improved range and level of clinical services—however, specifically excluding any tertiary services; a major enhancement of the hospital's ambulatory and outpatient care capacity; a replacement of a number of existing facilities that do not meet the contemporary service delivery standards; an efficient functional configuration; and facilities to enhance the hospital's education and teaching capacity, which will further assist in the attraction and retention of key expertise.

The key components of the proposal include the following. Emergency Department: relocate and expand treatment cubicles from nine to 16. For medical imaging—and I had a look at the medical imaging facilities when I was visiting the hospital at the beginning of the year and I would have to say that they are totally inadequate and totally out of date—the size is to be increased to 1 200 square metres to allow for a more functional layout. These are very crowded at present. Ambulatory care: areas are to be redeveloped and expanded to include same-day surgery, gastroenterology, oncology, haematology, pre-admission clinics and angiography suites. Pathology: relocate the laboratory in closer proximity to the wards. Pharmacy: relocate the pharmacy in closer proximity to the wards. Intensive care and coronary care: increase the area to provide space for a 14 bed collocated area. Medical hospice ward: ward in need of upgrade, no additional beds to be provided. Medical records: provide expanded area and centralised area for enhanced access. Out-patients Department: expand area to cater for increased clinic demand. Administration, teaching, conference inquiries and hotel services: relocation of areas to provide for the reconfiguration of essential services into more efficient locations. An amount of $40 million has been allocated for this project over the next four years. Of this, $2.16 million is anticipated to be spent in 1998-99.

Ms STEVENS: And $40 million is it? Is that correct, Minister?

The Hon. Dean Brown: $40 million.

Ms STEVENS: No more reductions?

The Hon. Dean Brown: No, I do not expect so.

Ms STEVENS: I turn to the Northern Metropolitan Community Health Service upgrade. Even though this project was certainly in last year's capital works program, and I think the year before as well, it is not in the program at all. Minister, I know there have been some issues in relation to the site of this in Elizabeth, but I want to know what is going on and whether you still intend to proceed with such a facility.

The Hon. Dean Brown: There are discussions going on at present. We are looking at what new community health centres are required. We have not made final decisions about these yet. Discussions are going on with both the council, I understand, at Elizabeth and a developer about a possible location and a possible site, but no commitment has been given at this stage.

Ms STEVENS: Just to clarify that, Minister: are you saying it may not happen?

The Hon. Dean Brown: That depends on what we come up with. I do not want to get locked into anything because no decisions have yet been made. If I can outline one of the reasons that this occurs. It occurs in a number of areas and there has been some thought about what we do at Noarlunga, Marion, Tea Tree Gully and at Elizabeth. One issue that we are working on is how to collocate, if possible, any new community health service with housing and community welfare, because it makes a great deal of sense. I have talked about how we want to try to have one access. Therefore, just the formation of the new department has meant that we have to go back and rethink all previous plans, because all the previous plans were not based on collocation. If it is the preferred model there is not much point in having parts of the agency scattered within the one area. I have recently been involved in some talks with the Marion council about what might be done there, and the Marion council is supportive of trying to make sure that we have a common facility there. It is an issue at Noarlunga as well and we are having talks down there; and the same situation applies at Elizabeth. In all those areas, nowhere have we made any decisions yet.

Ms STEVENS: When will you be making the decisions?

The Hon. Dean Brown: When we are happy with the recommendations that are put forward.

Ms STEVENS: Can you give us a time?

The Hon. Dean Brown: No, I can't.

Ms STEVENS: Some time in the future?

The Hon. Dean Brown: I guess if it is after today.

Ms STEVENS: My next questions relate to dental health. The Senate Report on Public Dental Services dated May 1988 states that since the abolition of the Commonwealth dental health program waiting times and waiting lists have increased dramatically. The number on the waiting list in South Australia is shown to have increased from 53 800 in mid 1996 to 78 000 in mid 1997. The estimated average waiting time is given at 22 months.

What action has the Minister taken in this budget to ease the pain and suffering of the 78 000 people on the waiting list for dental treatment, particularly the aged and disadvantaged people, or has the Government decided to continue to do nothing and blame the Howard Government's decision to scrap the Commonwealth program for the spiralling number on the list?

The Hon. Dean Brown: The honourable member has clearly identified why the problem has arisen—the loss from 1 January 1997 of the Commonwealth's dental health program which put $10 million into this area each year. As a result of that there has been a spiralling in the waiting list. I think the situation is unsatisfactory and I have made statements to that effect. I have put out the details of the waiting list and highlighted the extent to which that waiting list has increased each year as a result of that withdrawal of $10 million by the Federal Government.

We are not sitting on our hands on the issue. A proposal has been put to me but I thought that it was unsatisfactory. I think that any proposal has to be able to meet the needs of people who are most in need—after all, this is a service for people in need—and it is important that whatever we put up as a solution or partial solution to try to reduce the waiting list or at least to hold the waiting list steady needs to be one that the participants in the scheme can afford.

Therefore, a strategic plan for dental services is being developed. Where people have urgent needs, we have drawn that to the attention of the dental service and it has normally been able to facilitate those people. For example, we made sure that someone who recently had to have their teeth removed before undertaking cardiac surgery was able to get their dentures. We try to deal with people on an immediate needs basis. Clearly, now that the Federal Government has withdrawn from the service it is putting enormous pressure on the Dental Health Service.

We are trying to respond by increasing the number of people helped by the service. We want to make sure that we have the right target group using public funding, that we have the right balance for services between children and adults and among emergency, conservative and denture services. We want to make sure that what we are delivering is efficiently done and is very effective, and we want to benchmark against what is occurring in other States of Australia.

From what I have seen, this is a problem throughout the whole of Australia. I think it is unsatisfactory and I believe that the Federal Government should come back into the field as quickly as possible and put in additional finance. I raised this matter at a Health Ministers' meeting and found that there were similar waiting lists in other States of Australia—not that that suddenly makes it okay here; it does not and I am not attempting to make it so.

I think it is fair to say that the waiting list is about 80 000. Recently I opened the new facilities at the Dental School; these new facilities are very good and are some of the best one could find anywhere. But what we need to do is ensure that we are treating more people. I stress that a State Government cannot suddenly pick up the responsibility of the Federal Government. I am sure the honourable member understands that.

Ms STEVENS: Following on from that answer, you said that you were developing a strategic plan. How much resourcing do you intend to devote to this? Will this resource allocation be an addition to the Dental Health Service's budget or are you expecting to get that money by reallocation within that area?

The Hon. Dean Brown: I cannot answer that yet because we have not finalised the strategic plan. Until it is finalised I cannot give any commitment.

Ms STEVENS: I want to return to Mental Health Services and Glenside Hospital. I heard the reply that was given earlier but I want to ask some extra questions on the matter. On 28 May, in answer to a question I asked you about whether Glenside would close, the Minister told Parliament that the Government would be providing long-term care facilities for people with mental illness at Hillcrest, and he said that the funding was 'part of the budget'.

Can the Minister explain the scope of the works to commence at Hillcrest this year? How many beds will be provided, when they will be completed and why Budget Paper 5, Capital Works, does not mention any such project at Hillcrest?

The Hon. Dean Brown: In terms of the budget process, I was talking about the three year budget process, not this immediate budget process, because Glenside still will have all the patients there. I was talking about post the period of building the new facility down at the Flinders Medical Centre. Since the honourable member raised that question with me, I have gone back and raised it again with the department and I have had a discussion with the people responsible for Glenside. I must say that I think my answer to the honourable member in May was inadequate because it did not reflect enough some of the other options at which it

is also looking. It is looking at a range of coordinated care within the community at different levels. It is still working through the detail of this. Those units or services still to be relocated as part of the realignment of the process include Cleland House at Glenside Hospital to the Royal Adelaide Hospital, and the Patterson East Wing at Glenside Hospital to the Flinders Medical Centre. That is the facility that is still to be built but Cabinet has signed off on the money and I think it is before the Public Works Standing Committee at present. Also included are the rural and remote inpatient unit at Glenside, which will go to the Flinders Medical Centre; and the Helen Mayo House at Glenside will go to the Women's and Children's Hospital.

Also, the adult extended care services at Glenside will go to mainstream services, and the acute psycho-geriatric beds at Glenside and Hillcrest Hospitals will go to the Royal Adelaide Hospital or the Queen Elizabeth Hospital and the Repatriation Hospital. Psycho-geriatric extended care services will go to mainstream services. Cabinet has approved the development of a 50 bed acute mental health unit at the Flinders Medical Centre to accommodate the rural and remote inpatient unit, the beds for the southern area currently at Patterson East, and the eight beds for young people from the southern region.

I said that the closure of Glenside was expected to take place over about a four year period and that the Government was looking at releasing some money from the sale of Glenside land to help build and provide some of these facilities. They are looking at other facilities: some so-called 'in-community' long-term facilities may need to be provided at Hillcrest, but they are still working through those options. When I previously answered the honourable member I had been given the impression that all the options had been worked through and finalised pretty well; I have since learnt that that is not the case and that more work needs to be done on it. I ascertained this by talking directly to the person responsible for the Glenside Hospital.

Ms STEVENS: Do you now have an overall plan for the closure, with a month by month time line across the four years?

The Hon. Dean Brown: No; we do not yet have that in absolute detail yet.

Ms STEVENS: When do you expect to have that?

The Hon. Dean Brown: When I found out that more work was required on this (and I spoke to the person responsible about two or three weeks ago), I came back and raised the issues with the department, and it is working on it further. I do not know of the exact time; some of it depends on providing these community facilities and we have not yet done the detailed planning for that.

Ms STEVENS: It is fair to say that the planning for this is in its infancy?

The Hon. Dean Brown: It depends what you call infancy, because a key part of this is the Flinders Medical Centre. I do not think you would say that it is in its infancy if the design work and 12 months of planning have been done, Cabinet has signed off and the money has been allocated for the 50 bed facility there. Some parts of it are well advanced in their planning and are about to be implemented, but other parts of it are still in their early stages.

Ms STEVENS: From my understanding, for a number of years there has been a recognition and understanding that certain sections of Glenside Hospital were to be moving out to the community, so we have had the Queen Elizabeth, Flinders, Lyell McEwin and Noarlunga Hospitals. However, on 6 May you announced the total closure of Glenside, which seemed to take a lot of people by surprise.

The Hon. Dean Brown: The honourable member should appreciate that, at the Mental Health Summit where people raised this issue about what would happen with Glenside, I did not make a formal announcement about the closure of Glenside. I was asked the question and I said that, yes, eventually Glenside would close and that we anticipate that it would be over about a four year period. It needs to be put into context. I have worked through all the detail of where different parts are going, but some of those facilities are not yet finalised.

Ms STEVENS: In the letter of 6 May that was sent out under your name to the families and relatives who were alarmed by your announcement of the closure of Glenside Hospital, you stated that those families and relatives would be involved in community consultations. What has happened in relation to that undertaking given to those people about this process, and what consultations have occurred with them to this point?

The Hon. Dean Brown: First, I said that it was proposed to close Glenside Hospital within a three to four year period. That letter was sent last month, in May. I emphasised in the letter that alternatives were being addressed and that, when they were finalised, we were looking at appropriate supported residential facilities in other hospitals and within the community. The letter also stated that a further step in the reform of our public mental health system can now take place, with the planned closure of the old Glenside, and new and improved residential services can be created. They will be less stigmatised and more accessible. These alternatives will come to provide the necessary care and support for people with serious and chronic mental illness but will better assist individuals to rejoin the community.

I indicated also that there would be consultation with them—and that will take place—but that the planning of these alternative supported residential services would take place over the next 12 to 18 months. Customers, families and service providers would examine a number of models aimed at providing a much more individual service to patients who require that long-term care and support. I guess that, over the next two years, we would hope to finalise some of the options and then have the consultations.

As we have said, in some areas we are already building the facilities such as those at the Flinders Medical Centre. Therefore, there are still two years before the closure is likely to take place, so I think that is a reasonable sort of time frame.

Ms STEVENS: What plans are being developed to ensure that community-based support services and the new residential facilities that you are talking about are operational before the Glenside services are reduced in preparation for its sale?

The Hon. Dean Brown: We will not be able to close Glenside until we have those other facilities in place; that is obvious.

Ms STEVENS: It is not obvious to a lot of people in the community who, even when they read your letter, said that it was a lot of vague wording with no specifics. People are saying that they are really worried that what happened with Hillcrest will happen again and that people will be left with nowhere to go. That is of considerable concern to many people in relation to the closure of Glenside Hospital.

The Hon. Dean Brown: I am aware that in 1992 the honourable member's own Party started taking decisions and closing down Hillcrest without providing community

facilities. This Government has had to pick up the task of providing those facilities as quickly as possible. I highlight that I have recently opened the new facilities at the Queen Elizabeth Hospital, a project which has had to be picked up by this Government. We have done the right thing in this case; we have announced that we will build the new facilities before closing down the hospital. The previous Government closed down parts of the old Hillcrest Hospital when it had not even started to build the new facilities. We have done it the other way around. The honourable member should be saying, 'Congratulations on doing it the correct way.' We acknowledge that, for some patients in Glenside, there will need to be further development of proposals and facilities, and discussions with them over the next 18 months to two years so that those facilities are there before Glenside is shut. However, if the honourable member is looking for a clear commitment that we will not suddenly turn people out onto the streets, I can assure her that that will be the case. We are already starting to put in place those facilities.

Ms STEVENS: I asked this question because the record of the Minister's Government in relation to mental health services has also not been a good one. His Government also closed wards, turned people away from Glenside, and put people in hotels in Hindley Street—and the Minister would know this, because he was the Premier when a lot of this was happening. We admit that there have been faults on both sides in the provision of mental health services. The community and I want an assurance that we have both learnt from this and that it will not happen again.

The Hon. Dean Brown: I would have thought the commitment given at the end of the mental health summit and the whole planning and process of the mental health summit was a clear statement that we want to make sure that we provide more effective services for people with mental illness in the community. This Government has increased funding for it. It has increased funding in this current year. We have now given a commitment to increase it further for the next four years. Let us look at the history of this, so that people can make their own judgment. In 1992, in metropolitan Adelaide, there were six community teams, an accommodation service and a limited out-reach service from Glenside and Hillcrest Hospitals. That is in 1992, when the former Government started to close down Hillcrest. Today there are 30 teams—I mentioned six in 1992—spread throughout the metropolitan area. Accommodation services are no longer provided through mental health services but through Metro Access—formally SHOP—which is a joint project between the mental health services and the Port Adelaide Central Mission.

In 1992, there were 139 full-time equivalent staff in the community. There are now 398 full-time equivalents in the metropolitan area, and 69 full-time equivalents in the country. We have gone from 137 under the former Labor Government to 467 now before we have put in place the additional funding. In 1996, 6 770 clients were receiving services from the metropolitan and Tanunda health teams. It is expected that approximately 7 000 clients will receive specialist treatments in 1997-98. We cannot be accused of doing nothing, which is the accusation, when we have gone from six to 30 community teams, from Labor to now, and from 139 full-time equivalents to 467 full-time equivalents. I would have thought that was a clear statement of a significant effort over the past four to five years.

Ms STEVENS: How does that compare with the level of unmet need for people with a mental illness, in both the metropolitan and country areas? What is your long-term aim?

The Hon. Dean Brown: The long-term aim is clearly spelt out in both the final report of the Mental Health Summit and my formal response to that. I think you were there at the time.

Ms STEVENS: I want to know numbers for your teams.

The Hon. Dean Brown: I picked up and highlighted our commitment in terms of both funding and meeting services. I have given numbers for this year at 7 000.

Ms STEVENS: The Minister gave those numbers in terms of the staff in the community. How does that compare with the level of unmet need? What is the level of unmet need? Do you consider that you have met the whole lot now? You have done it; is it all finished?

The Hon. Dean Brown: No.

Ms STEVENS: So, it is not finished. What is the unmet need?

The Hon. Dean Brown: It is certainly not finished. The unmet needs were highlighted in the Mental Health Summit. In many cases, it involved not numbers but services. They were looking for a 24 hour crisis service—

Ms STEVENS: And many other things, Minister. I have read it, too.

The Hon. Dean Brown: —and then the education aspects of the GPs and the broad education for the community. There needs to be more emergency accommodation, and we are looking at that through the housing side of the portfolio. I am the first to say that, despite a significant increase in effort, there were gaps there. We have responded by putting in place a community based approach to identifying those gaps, and now we have moved to put in extra funding to help make sure that we fill those gaps. I suggest that the honourable member read the latest magazine that comes out on mental illness, because that is highlighted.

Ms STEVENS: What is the name of this magazine? There are lots of magazines on mental illness.

The Hon. Dean Brown: I forget the name, but I will get the honourable member a copy of it.

Ms STEVENS: Will the funds raised by the sale of Glenside Hospital be fully allocated to mental health services?

The Hon. Dean Brown: We cannot indicate that at this stage, because we are using money from outside mental health services to put in the facilities. We do not take our capital funds and break them up into funds for mental health and general health in that manner. The important thing is that I have made this significant commitment to put $7.5 million into the Flinders Medical Centre.

Ms STEVENS: Following the release of the report into the community consultation into mental health services in South Australia, which summarises findings from six workshops, has the Minister consolidated the ideas in this document into a plan for change in mental health services in South Australia? Is there also a plan for implementation and a plan for funding outcomes, and what are the time lines?

The Hon. Dean Brown: The consultation process from the summit highlighted a five point plan: a sustainable funding base for mental health for the next five years, and I have given commitments for the next four (I cannot commit other Governments); a range of service developments better targeted to the needs of particular groups in the community; a framework for education and training on mental health issues; the development of community support networks; and

the injection of capital funds to ensure the regionalisation process continues. An increase in recurrent funding of $8.25 million per year, or $33 million over the four years, was committed. As a result of these consultations, key issues in mental health service provision have been reassessed within a broader service provision framework to blend in then with the budget process. Information from the consultations and the work priorities which eventuate will form part of the State mental health plan. The time line for this has been extended to 31 October in order to accommodate consultation as part of the process. So, by the end of October we expect to have the Statewide mental health plan in place.

Ms STEVENS: I presume there will be a lot more detail than you have just given in relation to the five major points.

The Hon. Dean Brown: Yes, I have given you some of those today.

Ms STEVENS: I have received a letter from the Chairperson of the Medical Museum of South Australia Steering Committee in relation to Glenside campus and the heritage buildings. The organisation is very interested in having some of those heritage buildings. The letter states:

> We would be very keen to see the buildings being used for medical and heritage purposes and, in fact, have been actively seeking to have The Elms Building developed as a medical museum. Such an outcome would put SA in the forefront in this area in Australia, add to the State's tourism income, and could even rival important overseas cultural institutions such as the Wellcome Medical Museum in London.

I presume that you also know of this request from the Medical Museum of South Australia Steering Committee, and I wonder what your response is at this time.

The Hon. Dean Brown: A number of groups have asked for consultation over the future use of Glenside, one being Burnside council. We have not yet had those consultations. Because we are talking about something that is still four years away, it is not the highest priority for us. We would anticipate using the facilities or any money raised from the sale of the facilities for the general health care of South Australians. I personally believe that our commitment must be on our priorities and that is to ensure, particularly in a public hospital system under some pressure due to inadequate Federal funding, that we put resources into those critical areas. No decision has been made. At this stage I do not see the Department of Human Services holding any land there, but we will have to wait and see. We have not had the consultations and we have not worked through the detail. A number of parties have put forward ideas and suggestions. I saw one letter in the paper this morning which suggested that we should have a wine museum there, but we have already selected a site for a wine museum.

Ms STEVENS: I would like to ask about the ACIS teams. I have three separate letters from people who have outlined situations where they say the ACIS team has not been up to scratch. All three have separately mentioned concerns that when they ring the ACIS team for help they are asked to ring the police. Can you provide some information about the ACIS team's operations and whether, in fact, you believe it is coping with the job that it is supposed to be doing.

The Hon. Dean Brown: I suggest the honourable member read what I said earlier when I gave a detailed answer. If you want me to repeat it, I will.

The CHAIRMAN: No, please don't do that.

The Hon. Dean Brown: Mr Chairman, I respect your views.

The CHAIRMAN: We have heard it once.

The Hon. Dean Brown: I gave quite a detailed response, but I do not think I gave the statistical information. The average number of face-to-face interventions in the metropolitan area is about 1 200 per month with about 7 500 telephone calls per month. The honourable member says that they were told to ring the police. If you pull one unsubstantiated case out of 7 500 telephone calls per month with no evidence and no details of the case at all, that is a loose accusation to make in a forum like this.

If the honourable member has any concerns about a particular telephone call out of the 7 500, I suggest that she get the details of the person who made the call, which ACIS team was telephoned and the date and approximate time of the telephone call, and we will investigate—as we should. I am not trying to say that there has not been an inappropriate response. If there has been an inappropriate response, we will follow it through—and that is why I welcome the information. I think we need the information, but to pick out one case from 7 500 telephone calls per month and to generalise is not particularly constructive to what we are trying to achieve.

Ms STEVENS: There might be 7 500 telephone calls a month, but if there is a huge need for mental health services it may have nothing to do with the fact that some people are not able to get the service. I received a letter from Ms Lynne Norton, and I quote:

> I have. . . heard many complaints from friends who have called them [the ACIS teams] in an emergency only to be told to ring the police if there is a crisis. No-one is on duty after 10 p.m., cases are assessed on priority, and unless the person seems suicidal they are being told to make an appointment with their own doctor the next day. This is an unacceptable situation and it puts huge pressure on carers and makes sick people think that no-one cares about them. Perhaps the role of the ACIS team should be reviewed and consideration given to what the people think their role should be.

I have other letters as well which say the same thing. I raise this issue because it is of great concern to families in the community who have to cope with these situations late at night on their own. I wonder whether, in fact, some review of the ACIS teams needs to occur?

The Hon. Dean Brown: The letter that the honourable member read out was only second-hand information. The author of that letter states, 'I have heard of many cases,' and they were very generalised cases. It was not a first-hand experience: it was 'I have heard of many cases.'

Ms STEVENS: You are not interested.

The Hon. Dean Brown: Yes, I am interested. I think that letter may have come to me as well and, if I remember rightly, because I have read something similar, I have asked for a specific follow-up of the concerns expressed in the letter because I am concerned about the quality of care. If it was not that letter, then it was a similar letter. We investigate each case. For instance, it may have been that it occurred with people under the age of 18. I have already highlighted today that there is no crisis care service for people under the age of 18 and there needs to be. That was the issue raised at the mental health summit. I put it as No.2 priority at the mental health summit about what we want to do.

There are links between these ACIS teams and other mainstream services. For instance, the Port Adelaide Central Mission provides community alternatives to hospitalisation projects; the Aboriginal health division has a project it calls the 'Forging Links' project; the general practitioners liaison and information sharing project; the Family and Community Services protocols project; some housing protocols; and drug and alcohol services protocols as well.

I invite the honourable member to refer the letter to me so that I can then get the staff to follow it through both with the writer and the appropriate ACIS teams to see whether there needs to be an amendment. If there is a genuine problem, let us investigate it and decide what appropriate action needs to be taken.

Mr HANNA: On 20 May 1997 the then Minister for Health announced the expenditure of $9.191 million on a high-tech computer system called Open Architecture Clinical Information System (OACIS) to link the RAH, the Queen Elizabeth, the Flinders and the Women's and Children's Hospitals. The Opposition has been told that the cost has now been dramatically increased. How much was spent on this project in the current financial year, what is the budget for the coming financial year and what is the new projected total cost?

The Hon. Dean Brown: We will take that on notice. OACIS first operated at the Queen Elizabeth Hospital in the Renal Unit on a small clinical trial. As a result of that, Cabinet decided to expand it further. There are three specific components, including the clinical information system (the application software that the system captures and presents patient data to the clinicians at the clinician work station). The clinical work station can be located anywhere, subject to security clearance. It is intended that the system will form the basis of a common, general and specialist clinical information system, with a common clinical PC display for patient information to simplify the presentation and a common medical vocabulary across the health sector. The project has achieved a combination system across renal units of the major metropolitan hospitals in the satellite centres and will ultimately be implemented to other clinical discipline areas.

The second is the clinical data repository. This is a whole of health store of large amounts of patient data that can be easily retrieved, interpreted and stored to provide valuable information about patients and clinical outcomes. It is intended that the repository would enable all health information about an individual to be stored throughout his or her lifetime, patient information to be viewed by appropriate health service providers, development of an enterprise-wide patient master index and an existing hospital-based numbering system to continue and allow implementation of the State or national patient based unique health identifier.

The third component is a business process reengineering and change management implementation strategy. I will not go into all of the details of that. I will have to obtain the details of costs. The question related to how much we spent in 1997-98 and how much is allocated for 1998-99. We will obtain that information. The pilot project was implemented in the renal units of four hospitals included the Queen Elizabeth, the Royal Adelaide, the Women's and Children's, and the Flinders Medical Centre.

There are some cases where OACIS is ideal, as has already been shown in terms of the intensive medical treatment that people get when they have renal problems. Whether that is an ideal system for a broader application across the health system, with all patients coming to doctors under the Health Plus model, we are reassessing. New technology might suggest that it may be better to go to something like a smartcard or a regional-based information system rather than a centralised system. With a smartcard you are putting the information largely in the hands of the patient, which would be reassuring to the patients, and would only allow information to be added to that information by an authorised person using some other authorised smartcard as well.

The University of Adelaide has developed a trial for such a system on a small scale. That is a potential model and we are looking at a range of models. I do not want to give the impression that OACIS will become the only data system for the whole of the health sector and be huge and centralised. The cost of that would be enormous. We are looking at ways of integrating OACIS with both Intranet and Internet and with smartcards. You may have a series of databanks on which you need to store information and it is appropriate that you concentrate on the people who use the health system the most—those with chronic illnesses—and Health Plus is one such area. The total budget for information technology within the agency this coming year is about $16 million.

Mr HANNA: Is the $16 million to which the Minister refers for OACIS or for a range of technological developments? Further, is the scope of OACIS still changing beyond what the Minister has already referred to?

The Hon. Dean Brown: Approximately $16 million of capital expenditure for information technology is across the health sector and not just on OACIS.

Mr HANNA: It is for much more than OACIS?

The Hon. Dean Brown: Yes, it is across the whole health sector; it is capital expenditure.

Mr HANNA: Will the Minister detail all costs which make up this year's estimate of $14.862 million for IT 2000 and say how much this project had in the forward estimates for the financial years 1999-2000 and 2000-01?

The Hon. Dean Brown: If it is a health project to 2000, I am not sure that we have got quite to the year 2001. This year (1997-98) the expenditure was $16.046 million estimated. The budget for 1998-99 is $11.2 million.

Mr HANNA: A budget cut—quite a drastic one?

The Hon. Dean Brown: A budget cut. Information technology costs are dropping. In many ways I would like to spend more than that. You need to appreciate that under the Medicare agreement there are some national development funds that might be used for information technology. That $11.2 million is provided from the State budget, but it could well be that under the new Medicare agreement there may be some money for information technology as well.

Mr BROKENSHIRE: My question concerns Aboriginal health partnerships. I refer to page 5.20 of the Portfolio Statements where it is indicated that Aboriginal health will continue to have a high priority in the 1998-99 budget, which I am pleased to see having visited Yalata with the former Minister (Hon. David Wotton) a while ago and realising that the health needs of the Aboriginal community are very important. Will the Minister provide an update on this strategy?

The Hon. Dean Brown: The first Aboriginal health regional plan was developed in this State and launched as a partnership in December 1997. It comprises eight separate regional plans covering seven South Australian rural and remote regions and the metropolitan area. The development of these regional plans, entitled 'South Australian Aboriginal Health Regional Plans: The First Step', means that, for the first time, organisations with the responsibility of funding Aboriginal health in this State have a clear and coordinated picture of current service provision to Aboriginal communities. Further, Commonwealth and State Aboriginal community-based organisations have a commitment to work together to implement this plan in 1998-99.

These regional plans identify seven key strategies: to review the status, support arrangements and training needs of Aboriginal health workers in South Australia; to continue to improve access by Aboriginal people to mainstream health services in South Australia; to develop a State-wide Aboriginal diabetes strategy; to develop a State-wide Aboriginal social emotional wellbeing strategy; to assist in the implementation of the State-wide substance misuse or abuse strategy; to ensure that Aboriginal health regional plans are incorporated in all relevant Aboriginal and non-Aboriginal business plans; and to develop strategies to ensure regional ownership of those Aboriginal regional health plans. That should give the honourable member some idea of the sort of strategy which is planned and which is already under way.

Ms BEDFORD: Given that the Garibaldi HUS epidemic occurred in January 1955, when will the Government honour its election promise of 1997 to amend the Food Act; what changes to the Act are proposed, and will draft legislation be circulated for public comment prior to its introduction?

The Hon. Dean Brown: I refer the honourable member to the answer I gave immediately before lunch when I pointed out that a national food code is being established and that one of the specific tasks of the national body is to develop national legislation. I urge the honourable member to look at what I said earlier. Not only is South Australia involved in this but there are also two national working parties. Basically, we are being held up by those national working parties.

Ms BEDFORD: But we are involved in it, are we not?

The Hon. Dean Brown: Yes, we are. If the honourable member reads the answer I gave earlier she will find that I said that we have formed the South Australian Food Hygiene Implementation Committee, that there are two national working parties, and that South Australia has set up two working parties to mirror those national groups. I also provided details of food companies and other community groups that are working as part of this process.

The Hon. R.B. SUCH: Will the Minister provide some new information regarding the expansion of telemedicine in South Australia?

The Hon. Dean Brown: There have been a number of new initiatives in the telemedicine area. Recently, I launched at the Women's and Children's Hospital a unique project using telemedicine to improve training on a State-wide basis. I cited an example of a doctor in the South-East. I think the member for Gordon will remember that this received a lot of publicity in the South-East because that doctor is involved in a specialist training program at the Women's and Children's Hospital.

The National Telemedicine Council, chaired by Andrew Davis from South Australia, reports to the Australian Health Ministers Advisory Council on the following major policy areas: funding and financing; standards; and legal and data definitions. The Department of Human Services continues to support the extension of telemedicine in this State. By 30 June over 20 country hospitals out of a total of just under 50 will be equipped for videoconferencing. The Women's and Children's Hospital has purchased telemedicine equipment, and all major metropolitan public teaching hospitals have videoconferencing equipment.

I was impressed with the facilities at the Women's and Children's Hospital. On the day of the launch, simultaneously, we were able to talk to a doctor in Mount Gambier, some family and community service workers at Port Augusta and some young people involved in youth mental health projects at Coober Pedy. That shows the capability of this program.

The Queen Elizabeth Hospital tele-renal program was started in June 1994 with the aim of using telemedicine in the supervision of renal dialysis patients at the satellite dialysis centres of Wayville, North Adelaide and Port Augusta. The project is run by Dr Alex Disney and has proved to be very successful. Currently, over 250 consultations per month occur over the videoconferencing equipment. A total of over 4 000 actual videoconferencing sessions makes this project a world leader in terms of hands-on experience. The service has been evaluated by the consultant Project Manager, John Mitchell. In summary, the service has provided a significant enhancement of the level of clinical supervision and has been well accepted by patients and medical and nursing staff.

Tele-psychiatry was initially trialled in South Australia in 1992 by Dr Peter Yellowlees and is now led by Dr Fiona Hawker, Director of Telemedicine at Glenside Hospital. The service supports GPs and mental health workers in looking after psychiatric patients in country towns. I think I am right in saying that there are now about 18 country hospitals with tele-psychiatry services. The service has provided over 1 500 clinical consultations and is well accepted by both the patients and the health professionals. I saw the one at Yorketown where it means that the people with mental health problems can stay within the community and visit the hospital perhaps three times a week or twice a week, have a half hour or a one hour consultation and then go back home. It is much more effective than having to come to Adelaide and being out of their environment. There is tele-oncology at the Royal Adelaide Hospital where they have a link to the Royal Darwin Hospital. That is a service that I helped launch in 1995. The Royal Adelaide Hospital provides multi-disciplinary advice on cancer patients. The service involves viewing a range of clinical information, including X-rays and other information. There is also tele-education at Flinders University, where a small group of medical students residing in the Riverland for an entire year are able to use that facility.

The other thing I had a look at yesterday is what a private general practitioner has developed here in Adelaide, which is a 20-foot shipping container which has been turned into a high-tech medical facility that can be taken out to remote areas and from where an enormous amount of information—and using videoconferencing—can be relayed back to a GP here in the metropolitan area. This I think has some potential for remote communities, Aboriginal communities, and so on, where perhaps a trained and experienced nurse could use the medical equipment there to effectively have consultations with the general practitioner in the normal clinic here in Adelaide. Certainly, I think it is the sort of thing we will see much more of in the future.

Ms BEDFORD: I really welcomed the Minister's announcement today that the second contract for the Modbury Hospital would be released. In the light of that announcement, when can we expect to see the first contract?

The Hon. Dean Brown: The Auditor-General's summary on the first contract has already been presented to Parliament. The first contract, of course, did have a confidentiality clause, and that has to be respected, but the summary, signed off by the Auditor-General, is in the Parliament.

Ms BEDFORD: I understand that the summary has been released but, if the second contract is out, why is it not possible, in the interests of full and frank disclosure, to be able to see the first contract?

The Hon. Dean Brown: Because a condition of the second contract was in fact that there had been no confidentiality clause on the second contract.

Ms STEVENS: A question again on mental health, Minister: it is assumed that the additional funds that you have announced for mental health projects will come from the community care and accommodation and care output class. Both of these output clauses have lower budgets for 1998-99 compared to 1997-98. So my question is: which services will be cut or reduced to accommodate the increases announced for mental health?

The Hon. Dean Brown: Firstly, the increased funds for mental health are coming from the overall budget, and the money there is coming from Treasury. I think the honourable member is trying to link the two areas. In terms of expenditure on community care variances, there was a very substantial carry-over from the previous year of $9.3 million. So, if we look at actual expected expenditure, in terms of allocation this year it has actually gone up, because of the carry-over from 1996-97 which went into 1997-98. The other issue that the member needs to be aware of is that some of the mental health money is in crisis and community care. We have allocated $8.25 million a year. An amount of $5.25 million goes into crisis and acute care and $3 million goes into community. So the extra money for mental health is split between both programs.

Ms STEVENS: So, Minister, you are saying it is extra money, that no programs within those two classes will be cut back as a result of that money going to mental health?

The Hon. Dean Brown: That is my understanding. We have not cut any programs to fund mental health.

Ms STEVENS: Minister, I received a deputation of three people representing returned ex-servicemen and women in relation to regionalisation in the south. Their deputation came after a letter to me from Mr Ian Dunn, State President of the RSL. He was accompanied by a representative of the Council of Ex-service Organisations and also a representative of the Vietnam Veterans' Association. They came to see me and gave me a copy of a letter that they had sent to the Leader of the Opposition. It relates to their concerns about the paper *Designing Better Health Care in the South*, ex-servicemen and particularly consultation with ex-servicemen and women in relation to changes at the Repatriation General Hospital. In the letter to Mike Rann, the Leader of the Opposition, they outlined that issue and said:

> Local ex-service organisations have expressed considerable concern over this proposal, especially as it was seen to erode the original arrangements agreed on the transfer of the Repatriation General Hospital to the State health system.

Their concerns, as I said before—and I will read it so that the Minister has it clearly from the letter—are:

> Recently the Minister for Human Services released a paper entitled *Designing Better Health Care in the South*. This project envisaged an original health model which would embrace the amalgamation of the Repatriation Hospital with the Flinders Medical Centre, the Noarlunga Health Services and Southern Domiciliary Care.

They finish by saying:

> Unfortunately, the Minister has seen fit to ignore any meaningful discussion with our organisations in regard to the matter.

When they saw me they were very concerned and reminded me that when there was the handover of that hospital from the Commonwealth to the State there was a stipulation that they be involved in all decisions in relation to it, and they feel that this has not happened in this case. I undertook to raise this issue with the Minister in this setting and I would like to be able to give them some feedback.

The Hon. Dean Brown: First, the paper to which the honourable member refers is put out by the people in the south: I do not think it is a paper that I have put out.

Ms STEVENS: They do work for the Health Commission.

The Hon. Dean Brown: Yes, but I got the key impression from what you said—and I will go back and check the transcript—that the Minister put out a paper. I think that was the exact phrase that was used. I have not put out a paper.

Ms STEVENS: That is what they said in their letter.

The Hon. Dean Brown: Well, I think a paper was put out in the south that talked about various options in the south, one of which was the amalgamation of the Repatriation Hospital and the Flinders Medical Centre. I do not support that. I have made that pretty clear to anyone who has bothered to ask me, and I will make it clear again today.

Ms STEVENS: You do not support the regionalisation process?

The Hon. Dean Brown: I have not supported an amalgamation of the Flinders Medical Centre and the Repatriation Hospital, but I believe there needs to be an integration so they work closely together. I presume from what the honourable member has said that the objection has been over a proposal to amalgamate them. That was a proposal floated by the people in the south and does not have my support, so it will not occur. I hope the honourable member notifies the people who came and saw her that she has raised the matter here and I have given that assurance.

Ms STEVENS: I certainly will. The other point they were making was that they felt, as the ex-service community, that they had been left out of the process. That is an issue for them as well which you might take on board.

The Hon. Dean Brown: I will take that up. They do have a representative on the board of the Repatriation Hospital: he is the Chair of that hospital.

Ms STEVENS: I understand that that is the case. Nevertheless, that is what they said to me and I am passing that on to you.

The Hon. Dean Brown: They ought to raise it with their representative to ensure that he consults them on things that are occurring.

Ms STEVENS: My next question relates to community based services. In March it was revealed that demand for community services, certainly in metropolitan Adelaide, had increased by 30 per cent, resulting in some frail aged and disabled people having enough assistance to shower only once every two weeks and their houses cleaned once a month. This information and evidence, and these stories and anecdotes were reported in the media widely and commented on by Domiciliary Care and the Royal District Nursing Service. Can the Minister say what he has done to address this serious and unacceptable situation?

The Hon. Dean Brown: This is an issue that comes under Ageing, so I will hand over to my colleague, the Hon. Robert Lawson QC.

The Hon. R.D. Lawson: I am pleased to answer this question. It is true, as the honourable member said, that in February this year the *Advertiser* ran a story suggesting that there was, as that newspaper put it, skyrocketing demand for domiciliary care services. It is true that there has been an increase in demand for those services. It is worth remembering that the expenditure by the Department of Human Services on domiciliary care amounts to, I think, some $24.5 million in the four metropolitan domiciliary care

services and some $15 million with the Royal District Nursing Service.

The increased demand has been attributed to a number of factors, not the least of which is the increased volume of people passing through the public hospital system. That has led to a consequent increase in the number of people requiring post acute support. This has had a particular impact on RDNS, where an increase in nursing support and palliative care has been directly attributable to the increased volume of clients through public hospitals.

RDNS estimates that post acute referrals currently make up 45 per cent of new admissions to its service. On average, each post acute client is within the RDNS system for 42 days. Western Domiciliary Care reports that the waiting list for complex clients who require case management has increased by 40 per cent over the past few months. It has been suggested, although not established, that the impact of nursing home charges and changes to the Commonwealth regime relating to nursing homes has led people to remain at home longer than they may have remained previously.

A couple of the domiciliary care services have attributed a rise in their activity levels to this issue. Of course, if it is true that people are remaining at home longer and being able to access domiciliary care services rather than enter aged care accommodation on a permanent basis, that would be to the benefit of the community. Members will be aware that the Commonwealth, in its Staying at Home package announced in April, committed further funds, although we would say not sufficient funds, to assist people in staying at home.

The domiciliary care services are also substantially funded through the Home and Community Care (HACC) program. Work has been done on appropriate changes to the domiciliary care arrangements to address the additional demand on services, and that work is continuing. The solution, it seems to me, is not necessarily simply additional funding: there may have to be a more fundamental change to the service system whereby funding is allocated, rather than through, for example in the metropolitan area, the four domiciliary care agencies, but managed regionally and provided around individual needs, which would have a more lasting effect on managing demand for services.

Recently, with the Federal Minister I have approved an assessment trial under the HACC program called the 'Northern single assessment trial,' which we hope will enable a single rather than multiple assessment process to take place, thereby reducing some of the assessment pressures—which are considerable—on the domiciliary care agencies. That process would release additional financial and care resources to facilitate the development of a new model. The Care 21 program and Health Plus are other pilot or trial programs of coordinated care services. The question of developing a new model for the delivery of this type of service is presently being examined in the Department of Human Services.

The Hon. Dean Brown: An earlier question related to the release of the Modbury Hospital contracts. I understand that Healthscope has also agreed to release the first contract.

Ms STEVENS: That was never a problem for Healthscope.

The Hon. Dean Brown: I would need to check that, but if that information is correct we will release the first contract as well.

Ms STEVENS: Thank you for that answer. I am not sure that it will do much for the people in my electorate in the north, who cannot even get on the list for any services from Northern Domiciliary Care, because many services from that organisation have closed. I am sure they will be pleased to see that you will be giving out the funds differently and have a new assessment process to ration the services, but I am not sure that it will do much for their quality of life.

The Hon. R.D. Lawson: The purpose of single assessment is not to ration services but to more appropriately distribute resources.

Ms STEVENS: Which quite clearly are not enough. Is either Minister aware that some branches of Domiciliary Care have unfunded liabilities? In one region (my own, the northern region) it is $500 000. What is the state of affairs in the other domiciliary care services and the Royal District Nursing Service; and will these budget shortfalls be met by the Government, or will next year's allocation be further compromised by carrying over a debt?

The Hon. R.D. Lawson: I will take that question on notice and provide a reply as soon as possible.

Additional Departmental Advisers:

Ms J. Whitehorn, Director, Policy and Development.

Mr R. Deyell, Senior Executive, Department of Human Services.

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

Ms STEVENS: Following the Auditor-General's Report in 1997, which highlighted serious deficiencies in financial controls within FACS which led the Auditor to conclude that there was no reasonable assurance that expenditure was made in accordance with the law, will the Minister confirm advice given to the Opposition that FACS faces a budget black hole this year exceeding $8 million, based on existing program expenditure?

The Hon. Dean Brown: First, in June 1997 the Auditor-General forwarded an interim audit report for 1996-97, which identified concerns regarding the adequacy of FACS's internal control environment and the department's ability to meet deadlines for financial statements and provide the supporting data that would allow the Auditor-General to form an opinion for publication in the Auditor-General's Report to Parliament. Ernst and Young were contacted to assist FACS staff to produce financial statements for 1996-97 and to provide supporting working papers and document procedures in future years. Each of the issues raised by the Auditor-General in the interim report was referred to the FACS officer responsible for that part of its operations, and a detailed plan to address each was formulated.

A response to the interim report was formulated from this plan and forwarded to the Auditor-General in August of 1997. Statements were made to Treasury and Finance and the Auditor-General in accordance with negotiated deadlines. The Auditor-General issued an opinion that the statements present fairly, in accordance with professional reporting requirements, the financial position as of 30 June 1997, the results of its operations and its cash flows for the end of the June 1997.

The published report of the Auditor-General maintained the concern regarding FACS's internal control. Ernst and Young commented that the number and classification of resources in the financial area were inadequate. As a result, the Financial and Physical Resources Branch was reviewed and a revised structure for the financial area was recommended. In October 1997, FACS became part of the Department of Human Services. Steps to amalgamate the finance and accounting areas have commenced with a consultancy by

Ernst and Young. Further considerations of resources will be undertaken as part of this consultancy, which is examining the financial structure and systems for the Department of Human Services.

The plan to address all issues raised by the Auditor-General targets the completion of all corrective action that was needed by the end of June 1998—in other words, we are there now, pretty well. For approximately 70 to 80 per cent of the issues proposed, action has been completed, progress continues to be monitored and a review has been requested at the end of June 1998. Audit has been provided with updates on progress against the plan and will be advised of the results as part of the review which is currently under way. Funds have been allocated from the 1998-99 budget basically on a no policy change for Family and Youth Services, and that also applies to contracted services. So far this month I have written a series of letters to the providers of many of the contract services that previously came under the Department of FACS, advising them that they will receive the same funds as they received for the past year. A lot of the programs have simply been rolled over.

Ms STEVENS: Is the Minister saying that the same funding will come through on the existing program expenditure? Can the Minister assure me that there is no budget black hole exceeding $8 million, based on existing program expenditure?

Ms Charles: It is not possible to answer the question in quite the way the honourable member has put it. The new budget arrangements have separated out the operational divisions—Family and Youth Services—and funding as being under review but the services are being maintained. There is a commitment to look at increasing services in a range of areas in the field. Central functions are being considered across the portfolio. As the honourable member would be aware, the head office is taking an integrated approach, and that means an opportunity to look at all the support services, policy, corporate services and internal functions across the board. As part of that review process, we are expecting to identify resources that may be able to be reallocated into the provision of services on the ground. We are not constructing a budget that equates to the structure of the Family and Community Services budget that existed up until now.

Membership:

Ms Ciccarello substituted for Ms Bedford.

Mr McEWEN: The South-East Anglican community care sees inequities in SAAP funding, and it has brought to my attention the fact that 27 accommodation and 30 out-reach places across the Iron Triangle and Port Lincoln are funded at a total expense of $1.205 million, whereas 25 accommodation places and 10 out-reach places in the South-East receive a total funding of $120 000. It is not concerned so much about the inequity *per se*, although it sees something like 10:1 funding being available the Iron Triangle and to Port Lincoln. Its problem is that, within its funding base, it cannot provide 24 hour supervision, and this is becoming a major concern, particularly since those requiring accommodation seem to require more support than has previously been the case. I want to know about the inequities and, more importantly, about what opportunities there might be to provide 24 hour supervision for the accommodation in Mount Gambier that is provided by Anglican community care.

The Hon. Dean Brown: Is the honourable member talking specifically about the domestic violence part of SAAP?

Mr McEWEN: I have to admit that I do not know even what the acronym SAAP stands for. That is why I also had to check with your learned colleague as to when I should appropriately ask this question.

The Hon. Dean Brown: SAAP stands for Supported Assistance Accommodation Program.

Mr McEWEN: I am not familiar with the exact nature of the 25 assisted accommodation places that are provided at Bethesda in Mount Gambier under the umbrella of the South-East Anglican community care group. I cannot give you further detail. Perhaps if you took the question on notice, we could have a look at whether the mix was the same, because perhaps some of the inequities might be because the accommodation support clients are different.

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

The Hon. R.B. SUCH: I refer to the budget estimates (page 5.4) and the strategies of examining concessions and subsidy arrangements. With the new portfolio structure, will the Minister outline the implications for the current arrangements and the broad scope of the assistance and to whom it is provided across the portfolio?

The Hon. Dean Brown: Concessions and subsidies are provided by the Government to a value of about $300 million a year. The largest proportion of those concessions in excess of $230 million is contained within the Department of Human Services. Funding of some $67 million of that $230 million covers core concessions to pensioners and other beneficiaries for electricity, water and council rates, and transport. A sum of $11.94 million of the core allocation provides concessional travel on public transport. This concession is also extended to holders of senior cards who may not be covered by the pensioner arrangements. The transport concession is one which has a strong secondary benefit in that it not only deals with the affordability issues but also encourages older South Australians to get out and about, which is crucial for a healthy lifestyle.

Of the core concessions, $60.5 million is directed to pensioners, against $6.5 million for non-pensioners. Most of that $67 million for concessions goes directly to pensioners. More than two-thirds of pensioners are aged. The next largest group is the disability pensioners, and the smallest of the group are single parents. Aged pensioners have high home ownership rates and benefit from council rates, water and sewerage rate rebates, which are not provided to non-home owners. The Department of Social Security's data indicates that 75 per cent of home owning pensioners in South Australia are aged. Currently, pensioner couples receive the same level of electricity and water concessions as the single pensioner. Since 1993, both full and part-time pensioners are eligible for the full range of concessions in South Australia. The cut off point for the part rate pension is based on the Commonwealth income and assets test, which for a couple stands at $1 347 per fortnight on income, and $374 000 in assets in excess of the family home.

Whilst two-thirds of aged pensioners receive the full pension, the mix will change significantly in the future, given that, for people moving onto the pension over the past five years, two-thirds are at the part rate. A preliminary study undertaken by the Department of Social Security in 1995 reveals that there this is no basis for the belief that individuals granted a part-rate pension will move to a full rate pension within a few years. The indicators are that there has been a

change in circumstances of people retiring, with the majority having increased provisions for retirement. Of course, this reflects the thrust to the Commonwealth's retirement incomes policy and superannuation arrangements. In housing, there is $25.8 million in rental assistance, and $113.9 million in revenue forgone and subsidised rental arrangements. In addition, the full cost of providing public housing is boosted by adding approximately the $250 million *per annum* it costs for administration and stock maintenance. In January this year, Cabinet endorsed in principle changes to housing policy in South Australia to target public housing to those most in need, and I will not go into that detail. In particular, it involves the homeless and cases of domestic violence, people with disabilities, and those on extremely low incomes.

Estimates in health indicate concessions worth in excess of $26 million through the dental services, spectacle scheme, transport assistance, and equipment and pharmaceuticals provided by hospitals. These concessional benefits are extended to 142 202 holders of Health Care cards in South Australia, many of whom would not be eligible for core concessions because of the assessment provisions which are applied to non-pensioners.

Clearly, having a cross-portfolio focus is an important strategic direction. We need to develop a rationale and understanding of the overall assistance being provided and who benefits from what is a very significant expenditure for the Government. The output class, 'Full Accrual Cost of Personal Financial Assistance', is about the same—perhaps a bit more—as the value of the current funding provided by the Commonwealth through the Medicare agreement to South Australia. Currently, the department is gathering more detailed information on the health system to complete a comprehensive assessment of benefits, eligibility, mandates and costings for concessions and subsidies across the portfolio.

Mr BROKENSHIRE: I would like to ask about domestic violence. I refer to page 5.4 of the Portfolio Statements and the reference to the principle of prevention in service delivery. I think all members would agree that there are concerns within our electorates about issues of domestic violence and that one case of that is one case too many. It is a critical social issue where we must have a focus on prevention. Minister, I know that you are concerned about this matter, and I wonder whether you could advise what focus there is with respect to this matter and what form that focus takes.

The Hon. Dean Brown: The Government has a group working on prevention of domestic violence. First, that is driven by the Attorney-General, who chairs it as a Cabinet subcommittee. I am a member of that Cabinet subcommittee, along with the Minister for the Status of Women. In fact, we met fairly recently. A working group, which is working on a five year strategy, reports to that Cabinet subcommittee. That strategy, I guess, covers the target areas that they should approach, how they should do that, how they develop public education and how they put the whole strategy into operation. That is still being finalised.

There are some noteworthy projects within the Department of Human Services. The scope of prevention, in addition to minimising the occurrence of domestic violence in the first place, encompasses all those aspects of intervention which aim to reduce the likelihood of continuing violence in the home. The violence intervention project in the northern suburbs provides an example of preventive measures which can be taken when domestic violence has already been brought to the attention of the courts.

The innovative Human Services funded pilot project, coordinated by the Domestic Violence Unit of the Office of Families and Children, is an interagency collaboration which provides a comprehensive range of responses to families experiencing domestic violence. Both the family and youth services and health groups in Human Services are involved, as well as the Department for Correctional Services, the Police, the Magistrates Court and non-government organisations.

Families are referred through the court system and the project has had separate workers focusing on men's, women's and children's issues. Male perpetrators are mandated to attend a men's program to assist in developing skills and attitudes to address their abusive behaviour. Evaluation of the pilot is being considered with a view to replicating the model in other areas as well.

Another example of preventive work involves the work of more than 30 domestic violence action groups around the State. These groups are made up of local service providers and concerned individuals from a wide range of disciplines and they receive some financial and in-kind support from the department. As locally focused and community-based organisations, they are ideally placed to raise awareness to enable better responses to domestic violence from service providers and the wider community alike.

We have been able to augment our commitment to domestic violence prevention through working with the Commonwealth on its Partnerships against Domestic Violence initiative which was announced by the Prime Minister in November 1997. Under this initiative, an initial amount of $200 000 was made available to each Territory and State, to be followed by $200 000 to $250 000 each year for the next three years.

A consultation process with key agencies in South Australia defined five projects for funding in 1997-98. These projects are all time limited, capacity building and not reliant on recurrent funding. These projects have a strong focus on prevention, early intervention and on enabling service providers to interrupt the cycle of domestic violence. The projects include the development of information resources for Aboriginal and non-English speaking background communities; development of a peer education project for young men promoting non-violence in relationships; research into the needs of people experiencing domestic violence to inform future projects and target interventions; a community education project focusing on young people and coordinated by the domestic violence action groups; and development of competency standards and training packages for workers in domestic violence. That covers the broad range of projects about which we are speaking.

Ms STEVENS: I want to return to my question to get further clarification. I am not sure I understood the answer that I was given by Ms Christine Charles. What I think I heard—and I would like it clarified—is that to obtain the savings that you will need to cover the shortfall of $8 million plus that currently exists in expenditure on existing programs, you will be rearranging things in head office. Am I correct?

The Hon. Dean Brown: I am told that we do not understand what the $8 million shortfall is about.

Ms STEVENS: So, there is not one. That was information that I received and I want it clarified. Is there or is there not a shortfall?

The Hon. Dean Brown: I am told that there is no $8 million shortfall.

Ms STEVENS: Okay, fine; thank you. Will the Minister provide on notice a reconciliation of the 1997-98 budget showing the budget allocations and actual forecast expenditure compared with the budget for 1998-99 for all Family and Community Services programs?

The Hon. Dean Brown: This comes back to the issue that we dealt with at the beginning of the day. Where we can do that readily, we will. In some areas we can do that. There are specific programs where funds have been allocated and where those programs are carrying on, so we are able to come back with that information. However, in some other areas, where you end up with more combined services, we will not be able to do that. But, we can generally do that. For example, under the SAAP program, our expected outcome for 1997-98 is $21.346 million and the estimated allocation for 1998-99 is $21.509 million.

Ms STEVENS: I am happy to take it on notice.

The Hon. Dean Brown: We will take that on notice because there are a lot of programs which we will have to work through systematically. I could spend from now until 6 o'clock going through some of the programs.

Ms STEVENS: I refer to the Gamblers Rehabilitation Fund. On 11 December 1997 the Minister told the Parliament:

> The annual $1.5 million contribution from the hotels and clubs to the Gamblers Rehabilitation Fund is now virtually committed to various services and projects. There is, however, the $1.8 million carry-forward funds, which are available for additional one-off projects. As I announced earlier this week $500 000 of the carry-forward amount will be distributed before Christmas.

Will the Minister reconcile his promised distribution of funds with the unnumbered page 5.33 in the Portfolio Statements that shows that the Gamblers Rehabilitation Fund will have a balance of $1.555 million at 30 June 1998?

The Hon. Dean Brown: The statement the honourable member has before her indicates that $1.555 million is expected to be in the fund as at 30 June 1998. The available funds are $1.5 million in recurrent and $1.555 in the carry-over funds. That is what we expect to open the new financial year with. In December 1997 I advised that the $1.5 million voluntary contribution through the ICG was virtually fully committed to ongoing gambling rehabilitation services. In 1997-98 $1 362 892 of recurrent money was committed to services and support initiatives. This is expected to increase in 1998-99 to $1.462 million.

In terms of one-off equity funds, in 1997-98, in addition to the funds for the ongoing services, $660 000 was approved for one-off initiatives. This includes $500 000 which was committed to the provision of material and financial assistance through the 'families in need' initiative. A range of these one-off initiatives approved in 1997-98 will incur expenditure in the 1998-99 financial year, given the lead-up time required to establish services and engage providers. This includes a telephone counselling service, promotion of the telephone service and a client advocacy service. Some of the money has been committed already, but the people delivering the service are still in the process of so doing.

The statement indicates that a further $535 000 of carry-over funds will be expended in 1998-99. The GRF Committee has prepared a strategy for the expenditure of one-off funds of more than $1 million over the two year period of 1998-99 and 1999-2000 which are currently under consideration. These initiatives will reduce the equity in the fund and ensure that it is fully subscribed.

Ms STEVENS: Despite the fact that you, Minister, announced in December how you would make sure that that money, and particularly the carry-over funds of $1.8 million, was spent, we find that we still have $1.555 million left at the end of this year. I find that very concerning. I would like a reconciliation of the fund for 1997-98 showing the opening balance, all receipts, all expenditure under individual headings, including departmental on-costs, and the closing balance.

The Hon. Dean Brown: That is part of the Auditor-General's Report and certainly will be provided. The honourable member needs to appreciate that the $500 000 which I allocated back in December and which was called the 'families in need' initiative was allocated in December to organisations for a range of services, but they have not spent all the money yet.

Ms STEVENS: But there is $1.3 million left of the $1.8 million that you had left over as carry-forward funds. You spent $500 000, which leaves $1.3 million, and now you have $1.555 million left.

The Hon. Dean Brown: I do not know the exact figure, but that assumes that about $200 000 of the $500 000 has not yet been spent. I assure the honourable member that it was allocated in December. I signed the letters to the organisations, but they had 12 months in which to spend the money.

Ms STEVENS: I think the Minister may have misunderstood. You had $1.8 million of carry-over funds that were surplus in the Gamblers Rehabilitation Fund. You used $500 000 at Christmas time, which means that you had $1.3 million that you were going to spend on all these one-off projects so that you could make sure that that money was being used, because it has not been fully used over the entire time that the fund has been in existence. Your own papers show that you will still have $1.555 million left there as at next week. There is a lot of need out there and I ask again why the money is not being spent. The Opposition has focused a number of times on why the money is not being spent, and it has happened again.

The Hon. Dean Brown: I will say it again: of the $1.8 million, $500 000 was allocated to organisations in the 'families in need' initiative. They were given 12 months to spend it and I sent out the letters in December. They have not spent all that money yet. I would have to check the exact amount and where it stands at the end of June. It has been allocated and there is a contractual commitment to the organisations, but they have not spent it. A further $160 000 has been allocated or committed: it has not yet been spent but has been committed to telephone counselling services, promotion of the telephone service and a client advocacy service. So, although there is still $1.555 million there in round terms, we have committed $660 000 of the $1.8 million.

Ms STEVENS: What about the rest?

The Hon. Dean Brown: We have committed $660 000 of the $1.8 million. Not all of it has been spent but it has been allocated to organisations. There is to be a further expenditure of $535 000 of the carry-over funds in 1998-99. Assuming that that is effectively contracted or committed, the commitment by the end of this coming financial year will be down to about $600 000 to $700 000 in round terms.

Ms STEVENS: Why does it take so long to spend this money when there is so much need?

The Hon. Dean Brown: I have asked the same question. A group wrote to me before Christmas to say that it had a particular need, so we allocated $500 000. That group has

since asked for the right to spend that money over 12 months. Major welfare organisations are doing this, and that is good because it means that they are allocating the money where they believe a need exists, and in some cases they believe that it will take up to 12 months to spend that money.

Membership:

Mr DeLaine substituted for Mr Hanna.

The Hon. R.B. SUCH: I refer to page 5.6 of the Portfolio Statements and the commitment to planning development for the second secure care centre in South Australia. What stage has the development of this proposed centre reached?

The Hon. Dean Brown: Last week, the Minister looked at land on the eastern portion of the Magill facility as a possible site for this development. No decision has yet been made. We are also looking at the possibility of expanding the number of secure beds for older youth at Cavan. So, we are looking at both expanding Cavan and building a new facility. No decision has yet been made in terms of the location for or the exact timing of that new facility. However, funding has been allocated in the budget to get that work under way. The aim is to provide about 120 secure beds, but I stress that that has not been finalised and will not be until we go through the planning process.

The Hon. R.B. SUCH: My next question relates to mental health assistance facilities for young people in custody or care. I refer to page 5.4 of the Portfolio Statements and the Government's commitment to improving the mental health system. What specific programs are in place to respond to mental health issues for young people who are in the custody or care of the department given that these are often the most vulnerable young people in our community?

The Hon. Dean Brown: I reinforce the point which the member for Fisher just made: young people are the most vulnerable when it comes to mental health problems. We have seen this in terms of the rate of youth suicide in the community and its extremely high level on a *per capita* basis in Australia. The figure has fallen from what it was in 1991-92, but it is still unacceptably high. Young people under the guardianship of the Minister or in the custody of the Department of Human Services through the juvenile justice system were identified at the recent Mental Health Summit as an extremely high need group who should be afforded priority in terms of the development of initiatives.

These young people are usually victims of abuse or neglect or extremely unstable and dysfunctional families. For those who are part of the juvenile justice system, these experiences are often the trigger for their offending behaviour. Unless they receive high quality care and support, their early experiences are likely to have an ongoing negative impact throughout their life. Consequently, there is now a strong commitment by district centres and young offenders and mental health services to work together to improve the outcomes for these people.

The Mental Health Unit now has a brief to pursue strategic planning and service development initiatives for children and young people with mental health problems right across the portfolio. Initiatives during recent months have included the allocation of new in-patient beds at the Flinders Medical Centre for adolescents and the establishment of the behavioural intervention service, which commenced operations in September last year and which has since accepted 22 young people into its program. This program was jointly developed by the Child and Adolescent Mental Health Service, the former Department of Family and Community Services and the Education Department.

Significant advances have been made in mental health services for young people in secure care. A mental health nurse is being employed to work across both training centres to assist in the assessment and development of care and release plans for and the treatment of residents with mental health issues. Increased funding is available to support intervention with individual young people through the Youth Crossroads Fund and brokerage moneys in alternative care. This will enable the purchase of additional intensive services for youth with the highest needs. A Suicide Prevention Task Force (to be chaired by Professor Graham Martin of the Flinders Medical Centre) has been established to implement strategies and service proposals for vulnerable children and adolescents.

New child protection positions have been established within CAMHS teams to provide services for young people who require ongoing support. Protocols and arrangements have been developed between the key players in the service sector. That information covers quite a few of the programs. That does not mean that there are not some areas where there are still problems. One issue that I highlighted at the Mental Health Summit was the need for 24 hour crisis care, especially for people aged 18 years and under and particularly in rural areas.

The Hon. R.B. SUCH: I refer to an issue raised by the member for Mawson earlier regarding domestic violence. Is the Minister's department looking at the issue of domestic violence where the perpetrator is a female, whether it be a teenager or an older woman? Whilst no-one would dispute that most domestic violence is perpetrated by men against women, research from overseas suggests that a significant element of domestic violence is perpetrated by women: whether it be teenagers against their parents or siblings or adults against their partners. The Minister may like to take this question on notice, but I would like to know whether that issue is at least being considered by the Cabinet subcommittee.

The Hon. Dean Brown: I will provide a detailed response for the honourable member. In response to the previous question: an article in this week's *Southern Times* refers to the Youth Mental Health Service at Bedford Park being in crisis. This program was funded federally, but that funding has now come to an end. We will look at what can be done to help this group. I stress that this situation has not come about because of a lack of commitment by us but through the withdrawal of Federal funds for that program.

Ms STEVENS: A quick question in relation to the budget black hole question that I asked before: Minister, is there any deficit in relation to expenditure on existing programs that exists at the moment? I talked about an amount exceeding $8 million, but is there any deficit existing and, if so, how much?

The Hon. Dean Brown: We will have to wait until we see the results for the end of the year. Just because the end of the year is in about a week's time does not mean that those figures are automatically available yet. But when the figures are available we can provide an answer to that.

Ms STEVENS: So you cannot answer that at this time?

The Hon. Dean Brown: Not for specific programs. There are bound to be some projects over, and some under I would think.

Ms STEVENS: You said that there was definitely no budget black hole in excess of $8 million, but at this point you cannot say if there is one less than $8 million?

The Hon. Dean Brown: You asked specifically what is the deficit across all of the programs and I cannot answer that. But we do not know of an $8 million deficit at this stage.

Ms STEVENS: And you are saying that you do not know if there is one less than $8 million?

The Hon. Dean Brown: Well, we do not know until we cross off the books. We are still in the financial year. No-one in their right mind could give that answer.

Ms STEVENS: Projections.

The Hon. Dean Brown: We will wait and see what the outcomes are. They are probably only a month away.

Ms STEVENS: The Opposition has been informed that, in relation to child protection services, 20 per cent of tier 1 child protection cases remain unallocated in district centres. We are also informed that 25 per cent of tier 2, children at risk cases—and, as you know, tier 1 are children in danger—also remain unallocated in district centres. Minister, can you confirm the accuracy or otherwise of this information and, if it is correct, what are you doing to address that appalling situation?

The Hon. Dean Brown: I am able to indicate that there are some unallocated, but we will have to take that question on notice to get the exact percentages. I can give the answer that, because of the demand out there some action has already been taken to deal with that increase in demand. Resources have been reallocated to the busiest district centres, including the central office. The children protection system has been reformed to ensure a better targeting of resources to children most in need and to provide options rather than investigation in response to notification. A central intake team has been established which removes the pressure of receiving notifications from district centres, and funding to the overall alternative care budget has increased which provides district centres and workers with a greater variety of options, particularly for purchasing individual support services for clients.

Ms STEVENS: Is that alternative care, did you say?

The Hon. Dean Brown: I said funding to the overall alternative care budget has increased.

Ms STEVENS: Minister, in terms of child protection it would seem to me that the frontline troops will be your district centres and your social workers, Family and Community Services centres, rather than an alternative care program.

The Hon. Dean Brown: And we have said that resources have been reallocated to those district centres.

Ms STEVENS: So there has been no overall increase in resources, just a reallocation of resources?

The Hon. Dean Brown: Yes. There is an increase in resources to alternative care.

Ms STEVENS: But that is foster care. I am not talking about foster care. I am talking about child protection, child abuse that is occurring out in the community, not about foster care.

The Hon. Dean Brown: The honourable member needs to realise that the district centres are part of implementing the alternative care programs as well, and if additional money has been put in then it goes through to those programs administered by the district centres. But we will get a more detailed response. Some more information has just been given to me here. Detailed planning for the service has occurred including the analysis of the needs of tier 3 families and research into the effectiveness of various service models. Discussions have taken place across community service, health and housing programs, in terms of an integrated approach. It has been decided that the tier 3 service—

Ms STEVENS: Minister, I was asking about tier 1 and tier 2, which are the important ones.

The Hon. Dean Brown: We will get a more detailed response in terms of tier 1 and tier 2.

Ms CICCARELLO: Non-government community service organisations report growing levels of demand for almost all community services, including higher growth in demand for poverty alleviation programs, which include emergency relief, yet funding neither matches growing demand nor is it indexed to keep up with the rising costs. How will the Government respond to the growing demand for community services, family support and poverty alleviation programs provided through community-based non-government organisations?

The Hon. Dean Brown: Christine Charles will answer that.

Ms Charles: It relates a little to the previous question, too, in that one of the things we are currently looking at is how we can actually balance the needs in the community with the sort of support structure we have in the centre. In terms of emergency relief, we are reviewing right across our programs to try to match the support from the Commonwealth in income maintenance with our capacity to provide crisis support. At a district centre level we are also wanting to make sure that we take a regional approach to human services into each of the districts and identify those in high need and try to get the most value out of a package of support through to people in crisis, which, if we link the housing component with the support out of community services, we believe we will actually be able to get far more value in terms of immediate support for both finance and services in response.

So, the budget process at the moment is actually going through a complete review of central office structures. We are looking to provide more on the ground service and one of the clear drivers in that budget process is to in fact move out of some of the developmental work that we see as support to district operations and actually provide more services on the ground. Over the last 12 months some one-off funding has been provided within Family and Community Services. We actually are now identifying ways of carrying that forward, and that includes the crisis response teams and central intake. So that is certainly putting pressure on budgets in other areas. We have not taken any decisions to de-fund services on the ground. We are really putting pressure on ourselves to find the resources to continue that. At the end of the day I think that, given the level of unmet need, it may not be possible to actually provide what even we would think would be a level of service we would like to provide within current budget constraints. To that end we would be looking to talk to the Commonwealth to try to get packages that more effectively link their income support through Centrelink and DSS packages with the sort of support that we can provide within State Government funding.

Ms CICCARELLO: It is understood that in that Commonwealth-State funded programs such as HACC the Commonwealth has indexed funding allocations for this year. Will the State match indexation and pass the full amount on to the service providers?

The Hon. Dean Brown: That is a question for Mr Lawson to answer tonight, so either you can ask it then or we will take it on notice.

Ms CICCARELLO: There was a SAAP program as well.

The Hon. Dean Brown: I gave the figure to the Committee just half an hour ago of what the indicative expenditure was for 1998-99, which was an increase on 1997-98. I cannot recall the figure, but I have already given that figure for SAAP. I am told that there is no index from the Federal Government in SAAP, that there is no growth in SAAP at all from the Commonwealth.

Ms CICCARELLO: There have been changes in the distribution of community and neighbourhood houses across the State over recent years. Currently there are no houses between Tailem Bend and Mount Gambier East and it appears that real dollar allocations to houses are falling. Given the effectiveness of community houses in providing a range of community development and support services, what plans are in place to enable communities in the South-East, Yorke Peninsula, Eyre Peninsula and the northern Adelaide Hills to gain funds for urgently needed new community houses?

The Hon. Dean Brown: What the member for Norwood is talking about is the Neighbourhood Development Service. That is part of the Family and Community Development Program which was due to expire at the end of June this year—in just over a week's time—and which I have just extended for another two years; and when I say 'just', I think it was done about three weeks ago. Letters were sent to all those organisations on that basis and a number of them have written back and thanked the Government for doing it.

A specific question was asked about HACC funding for 1998-99; I dealt with the SAAP one. HACC expenditure for 1998-99 will be $72.612 million compared to $70.411 million in 1997-98. So there is an increase in expenditure of $2.201 million. I think that answers the question.

Mr BROKENSHIRE: I refer to page 5.10 of the budget estimates. Will the Minister outline the steps he is taking to address what I believe is a serious issue at any time, that is, child abuse in our State?

The Hon. Dean Brown: In terms of child protection reform, in 1997 in response to long-standing problems in the child protection system a number of major reforms were instituted. Problems at that time included increased workload pressures due to rising notifications, inconsistent responses between district centres and concerns about the quality and effectiveness of the work. Reforms were introduced gradually throughout 1997 and became fully operational in 1997.

These reforms included the introduction of a central intake team in April 1997, including an Aboriginal specific team; the introduction of alternatives to the traditional investigative response to notifications; a new risk assessment and structured decision making process; and improved mechanism for cooperation between Government agencies. Given that the full reform has only been in place since November last year it is too early to gauge outcomes and there is not yet a full set of figures. However, sampling to date suggests that a higher proportion of notifications are being responded to.

Investigation rates have increased and there is a greater consistency of response between the district centres. The comprehensive evaluation plan which examines outcomes across the system, particularly for children and families, is currently being finalised. An extra $200 000 was allocated in the current year's budget, increasing it to $400 000 in recurrent funding for 1998-99, to establish a new service designed specifically for lower risk families. It is anticipated that this will commence in the northern suburbs in 1998-99.

Mr BROKENSHIRE: I refer to page 5.4 of the Budget Estimates. Will the Minister outline how the Government is working in partnership with the non-government sector with respect to the delivery of services?

The Hon. Dean Brown: I mentioned right at the beginning the importance of the non-government sector and the partnership that we are working towards, so I am delighted to take this up because it has been one area where there have been huge advances developed over the past year or so. My predecessor, David Wotton, did a great deal in this regard and I would like to pay tribute to what he did.

In the past year $40.38 million was provided in the Family and Community Services area to community service agencies across South Australia through a number of programs, and I will touch on those. That is a lot of money—$40.38 million. These programs included an alternative care program, $5.128 million; family and community development program, $6.713 million; gamblers' rehabilitation program, $1.8 million; Community Developments SA, $4.02 million; and supported accommodation assistance program (SAAP), $22.631 million.

More than 180 separate services received recurrent funding through these programs. In addition, 249 one-off programs were funded in 1997-98 through the Community Benefit SA Fund. Funding through most of the programs is committed through funding and service agreements which are negotiated on a long-term, usually three year, basis. This is intended to provide a level of security and continuity for non-government agencies in their planning and delivery of services.

Funding agreements for almost 80 low income support family development and neighbourhood development services which comprise part of the Family and Community Services Development Program were due to expire on 30 June this year. This has been extended for a further two years, which is what I mentioned just a moment ago. The gamblers' rehabilitation services, which were also due to expire at the end of June, have been renewed for a further 12 months. I signed those letters this morning.

Mr BROKENSHIRE: I have to agree. The experience in my electorate of those partnerships has been nothing but outstanding. I wonder about trying to allow a few more of these groups to come into the net in time. Would you, as Minister, be prepared to consider at any time in the future any remodelling of that to allow some of these smaller organisations that are doing pretty well with small amounts to have the chance to tender for other opportunities?

The Hon. Dean Brown: Yes. First, with regard to the Community Benefit SA program, most of that is money on a one-off basis. That $4 million is normally allocated each year as one-off and there are smaller grants to allow new services to get up and get going.

After that they are expected to be self funding if possible or to find alternative forms of funding. In one case we have notified the people that we have extended for two years, but we have indicated that within that two year period we will review the target group and the type of services provided and determine whether they can be delivered in a more effective way. That is not done in a threatening way but we want to do this periodically. This is not just about rolling over what is there, year after year: it is about critically analysing what is there and determining whether we can improve on the service delivery. These are very much partnerships with groups in the community, and I do not want them to feel that they are there for 12 months and are then suddenly cut off. We are trying

to help them to establish and keep going; but, with some notification, it might be that we reallocate some of those funds more effectively.

I can now give the member for Gordon an answer to the question about Anglican community care in the South-East which he asked earlier.

The CHAIRMAN: He is not the only one who will be interested in the answer.

The Hon. Dean Brown: Anglican community care is funded for a total of $242 000 per annum to provide supported accommodation services to families, homeless adults and young people. Of this funding, a total of approximately $104 000 is dedicated to youth services, which allows the service to provide supported accommodation for 25 young people over the year and non-accommodation outreach support to other young people in need. The funding provides salary and associated operating costs for 1.5 full-time equivalent youth workers. It also includes shift work and call-out allowances, which enable the youth workers to provide as required after hours support to young people accommodated by the service.

This has been considered an appropriate model to support young people in all areas. A pilot youth services project is currently being trialled in the Riverland; as in the South-East, a 24 hour staffed youth shelter is not available. This initiative will examine cost effective means of supporting young homeless people in country regions, where there is often insufficient demand to support a 24 hour staffed shelter. The results of this pilot will then be used to develop future models for the South-East and other country regions. The South-East service currently has available for young people one short term four bedroom unit, three medium to long term two bedroom units and two medium to long term three bedroom units, based in Millicent.

Mr McEWEN: That is the information I have been given. South-East Anglican care estimates that it is probably spending closer to $120 000 on that service, so it is a little more than the $104 000 it receives. That might just be the way it accounts. In light of the fact that close to $1.2 million is spent on similar services in the Iron Triangle and Port Lincoln and because of the change in the nature of the young people needing the support, given that they are having a lot of difficulty with not being able to provide 24 hour supervision, they are now finding that the call out is not working. Some of the drug related problems and other difficulties at the centre mean that they are hoping that the funding and level of supervision can be increased, consistent with the level of services provided elsewhere.

The Hon. Dean Brown: We are hoping that something might be done there in terms of the pilot program. That should be seen as a way of providing that additional service.

Mr McEWEN: Thank you; I am happy to pass that information back to South-East Anglican care.

The Hon. Dean Brown: Another win for the South-East!

Mr De LAINE: The Commonwealth Government provides about $21 million to South Australia for distribution as emergency relief. However, no funding is available for the coordination of the distribution of this money. Does the State have any plans for providing funding to non-government organisations to enable effective coordination of emergency assistance to families in need?

The Hon. Dean Brown: The emergency relief program is in fact a federally funded program which goes directly to non-government organisations. The State Government is not involved in that; we would have no input into the emergency relief program.

Mr De LAINE: I understand that the Commonwealth provides the $21 million to South Australia and that that is a grant to the State Government to administer.

The Hon. Dean Brown: No; $21 million is spent in South Australia, but it is a direct grant to non-government organisations, not to the State Government.

Mr De LAINE: Funding for a number of State funded programs has just been rolled over for two years. They include the low income support program, family services, community and neighbourhood houses. However, the details are not yet available. Will there be any increase to the level of funding to accommodate increasing costs, such as salary, WorkCover and superannuation increases?

The Hon. Dean Brown: Generally, with perhaps one or two minor exceptions, those programs were rolled over at the same level. The details have been given to those organisations, and earlier I indicated that a number of them have written back to me and thanked me for the funding for the next two years.

Mr De LAINE: There will be an increase?

The Hon. Dean Brown: No; they have been rolled over at the same level.

Mr De LAINE: The town of Peterborough has a total population of 1 855 people, with 668 people in the labour force and an unemployment rate of 22.3 per cent. Employment prospects are therefore very limited. Median individual income is $189 per week, or $9 828 per year. Median household income is $18 200, meaning that more than half the population is living on lower than half the average weekly earnings. Poverty levels are very high in Peterborough. The State Government funded anti-poverty program servicing the Peterborough area is for $54 000 to cover an area from Port Pirie to the Northern Territory, including Coober Pedy and Yorke Peninsula. About $3 000 of this $54 000 low income support program for this huge region can be allocated to Peterborough. Peterborough is more than 100 kilometres from Port Pirie, the nearest regional centre, but there are no public transport services from Peterborough to Port Pirie. High poverty levels, lack of services and lack of transport combine to contribute to high levels of domestic violence and child abuse in the district. What poverty alleviation programs are planned for 1998-99, and how will poor people in rural South Australia—for example, in Peterborough—be better assisted with Family and Community Services this year?

The CHAIRMAN: The Chair is particularly interested in the answer.

The Hon. Dean Brown: I will have to answer this on a broad statement basis; I cannot get down to the detail of a town such as Peterborough. Income support is clearly a Commonwealth responsibility; however, through the Department of Human Services we do provide very substantial amounts of support to low income households.

In the Family and Community Services area, the anti-poverty program, which specifically addresses poverty related issues, includes concessions, financial assistance, financial counselling, funeral assistance and a range of community support through the funding to non-government organisations. The cost of this program is excess of $75 million a person. In addition, a range of programs in the department also target low income people but not specifically poverty related; for example, the Supported Accommodation Assistance Program, which we have talked about. In the housing area, rent subsidies to low income households in

Housing Trust accommodation and rent relief to similar households in the private accommodation market cost up to about $140 million a year; that is over and above the $75 million. So, there is $215 million, and in the health area there are a large number of concession schemes to ensure that low income households have access to health and disability services and the support they need. That is a general answer.

I am told that both the Housing Trust and FACS officers visit the Peterborough area on a regular basis. We will contact those officers and have a discussion with them. The honourable member has highlighted a problem which most would say is a fairly unique one and which involves a small community with a very low number of job opportunities. Therefore, a large number of people depend on support services. Let us get some information on Peterborough and then come back to the honourable member. I am sure the Chairman also would be interested.

One of the decisions we have made in looking at the reorganisation of the new department or organising the new Department of Human Services has been to specifically isolate out the country and to have someone overseeing the country area, because we think there are problems in the country that are quite unique to the country that we do not get in the city. Therefore, under Christine Charles as the CEO, there will be someone specifically looking after country services that will report directly to her as CEO.

Mr BROKENSHIRE: I was talking before about remote Aboriginal communities when we were looking at health. As I indicated to you when I was up at Yalata it homed into me just how important are the issues of health and support with community services in these communities, and it was reinforced at Ceduna as well. I refer to the Budget Estimates (page 5.4). The situation of remote Aboriginal communities is a significant issue. Will the Minister elaborate broadly on the initiatives in community services for these communities?

The Hon. Dean Brown: It is a particular interest to me and to the agency, and I know to the Chairman as well, as he has represented many of these communities. I will ask Christine Charles to go through that, because I know it is something that is of particular interest to her as well.

Ms Charles: Providing access to high quality culturally appropriate and effective services for Aboriginal people is a really high priority for this portfolio. The Human Services portfolio is one where we provide a large number of services to remote communities and to Aboriginal people more generally across the State. To recognise that, we have a specific responsibility for Aboriginal services represented in the senior executive of the new portfolio. That is one of six positions reporting to me. For Aboriginal people in remote communities, the disadvantages imposed by distance compound their vulnerable socioeconomic status. In three core areas—in community services, aged care, domestic violence and alternative care and child protection—significant initiatives will be introduced into remote communities over the coming year. In addition to that, the earlier answer that dealt with regional Aboriginal health plans is relevant here, because we are also hoping to build on those regional plans with the service development and delivery that we are doing in other areas of the portfolio.

The initiatives cover additional funding being provided through the Home and Community Care (HACC) Program for aged care services, in the review and restructure of domestic violence services, which has been running during this last year, and better services for Aboriginal women and children has been a major consideration. All agencies funded under the new system are required to demonstrate their ability to provide culturally appropriate services. In order to improve the level of service in remote areas, recurrent funding of $58 500 has been provided to establish a new domestic violence service in Coober Pedy. In addition, the existing domestic violence service provided out of Port Augusta is being converted to a dual service for Aboriginal and non-Aboriginal women. This will increase the capacity of domestic violence services in the northern country to provide for Aboriginal women and children.

In the area of alternative care, a major objective in the recent restructure was to improve access to culturally appropriate services for Aboriginal people. Aboriginal children are extremely over represented in care, and rates of family breakdown are far higher than in non-Aboriginal families. Experience has demonstrated that Aboriginal people are suspicious of and simply often do not understand mainstream services. It is true to say that the opposite is the also true that mainstream services do often not understand the needs of Aboriginal people.

In the sensitive area of child placement and family support it is essential that service are Aboriginal specific and Aboriginal managed. For the first time, Aboriginal family preservation services are now available in South Australia. Since December, these have been provided in the metropolitan and some country regions by the Aboriginal Child Care Agency, and arrangements are currently being finalised for the extension of these services to the remainder of South Australia, including the remote regions where the services will be run from local Aboriginal community organisations.

The services will provide intensive support to families in time of crisis to prevent family breakdown, and will work actively in a holistic manner to prevent the placement of children into care. As a portfolio, we are trying to implement the approach of early intervention for least cost to the community and the individual, which we think will provide the best outcome. We hope that the work we are trying to do in this area will be an example of that. Together, these initiatives are notable increases in improvements in services for Aboriginal people in remote communities.

Mr BROKENSHIRE: Help for parents is something that, I admit, even my wife and I would say you probably need because you seem to be on an ongoing learning curve when it comes to being a parent, yet it is the most important job in which anyone partakes. I refer to page 5.7 of the Budget Estimates regarding parenting support. What is your department doing to help parents in their important and difficult task.

The Hon. Dean Brown: A specific program called Parenting SA was started in 1996 by the Hon. David Wotton. It was a good initiative which had a very successful first year. As a result of that success, funding will now be committed on the basis of $2 million to be spent over the next four years.

I will touch on a couple of the components of the Parenting SA program. There is a statewide multi-media campaign to promote positive and realistic messages about parenting and to inform parents about the 24 hour parent help line. There is a 'Parent Easy Guides' which has been in great demand: about 3 million copies have been printed to date and it covers 48 topics. There is a range of subjects on which you can obtain information. Licences to use these guides have now been sold to Queensland, the ACT and Anglicare in Victoria.

Professionals in all States and Territories continue to purchase this resource. Commonwealth funding of $60 000

will enable 22 new topics to be written and produced; 12 topics are close to completion. Commonwealth funding of $80 000 will enable information to be available in different languages, as well as specific to Aboriginal parents. This year, more than $70 000 has been provided to 95 community groups as small one-off grants. These funds contribute to supporting creative activities within local communities to improve the knowledge, confidence and skills of parents.

The Parenting SA web site is being extended to provide a directory for professionals and parents of support services throughout the State. A set of standards will be developed and accreditation given to agencies and programs included in that directory. The parents' help line has been strengthened to provide a wider range of assistance to parents of adolescents. The sum of $100 000 has been received from the Commonwealth Government to provide Preventive Child Abuse and Neglect, a program to prevent child abuse and neglect.

A 12 month pilot home visiting service is now operating in the southern metropolitan area. In fact, I launched that service in, I think, May. In effect, it is like a parent-mentor scheme: a parent is allocated to a family that needs and asks for support and that mentor parent talks to the family and provides ongoing advice. I have met a number of people involved in that program. They are basically worldly-wise sort of people who have brought up a family and know what it is like. It is a bit of a cultural shock for the first time for most of us and, having been through the process, they can give advice in terms of how best to deal with certain situations. I think that program is very good, indeed. They have also initiated a research program to identify potential research projects concerning the needs of families. Parenting SA is a very comprehensive program and we have now given it certainty by funding it to the extent of $2 million over a four year period.

I refer to the Gamblers' Rehabilitation Fund, which was referred to earlier. When we rolled over the money for 1998-99, I approved a 5 per cent increase for the Break Even agency, and an evaluation of the programs that are being funded is under way so we can ensure the funds are being spent in an appropriate manner.

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

Membership:

Mr Conlon substituted for Ms Stevens.

Mr Scalzi substituted for the Hon. R.D. Such.

Additional Departmental Advisers:

Mr P. Willey, Acting Director, Policy Coordination, Department of Human Services.

Ms J. Murray, Manager, Executive Services.

Mr F. Turner, Director, Finance.

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

Mr CONLON: It is incredibly difficult, with the budget papers presented as they are, to find the continuity of information necessary to make this a worthwhile process. I understand that it may well be associated with the amalgamation of portfolios, but reading the budget papers from 1996-97 and reading them for 1997-98 makes it extremely difficult to follow any continuity of information. I make that point: although I do not expect anything to be done about it.

I refer the Minister to his ministerial statement of 25 February in announcing the development of new guidelines for applicants for the Housing Trust. It was said at the time that they would not affect people on the waiting list, but would affect all people from that time forward, being 25 February. It was said that the guidelines would be developed over the next couple of months. Will the Minister provide a copy of the guidelines applied to applicants since 25 February?

The Hon. Dean Brown: The issue raised over the format of the financial information given has been raised previously and was discussed earlier today. That is one of the problems when you bring the functions of three major Government agencies into one. We run the department not to make it a simple process for this sitting but to provide an effective service to the people of South Australia, who have a need. If that means that housing is interspersed with community and health projects, as long as it is providing a better delivery of services out there, that is the important thing. I assure the honourable member that, whilst I understand and appreciate the difficulty, further magnified by the problems with accrual accounting this year, it simply reflects an agency out there trying to meet the needs of the community.

Considerable work has been done by the Housing Trust in developing new proposals. They are now being further refined for a period of consultation in the community. Here we are talking about segmented waiting lists, eligibility and tenure. I have been through that detailed material that is shortly to go out for consultation. I have had discussions with a number of representatives of various groups: they are looking forward to the consultation and already many have given thought to some of the issues.

When I made the ministerial statement to the Parliament, as of that day a new waiting list was started. The old one was not wiped but a new one was started. I indicated that there would be some difficulty in working through both the new waiting list and the existing one, but that we would do that with sensitivity. I expect that we will have the new guidelines up and ready after the consultation in about two to three months. They will become the guidelines. I am going through a similar process with community housing and would expect similar guidelines to apply for community housing.

Since I made my ministerial statement to the Parliament we have had a meeting of Commonwealth and State Housing Ministers and the Federal Minister has been quite adamant that these are the reforms and principles we have to meet. The broad principles, such as segmented waiting lists, eligibility and tenure, principally aimed at making sure that housing is available for those in greatest need, have now been agreed to by all States. That need is assessed on a number of different criteria. That is the position.

For those already in a Housing Trust home, their life tenure will continue. The member for Elizabeth might like to take note that I have noticed that there appears to be acceptance of that life tenure because a letter signed by me was sent out through the trust highlighting that there was no need for concern. However, in Salisbury a number of people have been very concerned, believing their life tenure was about to be affected. I do not know why only in Salisbury that has been the case. It has not been a problem generally, but I have heard of a number of cases in Salisbury. If the honourable member finds the person spreading misinformation, she may like to correct them.

Ms Stevens interjecting:

The Hon. Dean Brown: It was in the general Salisbury area. I saw some letters and they were from Salisbury North or Salisbury East. I would appreciate any assistance to make

sure that there is no fear amongst existing tenants. I think that answers the question.

Mr CONLON: It answers most of it but, in respect of those people who have applied and been placed since 25 February, what guidelines were used?

The Hon. Dean Brown: Those who have been placed since I delivered my ministerial statement were placed under the existing criteria, as one would expect. If the honourable member listened to what I said on the day, my statement—

Mr CONLON: In my original question I asked for the number of those who have applied and been placed since 25 February. The statement says—

The Hon. Dean Brown: If the honourable member will allow me to answer the question he can then put a subsequent question. Those who were placed from the existing waiting list were placed according to existing criteria. That is what I said when I made my ministerial statement: as from that day we would establish a new segmented waiting list. The exact criteria that will apply to that waiting list are yet to be worked out, but at least we have drawn a line in the book and said, 'Here's the new list.' Those who have been placed are absolute priority allocations. I think it would be fair to say that they would have met the criteria under the old procedures or under the new procedures.

Mr CONLON: The Minister has categorically ruled out any changes in tenure for existing Housing Trust tenants. Does that mean that he has ruled out achieving in the short to medium term the reduction to 43 000 homes recommended in the triennial review? If that is not the case, how will that be achieved without affecting the existing security of tenure?

The Hon. Dean Brown: First, let us get the time frame for that reduction correct. I thought it was to be over a 15 year period. If you take the whole of that short to medium term period, you will live for a long time. In fact, 15 years is considered to be medium to long term: most people would call it long term; medium term is normally five years. Our target is 1 000 to 1 500 houses a year, many of which are sold to existing tenants. I also point out that there is a 50 per cent turnover every three years and a 60 per cent turnover every five years. That highlights the high turnover in Housing Trust homes. Therefore, achieving a targeted reduction of 1 000 or 1 500 homes is not unusual: we have been doing that for a number of years.

Mr CONLON: The review suggests that that turnover occurs in the least sought after homes, but there is a high percentage of people in the most sought after homes who enjoy life tenure and intend to stay there for the rest of their life. Whilst 15 years might be long term for some people, I do not think that in terms of life tenure people think that 15 years is that long. However, I appreciate the answer.

The triennial review recommends increasing rents over time to an average of 25 per cent. I think the time frame is about 12 months to warn of an increase and three years to introduce it. Will the Minister rule that out?

The Hon. Dean Brown: The Federal Government has also said that its target is about 25 per cent, but there is no time frame. The current average is 23 per cent. As part of our response we are reviewing rents for Housing Trust homes. What we decide to do is another matter, but I assure the honourable member that we are required to do that even in response to the Federal Government.

Mr CONLON: But the short answer is that the Minister cannot rule out increasing rents as recommended in the triennial review?

The Hon. Dean Brown: I have indicated to the Parliament that the Government has not accepted the recommendations of the triennial review. It has not considered them, because it is not a Government response; it is a response from an outside consultant.

Mr CONLON: I am not asking the Minister whether he has decided to do it but whether he will rule out doing it. Plainly, he will not.

The Hon. Dean Brown: I have answered the question.

The CHAIRMAN: I call the member for Elizabeth, who prior to the dinner adjournment indicated that she had a number of questions. I tried to facilitate the process by allowing her to put them on notice. Unfortunately, I am told that under the criteria used for these Committees that is not possible. I will give her the opportunity now formally to put them on notice if she so desires.

Ms STEVENS: My questions in relation to all departments and agencies for which the Minister has responsibility are as follows:

1. List all consultancies let during 1997-98 indicating whether tenders or expressions of interest were called for each consultancy, and, if not, why not; and the terms of reference and cost of each consultancy.

2. Which consultants submitted reports during 1997-98; what was the date on which each report was received by the Government, and were the reports make public?

3. What was the cost for the financial years 1996-97 and 1997-98 of all services provided by EDS including the cost of processing of data, installation and/or maintenance of equipment (including the cost of any new equipment either purchased or leased through EDS), and all other payments related to the Government's contract to outsource information technology to EDS?

4. During 1996-97 and 1997-98 were there any disputes with EDS concerning the availability, level or timeliness of services provided under the whole of Government contract with EDS; and, if so, what were the details and how were they resolved?

5. What are the names and titles of all executives with salary and benefit packages exceeding an annual value of $100 000; which executives have contracts which entitle them to bonus payments, and what are the details of all bonuses paid in 1997-98?

6. What are the names and titles of staff who have been issued with or have access to Government credit cards; for what purpose was each of these cards issued, and what was the expenditure on each card for 1997-98?

7. What are the names and titles of all officers who have been issued with Government-owned mobile telephones; what arrangements apply for the payment of mobile telephone accounts; and what restrictions apply to the use of Government mobile telephones for private purposes?

8. What was the total number and cost of separation packages finalised in the financial years 1994-95, 1995-96, 1996-97 and 1997-98?

9. What is the target number of staff separations in the 1998-99 budget; how many TVSPs have been approved by the Commissioner for Public Employment for 1998-99; and what classifications of employee have been approved for TVSPs in 1998-99?

10. How many vehicles by classification were hired in each of the financial years 1996-97 and 1997-98; and what was the cost of vehicle hire and maintenance for each of these financial years?

The CHAIRMAN: Some detailed information has been requested. It may not be possible for the department to provide that information within the time frame because it has other things to do besides answer questions of this nature. So, the honourable member may have to be somewhat patient.

The Hon. Dean Brown: I presume when talking about vehicle hire that, if the member was talking about someone who has flown to, say, a conference in Sydney and hires a vehicle for one day, she does not want all the detail for that vehicle, that she is talking about the vehicles that are generally on almost semi-permanent hire?

Ms STEVENS: Yes, that is fine Minister.

Mr McEWEN: Minister, in your opening remarks tonight you talked about the need to refurbish some of the old housing stock. I notice in the budget papers the words 'urban renewal' are used a couple of times. In some of the literature we also hear about precinct rebirth, and all these sorts of things. Within that environment, under the signature of the Mayor of Mount Gambier the Premier was written to asking whether the State Government would support all of the agencies, both local and State, getting together and focusing on the eastern area of Mount Gambier, so that all at one time could pool their resources in terms of upgrading what is quite clearly an area that does need refurbishment. So, everybody from ETSA to Transport SA to the Education Department to the City of Mount Gambier are prepared to focus their efforts at the one time. The Premier declined that offer and the city and the local agencies were somewhat disappointed. I wonder whether we can revise that. The synergies are obvious and I think it is a great way to use resources.

The Hon. Dean Brown: Firstly, it is a major part of the program of the Government, because of the age of the housing stock, to have an upgrade. It is an upgrade of the housing in some areas but, more importantly, it is an urban renewal program, because it does need to be more than just upgrading the houses. It is changing the whole appearance of the neighbourhood. In most of the cases it has been a joint partnership with local government. It has come in and tried to upgrade the streets, the kerbing and the vegetation. I always think that you can change the face of a suburb just by what you grow in the streets, and the appearance of the streets before you get to the houses. It is interesting to consider that some of the most sought after suburbs are only sought after because they have mature trees that change the face of the area. It is worth having a look across the whole of Adelaide from an aircraft or a helicopter to see the level to which street vegetation changes.

We are doing this in a number of areas at present—Mitchell Park, Hillcrest, Elizabeth North, which is called Rosewood, Port Lincoln and Port Pirie. We have opened Stage 1 at Port Pirie recently. We are going through a major study on The Parks area, with a view to doing something there. The Parks area will be the biggest of all of them. I received a letter from the Mayor of Mount Gambier—or was it the honourable member for Gordon? I have received a letter; I have referred it to the department and we are still considering it.

Mr McEWEN: In the meantime, the Premier has actually written back saying, 'No, not at this time,' which is disappointing because even people like the police were prepared to reconsider the way they dealt with the community and we also had the community residents group as part of the committee.

The Hon. Dean Brown: It may be a timing difference only, but let us continue to look at that. We are putting them into priority and, in saying what I have just said, we would be looking at this in the medium term, not the immediate future, because we have existing commitments and are working through area by area. We need to negotiate with the local government bodies involved. That in itself is a two or three year process in most cases. I am just saying that, whilst the Premier's response was probably a valid response from the point of view that it is not sitting there with the immediate priority of the department, that does not mean that we cannot look at this in the medium to longer term. I would urge the honourable member to pursue that.

Mr SCALZI: I refer to Portfolio Statements, Volume 2, section 5.7, page 4. Will the Minister outline the current progress on negotiating the Commonwealth-State Housing Agreement, which I understand expires on 30 June 1999? What likely impact will this have on South Australia, Minister?

The Hon. Dean Brown: The State Housing Ministers have met twice this year—once at the end of March where we met with the Federal Minister, and we agreed on the broad principles at that meeting, and there was no argument between the States, the Territories or the Federal Government on those broad principles. At that meeting we asked the Commonwealth to put down its offer. As Housing Ministers we have been waiting since early 1996 for the Federal Government to put its offer on the table so that we can start to negotiate it and talk about some of the issues. So far the Federal Government has not been willing to put its financial offer on the table. That concerns me because we have a year to go. I do not want to see a repeat of what has happened in the Medicare agreement area and, frankly, with housing we probably need even bigger time frames because we need to plan our works program in advance.

We have taken the initiative as State and Territory Housing Ministers. The Minister said, 'Look I am sure it will take you months to even sit down and come to any understanding of the principles, because there will be a multilateral agreement with all of the States and Territories and the Commonwealth and then there will be a bilateral agreement just between the Commonwealth and the States on aspects that only affect that State.' We said that we would hasten this process by actually sitting down as States and drafting an agreement that we all agree to, both a multilateral and a bilateral. We did that and met our deadline by the end of April and sent that to the Federal Minister—and the silence has been deafening. We asked the Federal Government to come back with a financial offer by the end of June. So far it has not come back with either a response on our multilateral and bilateral agreements or any offer. I think there has been a letter of acknowledgment only. So we are following that through, because it is important.

I am concerned because funding to the State has dropped 40 per cent since 1989-90. It has been dropping progressively. We need to make sure that we have the funds to carry out the housing program that we need, particularly the refurbishment program and some of the other newer initiatives with community housing. So, the response is that we are still a long way off because, although we have the nature of the agreement and everything else, we cannot put the dollars into it. We cannot even engage the Federal Government in dialogue to put the dollars in.

Mr CONLON: Minister, I think you said that you would be selling about 1 000 houses a year. How many houses per year over the next three years would the trust be selling? How many would it be building?

The Hon. Dean Brown: Generally the number of sales has been around 1 000. I put down a general target of somewhere between 1 000 and 1 500. I understand that for 1997-98 it was 1 170 and, in 1989, 950. The target for 1997-98 was 920, but in fact the number was 1 170, and the target for this year is 950. In 1996-97 the trust sold 1 044 houses. So we are averaging around 1 000 a year.

Mr CONLON: The other part of my question was how many you were building during that period. I have difficulty understanding the comment in your statement of 25 February that the changes will not affect those on the waiting list at that date. As I understand it, some 30 000 were on the waiting list and the bulk of those in the 'wait-in-turn' queue. You say that you adopt two streams for applicants, but, if under the new stream priority is given to those most in need and they are all going into the same housing stock, how does that not affect them?

The triennial review which you say you do not necessarily have to adopt—I do not think you would say that it was wrong—suggests that the outcome would be, if you accept that criteria, that you would have three streams—an urgent stream, which we have at present; a stream for those in greatest need; and an unrestricted 'wait-in-turn' category. I concede that if you adopt that for housing for the last category it would indicate that the trust has more houses than is required to meet its primary objective.

It seems that we are embarking on a project to reduce the housing stock to meet the Housing Trust's primary objective. In those circumstances, how can it be said that the new changes do not affect those people on the 'wait-in-turn' list (or the 30 000)? Because priority will be given under another stream for housing in need, should we not be honest and tell those people that they should start looking elsewhere because they really do not have a chance under the new system?

The Hon. Dean Brown: Those people with the greatest need are given priority—even under the old and still remaining criteria—and will go through, whether it is under the old list or new list. Those with the lesser need are the ones most likely to be affected because it may be that they are in a better financial position, may have someone in the household who has a job and have a reasonable income stream, but they still put their name on the Housing Trust's waiting list. Let me give you the detail and then I will answer the question as I understand you are asking it.

As at 30 June 1997 the waiting list was 33 361—that is, 12 months ago—which was a reduction of 3 000 on the previous year. The waiting list has been declining over the past five years: the number has declined from 41 693 to 33 361 as at 30 June 1997—and I will get that date checked. It says here as at 30 June 1997 it was 33 361, and it then says in the next paragraph that the current figure is 33 361. One of those is wrong. I think the 'current figure' is wrong.

The trust is streamlining the way it manages the allocation of public housing in light of the general trend towards better targeting of housing resources. In 1997 the trust introduced the following changes to the management of the waiting list: first, it reduced the number of offers of housing to applicants from three to two—they were given three offers now they are only given two—and two strikes and they are out; secondly, it did not allow applicants to remain on the waiting list if they request delays in offers of housing; and, thirdly, it cancelled all applications which had lapsed for more than 12 months. These changes will enable the trust to house its customers more quickly and to ensure that the waiting list is a more accurate measure of the number of people who really need housing.

The reduction in the waiting list may also be due to an increased community understanding that the trust largely houses those who are disadvantaged. Further work on introducing eligibility criteria as well as segmenting the waiting lists so as to house needy households is currently under way, as I mentioned earlier. The Housing Trust also introduced the Deposit $5 000 scheme which, in many ways, was really targeted at a lot of people who might have been on the waiting list and who had a lesser need because they had a job or something like that. Deposit $5 000 has helped approximately 1 700 people in South Australia to move into a new home who otherwise could not get together the money for a deposit. In that way I believe it has been very successful in targeting a number of the people on the waiting list.

Also, we continue to offer these people Homestart finance and other means of getting into a home. One initiative I am taking is to change what has traditionally been a choice in South Australia—you either had Housing Trust accommodation, private rental accommodation or bought a house. They were the three choices that you tended to make at the beginning of your adult life and you said, 'That's the path I'm going to head down.' We are now looking at creating a greater number of options and those options, without being absolutely black and white, will meet different criteria and different needs.

First, you will have the Housing Trust for those most in need; secondly, you will have community housing, which is similar to the Housing Trust but perhaps for those with a slightly lesser need, but again that will depend and there will be very similar circumstances; thirdly, there will be Homestart finance, and we are looking at whether we might make some adjustments there to help those with a greater need; then schemes like Deposit $5 000—not that it is applying at present but like that—which might even help people in Housing Trust houses to move out of their homes. The other option is that you have rented accommodation with Commonwealth rent assistance, and in some cases rent assistance from the State Government, which I talked about earlier today.

That will provide more options than people have had in the past and, hopefully, will better match the ability and needs of people with the type of housing more effectively than has been the case in the past. Incidentally, an audit of the Housing Trust waiting list is done once a year.

Mr CONLON: I would like to hear from you, Minister, and the trust about what can be done about the following problems. This fits into the matters that you have just talked about, namely, the changing nature of people that the Housing Trust has accommodated over the past 40 years. In my electorate I have a large block of ageing people, many of them ordinary working people. They live in areas where the Housing Trust has been established for a very long time. They are life tenants and are now in their twilight years and some of them, through the vicissitudes of time, are not there with us any more.

This is a genuine problem and has been a problem for me as the local member. What is happening is that the new criteria in the Housing Trust are giving accommodation to those most in need, and, as you explained yourself, those whose needs are more than simply financial and are more complex, coupled with the process of deinstitutionalisation. This has resulted in the situation that we have seen in my electorate, where a number of people with very special needs, who are extraordinarily difficult tenants not only for the

Housing Trust but also for the people around them, land in a street which may have an elderly couple on either side of them and across the road. They cause enormous traumas to those people, to the extent that those people consider leaving their house. I can refer the Minister to a couple leaving the house they had lived in for more than 20 years. Is there a process to prevent that occurring? It is grotesquely unfair.

The CHAIRMAN: I share the honourable member's concerns.

The Hon. Dean Brown: I am very mindful of that, and a number of cases have come to my attention. Let me deal with this in a sensitive manner. First, for people with a mental illness or mental health problems we would like to see supported accommodation where it is needed, and I think that is important. Secondly, I have indicated to the trust the need for more effective management of people who are bad tenants because of drunkenness or something like that. I have noted from the comments on both sides of the Chamber here tonight that you would all want to approach this in a sensible way that was more effective. I have put up the suggestion, which I have picked up from one of the other States, of a probationary period of, say, six months, for people who go into a Housing Trust home. This is one of the suggestions on which we are going out to consult, so it will be out there for a period of consultation in the community. I would certainly welcome any comments from the members of Parliament on this. I have suggested a probationary period so that if significant complaints are made during that period we can take action. The person or people need to understand that they do not have an absolute right to a Housing Trust home if they abuse the situation.

I think a probation period of six months would be good, but we are also looking at some other measures. Given a limited period of tenure, those with long-term needs will be able to roll over that, but we will have the chance to review the tenure of those who are bad tenants, even after six months. Frankly, I think that is what is needed. The response I have had from members of Parliament is that they are sick and tired of tenants who go in, disrupt a whole neighbourhood, for which they have no regard, and, as a result, force out of their homes other people who have been there a long time. I think we ought to deal with that effectively. I have had to deal with such a case in my own electorate. We must also make sure that effective measures are in place to allow us to take action against bad tenants, that is, those who disrupt a neighbourhood. Let us develop a bipartisan approach on this and take action.

Mr CONLON: I appreciate the Minister's comments and that he would see that as a genuine attempt to deal with the problem, but the difficulty is that there are people who to some extent will always be the responsibility of the State, because they are incapable of being responsible for themselves. I am not talking about the bad tenants who are wilfully bad: I am talking about those tenants who may have mental health problems or anti-social problems. These problems will pop up somewhere else, because these people are not institutionalised. I do not know the answer to that, but I suggest that some sensitivity should be exercised when placing these people so that they are not placed among elderly communities who have lived in a quiet place for a long time. I do not know whether that is possible, but there are fundamental problems with this. I raise this not as a political matter but as a matter that needs to be fixed.

The Hon. Dean Brown: Your comment has been noted. I know that others have similar concerns so, if you can bring specific cases to my attention, let us deal with it so that we do not have that problem.

Mr CONLON: People are terrified of making a complaint about people living next door to them.

The Hon. Dean Brown: I think people ought to make complaints. Members of Parliament have been to me and in some cases we have worked through that problem.

Mr SCALZI: I refer to page 5.7 of the Portfolio Statements 4, Volume 2, with regard to housing reforms. What is the Government's response to the housing policy agenda?

The Hon. Dean Brown: I have talked already about some of the key principles of the Commonwealth State housing reform agenda. It is basically priority of access to public housing for those with the greatest need. That follows the agreement of the Housing Ministers at the meeting in Sydney to some principles that were put down in June 1997. The State Government has already committed itself to developing those new guidelines. That reform is well under way and will involve consultation. I announced some of these reforms in Parliament on 22 February, and in another statement to Parliament I announced further reforms.

The first eligibility criterion will be urgent need involving homelessness, domestic violence or priority housing applications, etc; and the second criterion will be inability to sustain private rental housing in the medium to long term, covering refugees or people with mental illness, disabilities, or particular medical problems. The third category would be low income applicants who meet income eligibility criteria, including low income elderly people; and the fourth group are current trust tenants seeking to transfer.

When you are the Minister you realise this: I would urge members not to consider the waiting list or the Housing Trust stock as being homogenous. Some areas are far more in demand than others, and some types of accommodation are much more in demand than others. Whilst you may say there is a waiting list of 30 000 people, if some people were really desperate for a home and were willing to relocate to a particular area, we could give them a home tomorrow. So, people are exercising a choice about where and in what type of home they want to live.

Instead of people indicating their two preferred suburbs, I think we should have them nominating a small region—a collection of several suburbs—where they would prefer their home to be. That would give us a slightly greater choice and facilitate our putting them into homes more quickly than we can now. I stress that members need to realise that the waiting list has a great degree of variability, as do the people who want accommodation.

Mr De LAINE: The Minister mentioned The Parks urban renewal project, which was announced in 1994. Being the member for that area, I know that there has been a lot of disquiet—and I do not blame the Minister for it, because there were three Ministers before him. This disquiet has been going on for four years now, and people who have lived in the area for 30 and 40 years are concerned about their future and about being transferred to other homes or even to other areas. I note from this year's budget papers that this project will be subject to Cabinet approval again. As this has been announced for four years, and every year it seems to be subject to Cabinet approval, what is the holdup?

The Hon. Dean Brown: I understand the frustration of the member for Price over the length of the process. I have been trying to speed that up. We have a preferred private sector partner in that. We are waiting for them to give their commitment and, of course, the Cabinet itself has to agree to the

broad principles once that is finalised. My hope is that it will be done fairly quickly, but I cannot be absolute about that. Our commitment—and that is where I can give you a commitment—is to have an urban renewal program there. We have negotiated with the council and received its support. If this private partner does not finally agree, we will put in place something else which is smaller and much quicker to implement. We are now looking at developing much smaller contracts for renewal of the homes. That is one other alternative: we could let out a contract for a builder to renew 100 homes in a contract. That would allow a particular builder to come in, and that would be a much quicker process.

Mr Black: We are converting all our contracts for upgrading from small scale to large scale. It is a two stage process, and by the end of the calendar year there will be a smaller number of large scale contracts for the whole of the upgrading program, which will involve approximately 950 homes during 1998-99.

The Hon. Dean Brown: I mention that only as a fallback position if the present commercial negotiations do not come to fruition. We are pushing to bring those to completion as quickly as possible so that a final decision can be made. I ask the honourable member to explain that to his people. Frankly, they have been very tolerant, and I do not blame them for being frustrated. However, we are trying to get the best outcome for them. Commercial negotiation is the best outcome for them, but that has not yet been finalised by the private partner.

Mr De LAINE: As the Minister would know, The Parks project will be done in several stages, stage 1 being the Ferryden Park area. Notwithstanding that, there is a freeze on the sale of Housing Trust homes, even to the people who currently occupy them. Quite a few of my constituents wish to purchase their homes. I can understand to some extent the reluctance by the Government or the trust not to allow tenants to purchase homes in the stage 1 area, for instance. However, people are being denied the opportunity to purchase their home in other areas, which will probably be redeveloped 10 years down the track. Why is this? Is it intended that this freeze will continue?

The Hon. Dean Brown: It is to make sure that the redevelopment is an effective one. If the honourable member has constituents who have a very good case, and therefore want to buy, we will deal with them on a one on one basis. We have made some exceptions. If the honourable member hears of cases such as that, where the redevelopment looks to be a long way off and family members are in adjoining houses, I want to make sure that we make the best decision for them. However, at the same time, we just need to be careful (and the honourable member would understand this) that we do not destroy the effectiveness of the urban renewal program.

Mr De LAINE: I refer to the age old problem of damage that is created by some tenants and the lack of standards that has lead to tenants' being evicted and the trust's having to come in and clean up after them at great expense. Have any figures been done on the yearly cost of repairing the damage and for cleaning up after untidy tenants? How does that compare with the cost of something I have been advocating for many years, namely, the reintroduction of inspectors? Inspectors tended to keep people on their toes and make sure that things did not get out of hand. Since inspectors have disappeared off the scene, this sort of damage has been done, and it has happened at great cost to the Government and to the trust. Are there any figures to indicate whether it would be cheaper to appoint inspectors again or just continue to pay for the damage and the clean up?

The Hon. Dean Brown: The honourable member will be pleased to know that we are about to recommence home visits in August. We expect to visit every property once every two years. We also have a six month probationary period, towards the end of which there will be a visit. That should target some of those people who are more difficult to start with. I drove around a fair bit of The Parks area and looked at a number of homes. I was concerned by what I saw. I picked out certain properties and asked, 'Who owns that? Why is that like that?' I found out that a number of them were privately owned. Some of them looked like car wreckage yards, and it is a disgrace. Frankly, I am concerned that the council ought to be taking action against those people. In one place, the wreckages were in front of the house and in another on the footpath. I hope that, under our program of urban renewal, we will start to really clean up some of these areas. Some of those houses are a disgrace.

One Housing Trust home had heaps of beer bottles in the yard; the grass had not been cut; and there were heaps of rubbish. All that house needed was a proper cleaning up, and it would have made a world of difference. Why should neighbours have to put up with that sort of neighbourhood? They must feel angry at times, having to put up with the laziness, sloppiness and untidiness of some of the neighbours. We are trying to tackle this, and that is why home visits have been reintroduced and a probationary period put in there as well.

Mr De LAINE: Would you say that the majority of tenants are good?

The Hon. Dean Brown: Yes, and some of them have a real pride in their place; they tend to their gardens. I went to one place at Mitchell Park and was amazed to find that the couple had been there for 40 years. Their place was absolutely spotless; the garden they had developed was a real statement of pride and commitment in terms of what they were trying to achieve. They were a happy couple within the Housing Trust. I think the majority of our tenants are like that.

I also want to compliment the trust on its initiative to develop gardens. We recently gave away free plants. Any tenant could come along and take away three plants to help improve their garden, and I think that is a good initiative. I would also like to see more of them start growing their own vegetables. If the Minister can do that, I can't see why some of the tenants can't.

The CHAIRMAN: What is the total indebtedness of the Housing Trust and why?

The Hon. Dean Brown: The total debt of the Housing Trust is just over $1 billion and it will go under $1 billion this coming year. About $900 million of that is what we call low interest loan at only 4 per cent under the Commonwealth-State Housing Agreement. The figure at 30 June 1997 was $1.067 billion, of which $170 million is high interest rate—that is probably the more normal average of around 10 per cent interest—and $897 million is at the concessional interest rate of 4 per cent.

At the end of June of this year, it is expected to be $979 million of total debt, of which $95 million will be high interest rate and $884 million will be concessional rate. By 30 June 2000 we expect the total debt to be $856 million, of which none will be high interest rate and $856 million will be concessional interest rate. At 4 per cent interest on the concessional rate, you would not want to be busting your guts

to pay it off. It is over 53 years at 4 per cent, so obviously you would not want to reduce that, but the high interest debt is an area we are working on; we are paying that off with an accelerated repayment scheme and within two years that will be paid off.

Membership:

Ms Bedford substituted for Mr De Laine.

Additional Departmental Advisers:

Mr Lange Powell, Executive Director, Disability Services Office.

Mr Jeff Fiebig, Director, Office for the Ageing.

The Hon. R.D. Lawson: I have a brief opening statement. I am pleased to present the budget estimates relating to the disability and aged support functions of the Department of Human Services. This Government has a significant investment in older people and people with disabilities and is committed to optimising the programs and services available to them. The support needs of older people and people with disabilities are often quite similar. However, the service systems that support them are complex and can be difficult to negotiate. They and their families want greater simplicity, clarity and coordinated provision of care.

The establishment of the Department of Human Services has already begun to improve the coordinated planning and policy development in areas of common need for people with disabilities and for older people. Some examples include joint planning arrangements for the HACC program, planning for a single equipment purchasing scheme for older people and people with disabilities, a thorough examination of respite and other community care arrangements for people with disabilities, older people and their carers, and coordinated assistance for people in public housing with common tenancy support needs.

As is well known, South Australia has proportionally the largest population of those over the age of 65 years in this country. We also have in this State a larger than average proportion of people with profound or severe handicap. The Government has recognised this important area of need and has devoted substantial resources to a range of accommodation and support services. The disability services budget in 1998-99 will include a full year effect of the $5 million of new funding announced last year, which allocation I announced in February. Nearly one third of the State's total outlays on disability services derives from Commonwealth sources and I was pleased to announce recently that the second Commonwealth-State disability agreement was signed after some 12 months of intensive discussion with the Commonwealth. We did achieve a satisfactory result for South Australia, both in respect of the growth funding and also in respect of one-off funding.

Our total recurrent funding to be received over the term of the agreement will constitute over 12.4 per cent of all Commonwealth CSDA funding to the States. This is well above our weighted per capita allocation of just over 8 per cent. This will result in an additional $5.125 million becoming available for new or expanding disability services.

In the ageing portfolio the emphasis of disability policy over recent years has been on tailoring services to the needs of individuals and on improving their quality of life at home and in the community, wherever possible. This emphasis is reflected in the funding arrangements for disability services and the development of the options coordination system for case management and purchase of services. Options coordination was introduced in 1995. It is now half way into its implementation phase. As in many other human services fields, the demands for disability support services frequently exceeds the resources available for their provision and options coordination cannot always bridge the gap. However, the system has led to a more equitable distribution of these resources, simpler access to support and real service choices for many people.

The current year has seen the further consolidation of the Government's commitment towards older people and delivering on the commitments we made in 'Ageing—a 10 year plan for South Australia'. We are looking forward next year to the International Year of Older Persons. A South Australian, Prof. Gary Andrews, is President of the International Association of Gerontology and is to lead up the United Nations post for that year. With Prof. Andrews and other researchers in the field, this State is at the forefront of innovative forms of care for older people with programs such as Care 21 and Health Plus—both highly innovative pilot programs, which should lead to enhanced service delivery mechanisms.

The HACC program for older people with disabilities and their carers continues to be the cornerstone of delivery of services to older people. For the fourth consecutive year this Government has either met or exceeded the Commonwealth offer of growth in HACC. Since 1992-93 the Government has contributed to an increase in funding into the program, which has now risen from $47 million at that time to $70 million now, an increase of nearly 50 per cent in the program and a substantial improvement on that undertaken by our predecessors. Many South Australian organisations, unknown to the wider community, receive the bulk of their funding through the HACC program. Of the $70.4 million allocated in the current year, services such as the Royal District Nursing Society received $12 million; country domiciliary care services, $7 million; Community Support Inc. (CSI), $6 million; domiciliary care, almost $10 million; Meals on Wheels, $1.3 million; aged care and housing, $1.2 million, and the list goes on.

So, the HACC program is important. Later this week, I hope to announce with my Commonwealth counterpart the final 1997-98 funding round which will deliver additional funds to that program. The Government and community partnerships in promoting the wellbeing and living standards of South Australians are at the centre of disability and aged services systems. I am pleased to note the constructive relations between Government and the many service providers and consumer organisations in this field, and I look forward to further strengthening these relations in the interests of some of the most vulnerable people in our community.

Membership:

Ms Stevens substituted for Mr Conlon.

Mr HANNA: The Minister will recall that last year with the member for Taylor and I he attended a meeting at St Ann's Special School in Marion in my electorate concerning the plight of a number of families and children with disabilities who for many years had attended the Minda premises for vacational care programs. There were two aspects to the problem. First, although all the young people up to the age of 20 years were able to attend public schools, those aged over 15 years were not eligible for any child care

and those aged from 12 to 15 years were affected by changes to Commonwealth guidelines regarding child care, leaving their families very much in the lurch.

At that meeting the Minister made a commitment that State Government funding would be maintained but, as it was brought home to him at that meeting, without Commonwealth or additional State funds this vacational care program which was so important to those families would not continue. My question is: has the Minister, with others, been able to resolve this issue or does he admit that he has failed to resolve it to the satisfaction of those families?

The Hon. R.D. Lawson: I do not accept that the Minda vacation issue has not been resolved. I recall attending the meeting of concerned parents at St Ann's School earlier this year. In February this year changes to Commonwealth subsidies for vacation care for children with disabilities raised the possibility of the Minda vacation care program being discontinued after the April school holidays. Not surprisingly, that generated concern amongst parents, and an action group was formed. There were representatives at that meeting not only from the Opposition but also from the Department for Education, Training and Employment as well as a Federal member of Parliament together with, I think, a representative from the Intellectual Disability Services Council.

Following that meeting, it was agreed to explore avenues to maintain the program beyond April, but in doing so a couple of factors were accepted. First, the Minister for Education, Children's Services and Training was considering options for funding the participation of children aged between five and 15 years. IDSC (the Government organisation within the disabilities sector) confirmed that it would fund the participation of up to 28 children and young people in the 15 to 20 year age group. That would have provided coverage across the whole group of clients and potential clients of the program.

A number of issues arose around the situation, not the least of which was a perceived ambivalence, I think it is fair to say, within Minda Inc. about maintaining the program at all because, as members may know, Minda has closed its special school, and I am advised that Minda does not necessarily regard vacation care as being of a high priority in the wide range of services that it offers. The format of the program was limited largely to outings for participants providing only limited opportunity to focus on individual growth and development. That was seen by some as not a terribly positive aspect of the program.

I should also mention that this program covered a very wide range of ages from five to 20 years which, as I was advised, was not considered necessarily to be in the best developmental interests of all participants. However, notwithstanding those reservations, this program was recognised as offering major benefits to parents in full-time employment whose working arrangements might need to be modified if full-term vacation care were not available.

There have been ongoing discussions, certainly between some Government agencies, and I shall ask Mr Powell to indicate to the Committee the current state of those inter-agency discussions.

Mr Powell: As the Minister has indicated, there are ongoing discussions between the relevant parties, the Department of Education, IDSC and the Disability Services Office. It has been confirmed that a joint proposal will be put to the two responsible Ministers to continue funding the Minda vacation care program through the next Christmas school holidays, so through the next three holiday programs. That will provide enough time for exploring with the parents' action group that convened the meeting at St Anne's School, and with Minda and other interested parties, a range of program possibilities for children of working parents. One of the major points made by the parents' action group was that there was very limited choice in the way of programs for parents in full-time employment. So we need to be looking at a range of possibilities for them. We will also be considering a range of possible auspices for programs of this nature. I know that the Department of Education is keen to explore the potential for vacation care programs for children with disabilities to be linked into schools as a means of facilitating access to Commonwealth funding. It was the break in that nexus that caused the problem in the first place.

Mr HANNA: Why have those interagency discussions taken over a year to get to this point when there is still no guarantee of such a vacation care program continuing?

The Hon. R.D. Lawson: At the meeting in February the issue was whether or not the program would continue into the April school holidays. Commitments were given and the program duly continued. So far as I am aware it has continued and will continue throughout this year and, as Mr Powell has indicated, discussions are actively being pursued about the arrangements for the Christmas vacation. I have every confidence that a satisfactory arrangement will be arrived at.

Mr SCALZI: Minister, I refer to page 5.6 of Portfolio Statements and to transport for older people, particularly in rural areas. It was identified as an issue in the Government's Ageing 10-year Plan and in the Home and Community Care 1997-98 Annual Plan. What is the Government doing to address the matter of access of older people to community transport?

The Hon. R.D. Lawson: The Government is doing a great deal to address that issue and has been doing so over the past few years. We have encouraged and fostered links between the Government transport systems and local communities, so that appropriate and accessible services for older people, and younger people with disabilities, can be developed. One of the major initiatives has been the development of community transport networks in country areas in conjunction with local governments and community groups. This program has been funded largely through the Home and Community Care program. It was initiated by the Office for the Ageing in conjunction with the Passenger Transport Board. These services are sometimes based on small buses and mini-vans but, more often now, standard vehicles and station wagons, very often driven by volunteer drivers, and often serving additional routes and a different clientele to that which is served by community bus networks for shopping purposes, which conventionally are run by local government.

Six services are already fully operational. Services in the Barossa and the Victor Harbor areas have already operated successfully for some years. Newer developments have occurred in the Murray Mallee, the Riverland and the Mid North. I personally launched the Riverland service in Barmera a couple of months ago, and it was very warmly received by those with disabilities in the Riverland area, where there is a quite good system of transport, good road links and good regular bus links, but for those with disabilities and certainly older people it can be difficult to obtain transport to medical appointments and the like, and the only satisfactory means of doing that is through a volunteer network of this kind.

There was resistance, as one might expect, from the local taxi operators, but after discussion in the community I am

told that the taxi operators were satisfied with the service and did not feel that their own services were being duplicated, and likewise the local bus operator was highly supportive.

In 1997 (last year) a metropolitan project was commenced in conjunction with the Southern Region of Councils to provide the services in the Willunga Basin area—an area with which the member for Mawson has very close affinity as regards the current electoral boundaries. Feasibility studies have been funded into the development of community networks on the Eyre Peninsula and Yorke Peninsula. These studies will be conducted by the Australian Red Cross and Yorke Peninsula Community Care.

The Kangaroo Island council has also been funded by the Passenger Transport Board to examine the possibility of a network on that island. In 1997-98 some $125 000 of State aged care funding was allocated to develop these networks. Other developments include the Adelaide Hills and northern areas. This year HACC funding for vehicles and vehicle support of $78 000 was provided to three groups—on the Yorke Peninsula, in the Coorong and for a metropolitan disability agency.

The Government's commitment to an accessible public transport network is well known. Our support of Access Cabs, taxi voucher schemes and the like show the commitment of the Government overall to providing flexible and appropriate transport to the community.

Ms STEVENS: Can the Minister confirm that the former Director of the Disability Services Office, Ms Colleen Johnson, has been paid out by the Government ahead of court action following removal from her position? What was the total of all amounts paid in settlement and from which agency or budget line was the payout funded?

The Hon. R.D. Lawson: I will take that question on notice and bring back a reply as soon as possible.

Ms STEVENS: Regarding HACC funding, on 26 March the Minister for Disability Services confirmed that the State Government had a commitment to increase its level of HACC funding to bring this State into line with national averages. The Minister for Human Services also confirmed on 26 March that the Federal Government had said that growth funding was conditional on States collecting 20 per cent in fees by 1 July 1998. The Minister also told the House that he was negotiating with the Commonwealth for an adjustment of the policy requiring growth funds to be contingent on fees of 20 per cent.

On 26 March he said that he was working through the details of introducing fees for HACC programs and highlighted the issues that some charges were already being levied and the important question of who should pay the new proposed fees. I understand that the introduction of this fees policy means for South Australian consumers of Home and Community Care programs—and we are talking about frail, aged people and people with disabilities and their carers—that, on present funding arrangements, they will have to find $12 million per annum to receive the services across the board. When will these charges apply and how will recipients be assessed to determine whether they are able to pay the fees?

The Hon. R.D. Lawson: The short answer in relation to both those questions is that no decision has yet been made by Government. That answer should, however, be seen in context. In its 1996 Federal budget the Commonwealth Government cut future Commonwealth funding into the HACC program. The announcement was made that the Commonwealth would assume that in the future the shortfall of its projected commitment to the HACC program would be met by fees paid by users of the program. The Commonwealth left it to individual States to make a decision about the level and nature of fees. Two States thus far have introduced user fees policies in relation to the HACC program; South Australia has not. A group of Commonwealth officers developed a fees policy, which has not been adopted by any Government as far as I am aware.

The fees policy identified a number of issues that would have to be addressed if such a mechanism were introduced. Such issues included the scale of fees to be charged; arrangements to determine requirements to pay—concessions; the effect of compensation and full cost recovery; the equity of fee charging; what was to happen in connection with those users who used more than one service; whether there would be a cap on the fees charged; and the status of fees collected by service providers—whether they would be retained by the service provider or whether they would be devoted to the program more generally.

Other issues included whether fees would be charged for information services, advocacy services and the like; fees policy in relation to the provision of equipment, which is an important part of the Home and Community Care Program; and the fees policy in relation to meals services and transport services.

On the subject of meals, it is of interest to note that in South Australia almost $7 million in fees is collected from the HACC program, bearing in mind that the current funding for that program is $70 million. Of that $7 million, about $4 million is collected by Meals on Wheels, which charges $3.40 per meal, or $17 a week. Issues around fees policy would have to determine whether a person who was a recipient of Meals on Wheels and who was therefore paying $17 a week should be required to pay additional amounts.

The method of fee collection is obviously a very important part of any user fees system, and the cost and impact of that collection would have to be determined. Also, issues concerning fee waiving, whether fee collection should be left to individual service providers or whether some form of central agency might collect the fees, and whether or not the voucher mechanism that had been adopted in Tasmania could be adopted are difficult and very important issues.

Ms Stevens interjecting:

The CHAIRMAN: Order! I do not want any interjections. It has all gone on quietly and I will not have any cross talk.

The Hon. R.D. Lawson: Because of the complexity of the issue and because the Government, in accordance with announcements that have already been made, is reluctant to step into the breach in respect of Commonwealth decisions about funding and, as it were, to make up either the funding deficits or to require South Australian citizens to make up those funding deficits, a good deal of consideration has gone into this issue. Cabinet has, however, very recently decided that it would be appropriate for a formal discussion paper to be issued to service providers and to the community generally to ascertain community views on the introduction of such a fees policy.

One difficulty in relation to introducing such a policy is that we are not, as I am advised, entirely sure of the precise nature of the client base. We have, of course, a generalised knowledge that most users are elderly and that a very large proportion of users are full pensioners. It is obvious from the nature of the services being provided and the assessments that are required before those services are provided that we are dealing with a very disadvantaged client base. The Govern-

ment and I, as Minister, do not wish to move precipitantly on this issue. Community consultation will take place before any program is introduced if, in fact, a fees program is introduced in this State.

Mr SCALZI: I refer to page 5.1 of the Portfolio Statements. As the older population in South Australia is growing rapidly, I understand that there is an increasing demand for services and initiatives to help them remain active members of the community. What has the Government done over the past year to help address these demands, and will commitments be maintained?

The Hon. R.D. Lawson: The Government has undertaken many programs to ensure that the demands are met. Within the Human Services umbrella I am determined to ensure that we maintain the level of services that are being provided. I mention briefly a number of the programs. I have already mentioned the Home and Community Care program and indicated that in 1997-98 we spent $70.4 million on that program. Certain additional funds will be made available in relation to the HACC agreement pursuant to an agreement that was reached between myself and the Federal Minister.

The OFTA grants program is one which provides seeding grants to community organisations to encourage full citizenship for older people through participation and integration of community activities. A number of projects are on my desk at the moment for approval under that program, and I hope to be authorising the distribution of in excess of $250 000 to a number of worthwhile organisations. Some of the programs which I have seen and which I am considering include computer and other technological skills projects which are of importance to the active older community.

Other initiatives include multi-generational activities. The *Advertiser* in this State is keen on describing South Australia as 'God's waiting room'. That is a very negative perception and I, as Minister, the Office for the Ageing, the Government and, in fact, the whole Human Services portfolio are anxious to dispel that very negative notion of ageing and to encourage positive notions.

So multi-generational activities are being sponsored not only through the OFTA grants program but elsewhere, and other similar programs are being pursued. I have been keen to ensure that groups representing people of non-English speaking backgrounds and also Aboriginal communities, rural communities, carers and persons at risk, all of whom can frequently be overlooked in funding decisions and many of whom are actually under-represented in programs, are appropriately recognised.

The Grants for Seniors Program, although it is not a large program in the total Human Services portfolio—it involves only about $150 000—will benefit more than 300 organisations, community clubs and the like. Once again, I am in the process of authorising those payments. I am reminded by Mr Fiebig that the total on the Grants for Seniors Program is closer to $200 000 with full year effect. There have been a number of ethnic aged care grants to promote and maintain aged care initiatives run by several peak ethnic aged care agencies, and about $200 000 was provided through Community Benefits SA to the Greek Orthodox community, Greek Welfare Centre, the Coordinating Italian Committee, ANFE and other organisations. This year we have also identified additional funds through the rationalisation of some activities in HACC, and we will be committing funds for the International Year of Older Persons. I am determined to ensure that that year be not just another international year, as they come and go with great regularity. There have been international years in the past that have been very successful in raising community awareness about particular issues. I am fond of citing the International Year of the Disabled.

The CHAIRMAN: I thank the Minister for the information. However, we are running out of time; perhaps the Minister could shorten his answer.

The Hon. R.D. Lawson: This is important.

The CHAIRMAN: The Chair agrees, but it would be helpful to the Committee if the Minister could wind up his answer.

The Hon. R.D. Lawson: Mr Chairman, you particularly would be delighted to know that the International Year of Older Persons will be an important event in South Australia and one which we are determined to promote. There is a whole of Government approach to that, which is being organised through the Human Services Department, with Government agencies and also non-government organisations through the Council on the Ageing (COTA), and also through an organisation called Coalition 99, which will be producing a great program for next year. They are some of the important initiatives for the ageing.

Ms STEVENS: My questions now relate to the Commonwealth/State disability agreement. I would appreciate a short answer. While there is no matching ratio in the agreement, South Australia has matched at just over $2 every Commonwealth $1 in recent years. In a recent media release, the Minister has announced that South Australia will get a total increase of $3.625 million over the life of the new agreement in recurrent funds, plus $1.5 million, once off. Will South Australia match this money at 2:1—'Yes' or 'No'?

The Hon. R.D. Lawson: The decision about funding into the future is not as simple as the member for Elizabeth might imagine. In South Australia, we have been increasing the funding over the years through the disability agreement. Each year, the priorities of Government across the whole portfolio will be determined. As Minister, I am determined to ensure that the disability sector receive absolutely as much as is possibly available within the portfolio. There may be other priorities, such as acute care, the demands of ageing, and also frankly the rationalisation of services between the Home and Community Care program as well as disability programs. One of the very purposes of creating the Department of Human Services was to examine more innovative means of service delivery and to break down some of the barriers that have grown up between disabilities, ageing and other segments of the portfolio.

Ms STEVENS: The new Commonwealth-State disability agreement contains an agreement that Ministers will meet to discuss the huge unmet demand for disability services which this agreement in no way addresses. The Commonwealth's own research via the Australian Institute of Health and Welfare gave a conservative estimate of total demand at about $500 million, not the $338 million which has been provided. The Commonwealth's own review of the Commonwealth-State disability agreement in its final report gave a figure as high as $900 million. As the Minister just stated in his previous answer, there may be other priorities, but when will the Ministers meet and when can we expect some action?

The Hon. R.D. Lawson: The renegotiated Commonwealth-State disability agreement contained a provision that in the first year of the agreement there will be a meeting between the Commonwealth Minister and State Ministers to examine the so-called unmet demand. It was a matter of disappointment that, having commissioned the Australian Institute of Health and Welfare report, the Commonwealth

did not in the final negotiations make any contribution to addressing that. We did, however, achieve some increases in the Commonwealth funding. We did, of course, obtain an additional bilateral payment from the Commonwealth. However, I am determined to ensure that that meeting with the Ministers does take place. I am advised that, at officer level, the Commonwealth and State administrators have started planning such a meeting. No date has yet been set. Obviously, if there is any Federal election, it may well be that the ministerial meeting will have to be built around that event.

Mr BROKENSHIRE: I am very interested in this issue of ageing. I refer the Minister to page 5.6 of the Portfolio Statements. With respect to fees and charges for State Government and residential services, is the State Government considering the introduction of complementary fees and charges for State Government managed and/or funded aged care residential services to those fees and charges that are applying under the Commonwealth's aged care reforms?

The Hon. R.D. Lawson: I am aware of the honourable member's interest in aged accommodation. As members will know, in mid-1997 the Commonwealth did introduce a range of changes to the residential aged care sector. In particular, the Commonwealth introduced accommodation charges for nursing home level care and also income tested daily fees for all services. The South Australian Government, through country hospitals and metropolitan health units, manages over 1 200 aged care beds across the State. Of course, those facilities are not covered by the Commonwealth decisions.

A number of policy issues arose in consequence of the Commonwealth's deciding to change the regime. I understand that a decision has been made very recently in relation to this matter, and I will take the honourable member's question on notice and bring back a reply in relation to any decision that has been made, if one has yet been taken, in relation to that.

Ms STEVENS: My next question relates to unfunded wage increases. I wish to quote from a letter written to the Minister on 29 April by Ms Terese Edwards of the SACOSS policy council. I understand that she was part of a delegation from ANGOSA who met with the Minister on Wednesday 26 November 1997 to discuss the disquiet of its membership regarding the current options coordination process and, in particular, IDSC. She writes that another issue was raised at that meeting, that is, the issue of unfunded wage increases. The letter states:

> Organisations are now experiencing extreme difficulties in reconciling budgets that include continued and significant increases, all of which are out of their control and industrially must be adhered to, such as national wage increases and superannuation contributions. The timing is most pertinent as many organisations are now commencing their budgets for 1998-99 and hard decisions will need to be made including a reduction of support hours, the only cost saving avenue available, with a possible reduction of staff. If there was any 'fat' it is reasonable to state that it disappeared with the 3 per cent efficiency cuts and the subsequent yearly increases in operational costs. I appreciate your willingness to review the situation and give the sector a clear response about funding increases to match wage increases as this concern will gain momentum as we prepare for the next financial year, and agencies do not wish to cut services.

When I was given this letter, they had not received a reply from the Minister. Will the Minister now tell us whether he will build in funding increases to match wage increases as has been requested?

The Hon. R.D. Lawson: It is not only non-government organisations which are under funding pressures. My colleague the Hon. Dean Brown has today indicated that Government agencies are under funding pressures and that centrally imposed requirements have to be met. So far as I am aware, no decision has yet been taken in relation to the matters raised in that letter. I will take the question on notice and if there is any decision, of which I am not aware, I will provide the honourable member with the information.

Mr SCALZI: I refer to page 5.6 of the Portfolio Statements regarding the International Year of Older Persons—and I know that the Minister touched on the subject earlier. I understand that 1999 has been proclaimed by the United Nations as the International Year of Older Persons. What will the Government do to mark that year?

The Hon. R.D. Lawson: Bearing in mind the interest that some members of the Committee showed in the answer I previously gave to this interesting subject, I will keep my remarks short. I have already touched on a number of them. I indicated that Coalition 99, auspiced by the Council for the Ageing, has been working in partnership with non-government, private organisations, with media and with professional university bodies to develop a program of events and activities which will involve communities right across the State. It seems to me that, if this important year is to be a success, it is important to engage a wide cross-section of the community.

It seems to me that there is little point in imposing upon the community some Government-inspired program for the year. Coalition 99 has already signed up about 70 participants, and planning is already beginning. I noted the fact that under the chairmanship of Ms Charles, as Chief Executive of the Department of Human Services, a whole of Government approach is being adopted to Government agencies. When I looked back at what happened after the 1981 Year of Disabled Persons and saw the measures that had been taken by Government agencies and departments during that year, it brought home to me the fact that, within their own internal organisations, Governments can bring about quite a number of significant changes. I am determined to ensure that across the whole of Government—and I have the cooperation of all Ministers—we will be able to show some positive achievements.

The Ministerial Advisory Board on Ageing, established under the Office of the Ageing Act, which advises me (and which is led by Dame Roma Mitchell), has already completed consultations with the chief executives of Government departments, and the board has passed on to me advice about certain suggested themes and policy issues that might be pursued. The board is keen to put particular emphasis on rural ageing next year, in recognition of the fact that more than a quarter of older South Australians live outside the metropolitan area. I already noted Professor Gary Andrews' important role but, as I say, a whole of community response will be required, and I am looking forward to it. Mr Fiebig might like to add something from his perspective, both as a member of the ministerial advisory board and as director of OFTA.

Mr Fiebig: The year will start on 1 October. We are working with the Commonwealth and the other States to come up with a national healthy ageing strategy that will launch the year and provide a framework around which a range of events will occur throughout the year, and which will provide an ongoing framework that the State hopes to use in order to tackle a range of issues around income security and taxation in relation to the Commonwealth and a number of issues that came up during consultations over the 10 year plan, in which it has been very difficult for the State to make progress. We hope that that framework will enable us to take

up those issues on behalf of older people in South Australia during the continuing consultations, particularly in rural areas, raising some of those issues as some of their major concerns at the moment.

Shortly, a published plan of activities will come out for the year, which will cover a number of areas including seminars, events, running things during law week, potentially using the Mitchell Orations and other events that will particularly range over areas of the rights and responsibilities that exist in relation to older people, particularly their responsibilities potentially back into society, and it will also look at issues around the social capital that is generated by the older population in South Australia.

Ms STEVENS: Currently, 1 100 people in South Australia are in three institutions: Minda, Julia Farr and Strathmont, and I suggest that the only other place in South Australia where such numbers are in congregate care are in our prisons system. What are the Minister's plans to change the situation?

The Hon. R.D. Lawson: The first thing that should be said is that the number of persons with disabilities, especially those with intellectual disabilities, in institutions is now substantially fewer than it was some years ago. The process of deinstitutionalisation and the return to community living for people with disabilities has been going on for some time. Presently in Strathmont there are about 370 residents. It is proposed that a number of those people will return to various forms of community living as a result of the redevelopment of the Strathmont campus.

In 1995, the Intellectual Disability Services Council undertook an examination of the future of Strathmont. The Parents and Friends Association of Strathmont supported a proposal for the redevelopment of part of the centre. It recommended partial closure of the site, with 150 clients moving into the community, by constructing a new 40-bed aged care facility and by providing community housing arrangements for the remaining residents. That proposal is continuing, and I am glad that in this budget a capital allocation was made to facilitate the progress of that development. It has not been possible to continue the rapid pace of deinstitutionalisation that occurred initially. Originally, the number of residents in Strathmont was 600. If that figure is not correct, I will correct the record and let the honourable member know in due course.

The idea at Strathmont is to redevelop the villas there. Already, one villa has been closed and has been redeveloped as a model to ascertain its suitability and also to ascertain whether it is practicable to undertake that type of renovation. Already, some of the land at Strathmont has been exchanged for a 1.3 hectare site at Northfield which was previously owned by the then named MFP Development Corporation. The aged care facility, which I think will be for 40 places, is an exciting development. I hope that, as this process develops, funds will be released to establish other group homes in the community. Of course, there will be an ongoing requirement for IDSC to support any people who leave Strathmont for community living. I am advised that almost all those at Strathmont at the moment do require relatively high continuing support. Of course, the costs of that are not inconsiderable.

The Julia Farr Centre is another organisation which has substantially downsized the number of residents in recent years. There are still 241 people at the Julia Farr Fullarton campus. However, the number previously accommodated was something over 700 but, once again, there is a reluctance, I am advised, on the part of many of those remaining at the Julia Farr Centre to proceed with the process of deinstitutionalisation. Julia Farr is establishing its own aged care facilities at Mitchell Park and Paradise on smaller sites to reduce the institutional nature of the care that is presently provided.

The cost of operating the Julia Farr Centre is in excess of $25 million for the 234 patients, which obviously shows an annual cost in the order of $100 000 per client a year. A change management process is under way at the Julia Farr Centre and that has been continuing for some time. There are obviously staffing and industrial issues that have to be resolved. The reluctance of some of the clients of Julia Farr to adopt other forms of accommodation is shared by many of the staff of that organisation.

Minda likewise is changing the model. It has opened a 48 bed aged care facility on the campus at Brighton for older persons with intellectual disability.

One of the great things about deinstitutionalisation is that in South Australia we presently do not have any children in institutional care, and that is a very positive development. The process of reducing the size of these institutions and providing more community based and less institutional based care is one that is progressing. It is not progressing as fast as some of those who are more zealous might require, but I am determined to ensure that the process is pushed on.

At Minda the number of residents is 344 but it supports 174 people with intellectual disability in group homes and provides outreach support to a further 44 persons. That seems to be the model that will prevail into the future.

Ms STEVENS: I am pleased to hear that the Minister is determined to ensure that the process of deinstitutionalisation is be pushed on. However, I bring to the Minister's attention some information I have and which is part of feedback given from South Australia to a national project undertaken by the National Disability Advisory Council this year on deinstitutionalisation. This feedback was received following a consultation with IDSC, and question No. 8 is the one to which I draw the Minister's attention. It concerns barriers which both Government and non-government organisations may be facing in the process of deinstitutionalisation and strategies that have been developed to overcome these barriers. This is what the IDSC said:

> I [the project officer] have been advised by the Intellectual Disability Services Council that barriers encountered include competing pressures for efficiencies, confusion about who will auspice the new services, shortage of public housing, lack of transport, lack of community endorsement and commitment—

The CHAIRMAN: The time has arrived, and I ask that that question be taken on notice. Questioning is concluded. I declare the examination of the votes completed. I lay before the Committee a draft report.

Mr BROKENSHIRE: I move:

> That the draft report be the report of the Committee.

Motion carried.

The CHAIRMAN: I wish to thank the table officers and *Hansard* for their assistance and forbearance during Estimates Committee B hearings, I thank all members for their participation and I declare the examination completed.

At 9.56 p.m. the Committee concluded.