HOUSE OF ASSEMBLY

Wednesday 21 June 2000

ESTIMATES COMMITTEE B

Acting Chairman:
Mr I.P. Lewis

Members:
Mr M.R. De Laine
Mrs R.K. Geraghty
Mrs K.A. Maywald
Mr E.J. Meier
Mr G. Scalzi
Ms L. Stevens

The committee met at 11 a.m.

Department of Human Services, $1 327 033 000
Minister for Human Services—Other Items, $9 020 000
Administered Items for Department of Human Services, $500 000

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

Departmental Advisers:
Ms C. Charles, Chief Executive Officer, Department of Human Services.
Ms J. O'Callaghan, Acting Executive Director, Statewide.
Ms R. Ramsey, Executive Director, Country Division.
Ms J. Murray, Manager, Executive Services.
Mr F. Turner, Director, Finance.

The ACTING CHAIRMAN: The estimates committees are relatively informal. The committee will determine an approximate time for the consideration of proposed payments to facilitate the change over of departmental advisers. I understand that the minister and the opposition spokesperson have agreed on a timetable for today's proceedings. Members should ensure that they have provided the chair with a completed request to be discharged form. If the minister undertakes to supply information at a later date, it must be in a form suitable for insertion in *Hansard*, with two copies submitted to the Clerk of the House no later than 7 July.

I propose to allow the lead speaker for the opposition and the minister to make an opening statement if desired of about 10 minutes but no longer than 15 minutes. There will be a flexible approach to giving the call for the asking of questions based on three questions per member from alternating sides. Members may also be allowed to ask a brief supplementary question to conclude a line of questioning. However, a supplementary question will be the exception rather than the rule and entirely at the discretion of the chair. So, if the chair cannot count, the committee will refer to rule number one, which is that the chair is in charge. Subject to the convenience of the committee, a member who is outside the committee and who desires to ask a question will be permitted to do so once the line of questioning on an item has been exhausted by the committee. An indication to the chair in advance from a member outside the committee wishing to ask a question is necessary.

Questions must be based on the lines of expenditure as revealed in the Estimates Statement. Reference may be made to other documents including the Portfolio Statements. Members must identify the page number or program in the relevant financial papers from which their question is derived. Questions not asked at the end of the day can be placed on the next day's House of Assembly *Notice Paper*. I remind the minister that there is no formal facility for the tabling of documents before the committee. However, documents can be supplied to the chair for distribution to the committee. Incorporation of material in *Hansard* is permitted on the same basis as applies in the House, that is, that it is purely statistical and limited to one page in length.

All questions are to be directed through the chair to the minister and not to the advisers. The minister may refer questions to advisers for response or undertake to bring back a reply. I also advise that some freedom will be allowed for television coverage and filming from the northern gallery. I remind all members, ministerial advisers and observers that mobile phones should be turned off. If a mobile telephone rings during the sitting of the committee, the member or adviser concerned will be invited to drop the offending telephone into a bucket of water. I declare the proposed payments open for examination and refer members to page 53 of the Estimates Statement and volume 2, part 6, of the Portfolio Statements. Does the minister wish to make a brief opening statement?

The Hon. Dean Brown: Yes, Mr Acting Chairman. The Department of Human Services in the health area has focused strongly in the past 12 to 18 months on producing a better outcome and better and more targeted health services for the people of South Australia. We know there is unprecedented demand both in South Australia and around Australia. We know that that unprecedented demand will continue for a number of reasons, one being the ageing of the population and another being new medical technology. We have responded as a department by carrying out a series of clinical reviews so that we make sure that our major public hospitals are able to cope with areas of specialisation and, in particular, increasing levels of technology and expensive areas of technology, but at the same time provide a broad service to cover all of our community.

By that I include not just the metropolitan area but also, very importantly, the country areas. Here in South Australia in country services we have done it more effectively than have the other states because we kept all the smaller acute country hospitals and turned them into organisations that provide high and low level aged care. Invariably they provide community health care, and in many cases one will find that the doctor's surgery is part of that facility. Country South Australia has done it more effectively than have other states of Australia. Our concern is making sure that we get timely treatment for the increasing demand on the public hospital system.

In recent days considerable attention has turned to the level of private health insurance because the federal government policy has been, first, to give a rebate and, secondly, to impose penalties on those who have not taken out private insurance by 30 June on an ongoing basis.

As a result, in the past two months there has been a significant increase in interest and sign-ups to private health insurance. Today, I understand, the federal minister indicated that he may consider extending the period for signing up

beyond 30 June. There is evidence that people are taking up cheaper forms of private health insurance—and by cheaper forms I mean that, often, they will pay the first $200 or $300, or more than that, before claiming against the private health insurer—and the intention may well be that those people will continue to use the public hospital system. There are signs that an increasing number of people with private health insurance use the public hospital system, particularly for emergencies. Elective surgery may be the only area where they will not use the public health system because of the waiting list.

An increase in private health insurance is welcome, because it should take some pressure off the public health system, but I question how much. It must also be understood and acknowledged that, here in South Australia under the Australian Health Care Agreement, we have a trigger point and, once private health insurance rises above $33.1 million, for every percentage rise above that we receive $7 million less from the federal government. So, there will be a reduction in funding to the states as a result of an increase in private health insurance. Therefore, if the level of private insurance cover does not result in a reduction in the number of people using the public hospital system, it will put even greater pressure on that system.

As a department we have put additional resources into key areas this year. We have tried to ensure that money for the treatment of patients is a first priority and, secondly, where there are special needs in the community—and a classic example of that is mental health—additional resources are provided. This morning, I announced details concerning dental care here in South Australia and, no doubt, that will be a matter for discussion later today. As a department, our focus is understanding the needs of the community and providing more resources in those areas, maximising the number of people treated in the public hospital system and, by improved efficiency, coping with the demand in delivering services.

I want to compliment the people who run the public hospital system, particularly the Department of Human Services staff, on their tremendous commitment not just in the past year but over recent years—the doctors, the nurses, the administrators and the staff of the department—in working through some fairly major reforms in clinical services and, at the same time, coping with the extra demand.

There is one other point that I want to make and that is the growing disparity in wages and income levels around the whole of Australia. There is a growing gap between the city and the country; and there is a growing gap between the capital cities. Sydney is surging ahead with salary increases while many of the other capital cities are lagging well behind. As a result, not only is the ageing factor in some states greater than in others but, here in South Australia, we have a higher percentage of people over 65 years compared with the level in other states. There is also an income disparity developing where a growing percentage of the population are low income earners—both in the city and the country. There needs to be national compensation for states with a lower average income so that the standard of health care, dental care and other health services for the people is maintained.

Whilst the Australian health care agreement adjusts for age and population factors, it does not adjust for significant income differentials between the states. I believe that that area must be redressed urgently by the federal government; only the federal government can do it, otherwise all the burden for that income differential falls onto the state government. State governments are not capable of picking up that sort of differential. They are some of the key issues that we are trying to grapple with, particularly in the health area. I think that this coming year will be another period where there will be growing demand, and we are trying to make sure that we handle that growing demand. No doubt during the day I will be able to give some information about how we are doing that. I conclude my remarks.

The ACTING CHAIRMAN: Does the lead speaker for the opposition wish to make an opening statement?

Ms STEVENS: No, sir. My first question relates to budget paper 4, volume 2, page 6.23. In spite of the assurances that the minister gave to the parliament on 2 May about our hospitals being prepared for the winter rush, the system failed on Monday night and a crisis situation occurred when hospitals were full and diverting patients even before the expected flu epidemic. On Monday night ambulances were being diverted from the Flinders Medical Centre, the Queen Elizabeth Hospital and major private hospitals, and I have been told that a sign at the Royal Adelaide told a long queue of ambulances that there was a nine hour delay. I have heard a report of one patient from Minda who was suffering from bleeding in the urine. An ambulance had been called; it could not attend Flinders or the Queen Elizabeth Hospital and was diverted to the Royal Adelaide Hospital. It finally returned to Minda at about 2 a.m. without that person being admitted anywhere.

On 2 May the minister said that because of the expectation of a flu epidemic he had taken steps to ensure that our hospitals could cope, but this budget cuts outpatients in metropolitan hospitals by 93 000 and inpatients by 4 000. So, why did the system fail on Monday night? Given the latest budget cuts, can the minister give a categorical undertaking that this will not happen again?

The Hon. Dean Brown: The system did not fail on Monday night. There were beds at the Royal Adelaide Hospital, and it was able to take the diversions despite the fact that three private hospitals closed. So, a lot of the pressure came out of the private hospital sector, not the public hospital sector. Three private hospitals closed, and two public hospitals were on diversion. The Royal Adelaide Hospital was still able to cope. I know there were some delays, but we have always said that that will be the case when we have increased pressure as a result of winter illnesses.

I assure the honourable member that we have put money aside, and if we need to open up additional beds we will. On Monday night there was the issue that the three private hospitals did not inform the Royal Adelaide Hospital of diversions, as they are expected to do under a protocol I set up last year. That is unfortunate. Amongst the public hospitals we do have a notification system. It has to go from the most senior executive officer on duty at the time to the appropriate hospital to where the diversion is occurring, so there is then full warning. We have taken that up today with the private hospitals.

I stress the fact that in wintertime there will be times of increased demand but, even though it was very tight on Monday night, we still had some beds at the Royal Adelaide Hospital. No-one who needs urgent attention will be turned away. Today I am able to report that, for instance, at the Royal Adelaide Hospital there are about 40 vacant beds; and the system today is coping, as it did last night, reasonably well. We get daily reports and we work on where the pressures are. If the pressure really builds up, clearly we will need to open up additional beds. I have never said I expected

the system to cope with everyone on exactly the same basis as when it operates under normal pressure. I have said that during the winter illnesses there will always be delays, and we apologise for them where they occur. We have a triage system, and those who need urgent attention will get it as quickly as possible.

Ms STEVENS: I wish to ask a supplementary question.

The ACTING CHAIRMAN: My subjective opinion of whether or not it is a supplementary question will determine that.

Ms STEVENS: I asked why the system failed on Monday night and the minister said it did not fail, and then he gave an example of how it did fail, because the system of notification of diversions did not work in relation to private hospitals.

The Hon. Dean Brown interjecting:

Ms STEVENS: But you are responsible for setting systems in place to ensure that we have people being placed appropriately in care, and that one did not work. I return to the minister's statement of Tuesday 2 May, when he detailed three steps that he was putting in place to cope with this winter. The first of those was to increase the potential for additional admissions through the A&E departments of our major hospitals. I again put it to the minister that certainly on Monday the only major hospital available was the Royal Adelaide Hospital. What has happened in relation to that first point? When will this $2 million, which apparently has been set aside, be used so that we have additional hospital beds and we do not have the same situation occurring again?

The Hon. Dean Brown: The member's claim that the Royal Adelaide Hospital was the only hospital that had any vacant beds is not correct. The Noarlunga hospital had 32 beds; and the Women's and Children's Hospital and the North-Western Hospital had some beds available. We had three private hospitals—

Ms STEVENS: The QEH was closed, with no beds.

The ACTING CHAIRMAN: Order! Remarks from both the members of the committee and the minister will be addressed to the committee through the chair.

The Hon. Dean Brown: Three private hospitals were unexpectedly full, and they diverted to the Royal Adelaide Hospital. We put in place a procedure 12 months ago, and we have again reminded the private hospitals of that procedure where, if they divert to a public hospital, they are expected to notify the most senior administrative officer of the hospital that they are diverting to. But we coped. That occurred in the public sector. The two major diversions that occurred were the Flinders Medical Centre and the Repatriation General Hospital.

I stress the fact that we had spare beds down south at the Noarlunga health service, the Royal Adelaide Hospital, Modbury and at the Women's and Children's Hospital. So, the member cannot claim that the system failed: it did not. In fact, the system worked very well. There was a diversion, as the whole system is designed to do, and we coped with it.

Ms STEVENS: My next question relates to the Australian health care agreement. I refer to budget paper 4, volume 2, page 6.39, which shows that the commonwealth grant under the health care agreement has increased this year by $28 million. Budget paper 4, volume 2, the bottom of page 6.23, gives the net output expenditure figures for admitted and non-admitted patient services. In 2000-01, funding for admitted patient services will increase by $3.2 million from $1 216 million to $1 219 million, or just 0.24 per cent, compared with an inflation value of 2.8 per cent; non-admitted patient services will increase by $2.6 million. So there is a total increase over both of those categories of $5.8 million.

How has the extra $28 million from the commonwealth health care agreement been allocated? It does not appear to have been passed onto the hospitals for patient services because, as I have just said, your own papers show only a $5.8 million increase in those categories.

The Hon. Dean Brown: The first thing I highlight to the honourable member is that she needs to read all the pages of her budget papers and she should also have read 6.44 which clarifies the point; that is, if you are making a year by year comparison of 1999-2000 with 2000-01, then you have to take account of one off circumstances. Can I give some examples? The basis for which insurance has been allocated to hospitals has changed. In 1999-2000, there were 26 pay days in the year. In 2000-01, there are 25 pay days. That is just a quirk of when the pay day occurs. People are still being paid on exactly the same basis, the same number of staff, but, because of where the fortnight occurs, there was an additional payment last year compared with this year, and there are a number of other circumstances such as that.

I will give the honourable member the actual figures which absolutely debunks the claim that we have taken the $25 million of federal money and put it somewhere else, as was claimed on radio last Friday. That is exactly the same line that the honourable member is raising here. If you take our casemix allocations to the public hospitals in South Australia this coming year compared with the last year, the allocation this coming year is $39.3 million higher than it was last year. There is about $25 million of increased funding from the federal government—not all of which has gone into casemix but most of it has gone into casemix—and the state government has provided the extra money. What this highlights is that, if you are comparing one year with the next and you are concerned about the actual services being provided within the hospital, the best comparison is made by comparing casemix allocation one year with casemix allocation the next year.

In the metropolitan area the increase is $29.6 million in casemix allocations and in the country it is $9.7 million extra. So you can see from that that we have not, as I was accused of doing, stolen or taken the money and put it somewhere else: we have allocated $39.3 million extra this coming year.

Ms STEVENS: I am interested that the minister has raised the comments of Dr Wooldridge the federal minister because I also heard his statements on radio on 15 June. It is interesting that he talks about $26 million, the minister talks about $25 million and we think the budget papers show $28 million. However, that aside, on radio Dr Wooldridge said:

> And I am very frustrated when I give this year South Australia an extra $26 million for health care and they take $20 million of their own money out. So the whole amount that we give does not get into health care.

Is the minister saying that the federal minister was not telling the truth?

The Hon. Dean Brown: No, I am saying that the federal minister failed to read the budget papers. I have a copy of the comparisons he had (which were prepared by one of his staff members) and it was along exactly the same lines as the honourable member has raised. In making the comparison he failed to look at the other detail in the budget papers, particularly 6.44 and 6.45, which highlight how there has been a change in some of the accounting procedures. You have to take account of that. If you are going to talk about the

genuine increase in funding or decrease in funding, then the important thing is how much money will be allocated to these hospitals to deal with patients. That is the crucial issue—what it is all about—not an accounting non-cash issue of insurance. The $36 million, the variation, is taken into account by a non-cash accounting adjustment in the way in which insurance was handled in the public hospital system. That is irrelevant.

What is important is how much money we are giving to the hospitals to treat patients and, as I said, it is $39.3 million extra this year for casemix allocation compared with last year. Certainly, we have now worked this out, because it was only at the end of last week that we had finalised the budgets for the hospital. I will certainly be indicating to the federal minister what the figures are, but I was not referring to his conversation at all: I was referring to another interview I had heard on radio where they had jumped to a false conclusion. I just say that I wish people, if they want to ask that, would come to me—and some people have come to me—because I would be able to correct them. If you are making a comparison, compare apples with apples; that is, compare the number of patients we are treating one year and the money we have allocated for treating those patients one year with the number we are allocating for the next year.

Ms STEVENS: Will the minister tell me what page he referred to in the budget papers when he was answering my question about casemix figures?

The Hon. Dean Brown: They are not, because—

Ms STEVENS: So how could I have found them?

The Hon. Dean Brown: You cannot, because—

Ms STEVENS: You suggested that I should have read the papers more thoroughly.

The Hon. Dean Brown: The part I was saying you should read more thoroughly are pages 6.44 and 6.45. On page 6.44 it is stated:

> The major variations between the 1999-2000 budget and the 1999-2000 estimated results include the following:
> · an adjustment of $36 million to the estimate of expenditure of funds, classified as non-commission funds, based on an assessment of the audited consolidated financial statements.

It has no impact on cash at all. I will not go through all the dot points but seven of them are listed. The important thing is that we have an allocation of health funds, both state and federal, we then sit down after the budget and work out what the specific allocation will be to the individual hospitals, and we are able to make a direct comparison with casemix allocations for last year compared with this year. When I say 'last year' I am talking about actual expenditure last year.

Ms STEVENS: On 26 May you said on radio 5AN that the human services budget had been cut in real terms. As we all know, there is a cash increase of $45 million from $2.633 billion to $2.678 billion, or 1.7 per cent against inflation of 2.8 per cent, which is a net cut in real terms. Budget paper 4, volume 2, page 6.39, shows that commonwealth grants for human services have increased this year by $47 million. Will the minister confirm that the cash increase in this year's budget of $45 million is made up entirely of the increase in commonwealth grants of $47 million and that there has actually been a decrease in state funding?

The Hon. Dean Brown: The honourable member is again trying to compare a pear this year with an apple last year. The budget papers list the specific allocations from the federal government, but there is a series of payments. For instance, one of those is a capital payment that was made last year under recurrent expenditure for the car park. That is a one-off, unique expenditure which has inflated the figure for last year compared with this year. If the honourable member wants to make a comparison, she must compare what is actually going to be spent on these services with what has been allocated to hospitals—and I have already given that figure.

The 1.7 per cent increase in the total allocation for the Department of Human Services is correct. The Treasurer said so in his speech, and I have acknowledged it publicly. However, regarding treatments within hospitals, which I think the honourable member is trying to highlight—and I think it is the best benchmark of all—there has been a 39.3 per cent increase in both state and federal additional funds.

Mr SCALZI: I refer to page 6.3 of the Portfolio Statements, which describes as an ongoing portfolio outcome that individuals and families receive care and support for their health and well-being at a cost which the community is willing to bear. What are the current waiting lists for public dental services and the reasons for their existence, and what strategies are in place to improve access to dental services in order to improve the health and quality of life of those who are currently awaiting treatment?

The Hon. Dean Brown: I appreciate this question from the honourable member, because he has many older people in his electorate and these are the people who rely most on public dental services. This morning, I announced that we have found an extra $2 million from a one-off benefit that we received through a lease agreement for one section of the department, and that money has been allocated to dental services. This is in addition to the $1.2 million announced in the budget through co-payments. This means that, this year, $3.2 million will be allocated for additional services over and above what was allocated last year.

We have reached an agreement with the Australian Dental Association under which it will undertake this work at a concessional rate to the public system. There will be a small co-payment similar to the co-payment that rural patients pay when they visit their private dentist. This means that we will be able to provide an additional 14 000 treatments this year in the public dental system. Allocation of those services will be through the public dental service. We will be able to step up the level of activity quickly because we will not have to build up the capacity. The capacity is already there in the private dentists, so we will be able quickly to start allocating those 14 000 dental services this year. I think that is very important.

In addition, we are taking a number of other initiatives with dental services. We have allocated $200 000 under the capital works program to refurbish mobile dental vans in the Mid North and the Riverland, and a new van will be provided for the Far North of the state in remote areas and Aboriginal communities. Those vans are expected to be ready by the middle of the year. We have allocated $370 000 for air-conditioning of the Adelaide Dental Hospital to improve patient comfort.

We have allocated $750 000 for urgent capital works at the orthodontic clinic of the Adelaide Dental Hospital as part of the ongoing development of the hospital. I visited the dental hospital this morning and, thinking back to my first visit there about 2½ years ago, I must say that the hospital has been significantly improved. We have allocated $340 000 to develop a new two chair clinic at the Mount Barker Hospital for adult patients and to complement the existing school dental service. There is a further $110 000 to improve wheelchair facilities for patients with special needs, and we will upgrade the information management system of the

dental service. This is important, because it will allow for improved provision of information between the dental clinics in the state and ensure that we better manage the current demand. There is $250 000 to establish a new general dental unit in the western suburbs to service one of our higher need areas.

That is a fairly significant capital works program in just the dental area alone. I assure members that the dental service will receive the normal increases from inflation and enterprise bargaining in the coming year. These 14 000 services are additional to the services provided through the dental service. I think they will go some way towards helping to relieve some of the pressure.

There are 100 000 people on the waiting list, which has been building up for a number of years, particularly since 1996. I do not expect to be able to solve this problem in one year. Ultimately, the answer is to have a national dental service which would operate in much the same way as the present Medicare system where a person who visits a doctor gets 85 per cent of the standard fee paid by the federal government. I believe that there also needs to be a national scheme for dental services, so that people who visit a dentist will get 80 or 85 per cent of the standard fee paid.

This is important, because the demand on the public dental system in this state and throughout the rest of Australia has increased, particularly as a result of the ageing of the population and the increasing number of people on very low incomes. Two years ago, 342 000 people were eligible for public dental services in South Australia. Two years later, the figure has increased to 441 000. That is a 30 per cent increase in the number of people eligible to receive public dental services in South Australia in just two years.

The state cannot expect to be able to cope with this sudden increase in demand. The only way this can be effectively dealt with is by having a national dental scheme and for it to be treated in much the same way as normal medical services. I have taken this matter up previously with the federal minister, as have some of the other health ministers, and I will continue to push for it. I will raise the matter at the ministers' conference in July this year.

Mr SCALZI: With reference to the broader oral health care issues in South Australia, will the minister advise of further policy developments which may lead to a possible improvement in dental services?

The Hon. Dean Brown: First, there is the importance of having a national scheme. As I said, the waiting lists in South Australia are not unique: they exist in all other states of Australia and are increasing dramatically. A national scheme is required to fix that problem. The other important issue is to make sure that we maintain high standards of teaching, research and public health treatment in South Australia. We train more post-graduate dental students than any other state of Australia. South Australia is the national centre when it comes to university and post-graduate training. These students come from a wide range of areas (not just Australia) including many of the surrounding countries, in particular, the Pacific islands.

In conjunction with the University of Adelaide, we are looking at the feasibility of establishing a centre of oral health. We believe that that will become an even sharper focus for what has been done here. This morning I was at the Colgate research facility—the other important centre we have here—which is regarded as the best dental research facility in Australia. It is heavily supported by Colgate, which we appreciate greatly, and it has operated in this state for a number of years. I think that this highlights how the state has become a centre of excellence in training, research and services in the dental care area. However, that does not mean that we do not have increasing pressure on the public dental system.

Mr SCALZI: Output class 6.1 on page 6.20 refers to admitted patient services. What impact will the increase in the private health insurance participation rate have on such services?

The Hon. Dean Brown: I touched on this briefly in my introductory remarks, but I will enlarge on it. Private health insurance across most of Australia had dropped to about 30 per cent. I think the figure here in South Australia was about 30.2 per cent some 12 to 18 months ago. The federal government introduced its 30 per cent rebate scheme for people taking out private health insurance as a carrot to encourage people to take out private health insurance. Here in South Australia that had only a marginal effect on the health insurance rate. I think it lifted after about 12 months to about 30.7 per cent.

The federal government then announced that there would be a whole-of-life policy—something that a lot of people had pushed for for a long time; it had been talked about and debated nationally—to encourage younger people to join early, because the real demand on health services occurs with people at about 50 years of age and over. Health care costs for those people almost exponentially rise to a point where someone about 75 years of age has an annual health care cost of about $7 000. That includes nursing bed accommodation, where necessary, but the average is about $7 100 a year.

Therefore, I encourage people not only to take out private insurance but also to use it to ensure that we have an effective abolition of the gap, because without abolishing the gap I think that it places an unfair expectation on people to take out private health insurance. They have done the right thing: they have paid the Medicare levy on their earnings and they have taken out private health insurance, so they should not have to pay a third time with the gap.

I might add that people with private health insurance can enter a public hospital and pay no gap for hospital services. In terms of doctor services, that is a matter for them or their health fund to negotiate with the doctors involved. However, in some cases, for instance, in the country where we pay a loading, the Department of Veterans Affairs has now agreed to pay the same loading as we do in the country. Increasingly, I think they are sorting out the issue of the gap, and from 1 July I think that all health funds are required to offer a no-gap policy.

The evidence is that, as I mentioned earlier, people are going into the cheaper forms of insurance. They might have a rebate, particularly younger people. They will say, 'We know the public hospital system is there as a fall back'. A lot of people say to me, 'Why don't you stop people with private health insurance using the public hospital system?' The answer is we cannot. Under the Australian health care agreement we are barred from doing so. So we have a universal health care system in Australia and I support that very strongly, but I believe that the private health insurance system must be attractive enough to allow people who have taken it out to use it because they have paid for it, and to use it without the risk of having to pay an unacceptable gap.

I think there are still quite a few things that the private health insurance industry needs to clean up with the medical profession. People should receive one account. If you build a house you pay a builder and all your payments go to the one

builder even though you have a plumber, an electrician, a tiler, a carpenter and everything else. However, one of the big problems in a number of cases where people have used their private health insurance is that they receive not only a hospital bill but also a bill from the specialist and a bill from the anaesthetist; and in another case I heard that the patient also received a bill from an assistant anaesthetist and an assistant surgeon. As one person said to me, 'I didn't ask for an assistant surgeon to be present'.

We need a system where, before the person goes into hospital, if at all possible, and particularly where they need surgery, they should be able to negotiate a rate and pay one person or one organisation. All the medical expenses and the hospital expenses should be wrapped up in the one account. Hopefully, we are moving towards that, but something must be done to bring private health insurance into the new millennium and design it so that people know with great certainty what their payments and obligations will be, and to try to negotiate to eliminate those, if at all possible.

The ACTING CHAIRMAN: Following a careful review of standing orders about 10 years ago by the Hon. Martin Evans and others, it was determined that the chairman, as a member of the committee, could ask questions, and I propose to do so now. My question follows on precisely from what the minister has been talking about, and it is something that has been bothering me for quite a while. Has the state government undertaken to get the federal government to lean on the health benefit insurance funds or to legislate to prevent the health benefit insurance funds from offering junk policies which plump up the insurance funds' bottom line and in doing so enhance the Commonwealth's tax collections from them on their profit, and in the process of leaning on those funds reduce or eliminate the tax?

When such policies are taken out by people they reduce or eliminate the tax surcharge that they otherwise, as prospective users of the system, would have to pay when they take out that policy, and result in those policy holders using the public hospital system or indeed the public health system overall, as mentioned by the minister. Has any attempt been made to get the federal government to lean on those funds to stop them offering the junk policies?

The Hon. Dean Brown: I guess this is something that is more recent. There has been a low level of participants in the private health insurance area taking out what are cheap packages, and particularly people on high incomes. First, they are able to avoid the extra levy that is imposed on them because they do not have private insurance. I think the point where that applies is about $70 000, and so those earning over $70 000 have an extra levy imposed if they do not have private health insurance. Taking out a cheap policy is one way of getting around that. Taking out a cheap policy means that you still receive the 30 per cent rebate. Of course, taking out a cheap policy now allows you to avoid a significant increase in premiums if you decide to step up your level of care later in life and to rely on the public hospital system.

State health ministers have raised this issue with the federal minister. It was raised at a time when the extent of the problem was not as great as it is now, because I believe in the past month or so there has been a significant increase in these cheaper policies, and we could well find that our insurance levels go up, we lose money under the Australian health care agreement and the pressure on the public hospital system remains because they will continue to rely on the public hospital system.

To give you some idea of the extent of that, a survey at the Women's and Children's Hospital suggested—and we have no way of being absolute about these figures—that up to 25 per cent of the women who had public deliveries at that hospital probably had private health insurance but were not using it. The federal government allows it and the Australian health care agreement allows it by way of legislation of the federal parliament. In fact, it prohibits us from forcing people to use private insurance.

The ACTING CHAIRMAN: Would it not be in the public interest for the commonwealth to issue a new kind of Medicare card which shows the electronic terminals authorised to read it whether or not the holder is insured, in order to prevent people from avoiding the tax liability and freeloading on the other taxpayers who are being honest and at the same time avoiding paying their legitimate health care costs when they present their Medicare card to obtain the service as public patients, even though privately insured?

The Hon. Dean Brown: As I said, the federal government has adopted a policy whereby we are prohibited from doing anything along those lines, therefore that sort of pressure occurs. I can understand, though, why people would do that if in fact they suddenly had to face a huge gap. They are saying, 'We have already made our contribution, our Medicare levy is deducted from our salary and why should we not be able to use the benefit of the public hospital system when we are ill, even though we might have private insurance?'

The ACTING CHAIRMAN: Minister, all members of the committee, including you and me, will have to pay even more tax to meet the costs of their personal selfishness, because they have avoided paying the surcharge as of 1 July yet they are still freeloading on the public health system, because of the fact that they have this junk policy that has been offered by the health benefit insurance funds. Is that not correct?

The Hon. Dean Brown: It is something that we will monitor very carefully now, because we believe the incidence of those cheaper health insurance premiums being taken out has increased quite dramatically in the past two months. So we will monitor it very carefully and, no doubt, the matter will be raised at the July meeting with the federal minister. We have a concern here. I had a telephone hook-up with other state and territory health ministers a week ago. It was raised briefly as part of that, and all of us are concerned with what you have said is about to occur. That just means that once again the states will miss out and the federal government will be making savings, because it will be reducing the payments to the states because the level of insurance has gone up.

Membership:

The Hon. M.D. Rann substituted for Mr De Laine.

The Hon. M.D. RANN: My question to the minister relates to budget paper No. 4, volume 2, page 6.7, regarding the environmental health management, including the management of hazardous substances. Minister, on 18 February 1998 the federal government announced that the Billa Kalina region in this state would be the location of the nation's low-level nuclear waste repository. In the press release announcing that decision Senator Warwick Parer indicated that the states and territories had already agreed with the collocation of a nuclear waste storage facility for long-lived intermediate waste, or medium-level waste, the higher grade waste,

alongside the low-level repository as its first siting option. So a public statement was made in February 1998, and obviously at that stage they were looking at a collocation in South Australia of a nuclear waste repository with low-level waste. As I mentioned, the federal minister said at the time that the states and territories had agreed with this collocation. We also know that the commonwealth-state consultative committee, which included South Australia, supported collocation of the two dumps. In fact, the committee took its decision in November 1997, just a month after the last state election, which we all remember.

So by 18 February 1998 it was clear that South Australia was the only option for the low-level repository and the first siting option for the medium-level nuclear waste dump. It is clear that the Olsen government supported as a first siting option the collocation of both dumps here in South Australia. So my first question to the minister is: given my understanding that the minister's department was represented on the commonwealth-state consultative committee, did the Premier ever give you as minister any instruction to oppose a medium-level waste dump in South Australia, given that the person on the committee reported to you as the minister?

The Hon. Dean Brown: The commonwealth-state consultative committee is run by the Department of Premier and Cabinet and, whilst we have the Radiation Protection Control Branch under the Department of Human Services, and it deals with matters where there is transportation of radioactive material, etc., the policy is developed through the Department of Premier and Cabinet. The responses to the federal government are dealt with there and they do come through me as minister.

The Hon. M.D. RANN: So the person who voted in support of collocation at the dump in South Australia, according to the federal government, was not acting on your instructions or reporting to you but was acting on the Premier's instructions?

The Hon. Dean Brown: Certainly, I know of no vote that was taken and I know of no request to me in terms of an instruction in that area. That has been my understanding, because, as you know, I knew that we had a body there when I was premier, and I knew that that body was responsible for negotiations. The Department of Human Services person would be there for technical advice in terms of transport or storage, but not specifically in terms of radiation. In terms of the development of policy, that is handled at the Department of Premier and Cabinet, and they run the policy.

The Hon. M.D. RANN: They run the policy. The Premier has told this parliament that there was no consultation with him. So now we hear that in fact they run the policy.

The Hon. Dean Brown: Can I also clarify the point that you raised about voting. Apparently, when they have these officials' meetings, the officials do not vote.

The Hon. M.D. RANN: Who votes?

The Hon. Dean Brown: I don't know, as I am not present at the meetings. I do not know that they have any votes.

The Hon. M.D. RANN: The federal minister said he had the support of every state for the collocation.

The Hon. Dean Brown: It is not my responsibility.

The Hon. M.D. RANN: 'No, no, not my responsibility'—it sounds like a pop song.

The ACTING CHAIRMAN: Order!

The Hon. M.D. RANN: Given that term of reference No. 4 for the commonwealth-state consultative committee requires the committee to report to ministers, and the Premier's statement to the parliament on 19 November last year that there had been no consultation whatsoever with the commonwealth, can the minister tell the committee how often South Australia attended meetings of the consultative committee and the dates of these meetings? What advice came back to the government, and were either you or the Premier informed? To clarify that: there was a consultative committee which went on for several years discussing this matter; you are saying that the policy is being run by the Premier; the Premier says there was no consultation, and then recently he said it was just a consultative committee. You cannot have it both ways.

Were you informed about what was going on, as is required under the terms of reference of the commonwealth-state committee, and were you advised as minister of the contents of the letter from the Prime Minister to the Premier early in 1998 which advised the government that the consultative committee had endorsed the commonwealth's preference for collocating low and medium level dumps? Did the Premier pass this information to you, did you pass it onto him and did the Premier advise you of his response?

The ACTING CHAIRMAN: That is abuse by the Leader of the Opposition. I have only nine fingers and I have run out already.

The Hon. M.D. RANN: I know—and I am trying to be helpful to you, sir. As you know, it is my way. We have a minister with a representative on the committee but you were not responsible because the Premier's office was responsible; and the Premier says he was not responsible and knew nothing about the consultations. Then we have a letter from the Prime Minister and a response from the Prime Minister. Were you guys talking to each other?

The Hon. Dean Brown: A body that is having a departmental consultation with the federal government is dealt with by the lead agency that reports directly to the minister and it gets its instructions from the minister. I pointed out that the commonwealth-state consultative committee was the responsibility of the Department of the Premier and Cabinet. It could seek advice as it needed to from the Radiation Protection Branch whenever necessary, but the Radiation Protection Branch has no role in terms of setting the policy, nor are they my representatives there. I do not have a representative on the committee. It is not a representative committee: it is a consultative committee between the state and federal governments and it operates, as I understand it, from heads of government to heads of government: in other words, Premier and Premier's department to Prime Minister and Prime Minister's department.

The Hon. M.D. RANN: The terms of reference say that the committee members are required to report back to their minister. You are telling me that that means they are required to report back to the Premier, but the Premier says there was no consultation. Who was steering this ship?

The Hon. Dean Brown: I cannot answer because they did not come under my responsibility.

Mr MEIER: I note on page 6 of the regional development statement a commitment to enhance and improve regional access to health services. At the outset I say a sincere thank you to the minister for what he has undertaken in regional health services over the past few years: it is greatly appreciated. The minister has pointed out before that, whereas governments in New South Wales and Victoria have closed many rural hospitals in past years, I believe that under this government not one rural public hospital has closed. That is a credit to the government's policy.

Last Thursday evening and Friday I had the pleasure of hearing the federal minister, Dr Wooldridge, speak about health generally, and it was interesting to hear him say that at a recent meeting he attended in the United States some 10 countries were present and the question was asked, 'What country do you rank as having the best health system?'. Even the federal minister was somewhat pleasantly surprised to hear that Australia came in as number one, certainly ahead of the United States, the Netherlands and other European countries. We still need to do more to attract GPs into country areas. Michael Wooldridge was at Moonta last week specifically to see whether the federal government could give any assistance to attract GPs into rural areas. Will the minister advise what is being done by this government to address a shortage of GPs in rural areas?

The Hon. Dean Brown: I thank the honourable member for his question. Along with the honourable member I have been to all the hospitals in his area on two occasions and he takes a particular interest in his local hospitals. That is appreciated by the hospitals and the staff. I find particularly in country areas that members of Parliament have a close affinity with their local hospitals. I have appreciated the level of support we have had from local members of parliament in trying to bring about changes and understanding some of the issues involved, particularly as we develop the regions.

The honourable member mentioned quality. The quality of the health care system here is good compared with that in other countries. We recently did a comparison of health outcomes in South Australia and in other countries, particularly European countries. With a five year survival rate for breast cancer we were the best compared with 10 or 11 other countries, mainly out of Europe; and with a five year survival rate for colon and lung cancers we were second best, only marginally behind the leading country. Putting the three criteria together, we were the most consistent best performer. We have the third best life expectancy, marginally better than for the rest of Australia—so stay here in South Australia if you want a long life.

Another important characteristic was the survival rate per 100 000 births for the first year after birth—a very important criterion—and we were the third best in the international comparison. We are consistently up there in the top few and probably the most consistent. That depends on suitable doctors being available within the community and there have been enormous pressures in rural communities to keep up the number of GPs. For 30 or 40 years the number of GPs in the country has been dropping. I put in place a round table strategy to recruit more GPs for country areas, which brought together federal and state governments, all the universities and the royal colleges and SAARMSA, a specialist body which we set up and which is jointly funded with the federal government to recruit doctors and to train and provide locums for doctors, and so on).

The good news is that we now have 50 more GPs in rural areas than two years ago, and that is the first turnaround for many years. We have stopped the decline, which was a drop of about 10 doctors a year in South Australia. We have stopped it and reversed it. We have done that partly because of the success of recruiting doctors from overseas. I put $100 000 into recruiting doctors from overseas through SAARMSA. The other body that has been very successful is the family medical clinic at Whyalla, which is part of the university campus—a joint facility between the University of Adelaide and the University of South Australia at Whyalla. I recently opened the clinic's new facilities and I was very impressed. It has recruited two GPs and a surgeon for Whyalla, two South African doctors for Port Lincoln, two overseas trained doctors for Booleroo Centre and I think one (but he has not yet come) for Port Pirie. They have been helpful and successful as well.

A number of different strategies are in place, including a scholarship scheme to encourage more country people to enter the medical and nursing professions. Twelve scholarships are awarded each year (10 funded by the state and two funded by the Benevolent Fund) which provide $5 000 to each recipient as an incentive to practise in country areas after completion of their training.

The federal government has also announced a package of incentives. We have a rural enhancement package, which provides $6.5 million for doctors in country areas to provide after hours services. Country doctors are required to work in their surgeries during the day and also provide country hospitals with excellent emergency services after hours; for example, at 2 a.m. someone might present at the hospital with an acute stomach ache. The MBS fee of approximately $20 for getting out of bed at that hour and going to the hospital to treat a patient is not very enticing to a doctor. Therefore, an on-call allowance is provided for this service.

Another incentive is the 25 per cent loading fee for service in country areas, because the number of patients treated in country areas is lower than that in metropolitan areas and, often, country doctors are required to travel long distances from one hospital to another. There is a range of other things that we have been negotiating with the federal minister, and there has been really good cooperation between the federal and state governments. The federal minister acknowledged this last week when he was in South Australia. Both the state and federal governments have put in a lot of effort and, as a result, things are starting to turn around. The federal budget contains a number of new initiatives, but many of them will not bear fruit for another five or six years—or even longer.

It takes probably 10 years to train a GP, commencing with their university training. It takes 13½ years minimum (but, more likely, 14½ to 15 years) to train a psychiatrist. As one can see, these initiatives have a long lead time, but I believe that the initiatives now in place will have a long-term benefit.

Mr MEIER: As the minister has indicated, the provision of GPs in country areas relates strongly to the provision of good hospital services. Over the years, I have seen examples of hospitals improving the provision of services in direct proportion to the medical staff available. In fact, another interesting statistic was provided by the federal minister last week when he referred to a recent survey canvassing people's opinion of services offered by hospitals. The survey was split into two groups: those who had been in hospital and those who had not been in hospital. In Australia generally—including people in South Australia—of those who had been in hospital 96 per cent said that the services were excellent; and of those who had not been in hospital only 26 per cent said that the services were excellent or good. It shows that those who experience the services provided by our hospitals have A1 satisfaction. It is a pity that the media does not highlight that sometimes.

Referring to page 6 of the 'regional development statement', I note the minister's commitment to enhance and improve regional access to health services. Will the minister advise what other strategies the Department of Human Services has in place?

The Hon. Dean Brown: Let me highlight a couple of those and one which we announced last week, and that is the

mental health services. Demand on mental health services in the country is a really difficult area, because in the city you have the specialists, psychiatrists and specialist facilities, and it is difficult to provide those services where there are many scattered, smaller communities. But we have decided to hand the responsibility for mental health care in country areas to the rural division. It will be making special budget allocations to the hospitals in rural areas this year, so the hospitals will get their standard allocations on casemix and then they will get an additional allocation specifically for mental health. They will not be able to go off and do hip replacements and so on with that additional allocation.

We see training as one of the big issues that we have to deal with the in the country, because there is a lack of trained mental health workers and nurses in the country. There are 28 or 29 visiting psychiatrists in the country, and we have an effective telepsychiatry service and we are boosting that. We have a very good rural triage service for mental health, and we will strengthen and maintain that with the new initiatives. Another initiative is that we are looking at providing supported accommodation in country areas, and last week I announced the first of those.

We are taking a number of other initiatives, including the implementation of what are called multi-purpose services sites (MPSs). The federal government is making allocations of additional funds to small rural communities particularly to provide non-hospital care, which may be aged care, aged packages or community care. We have a number of these operating in South Australia. We had three to start with in the Mid West at Wudinna, Streaky Bay and Elliston, Ceduna and the Aboriginal lands. An MPS was approved from April this year for Kangaroo Island. We expect to develop about 30 new sites over the next four years, and that will be a boost, particularly in providing better aged and community care in those communities.

The second project is more effective management of the regional budgets, and I think the regionalisation policy has been strengthened recently. My understanding is that the Social Development Committee has been around to all the country areas. The members present who served on that committee might like to correct me if I am misquoting, but my understanding is that generally the country people thought they were very well served by their public hospitals and the services they provided and in health care. The one area where they highlighted there was a problem was mental health, and we are addressing that.

We will continue to maintain an effort, particularly in aged care. For instance, in Waikerie we have almost finished building for 25 new aged care beds. We are doing some work at Jamestown, and they will be finished within the next six months. We have put a priority on upgrading. We are providing community housing at Minlaton, and recently we have provided aged care facilities in the honourable member's electorate at Maitland, Eudunda (which I know is not in the honourable member's area, but it is in the region), Snowtown and Riverton, where we are providing extra aged care beds. That is an example. We are also about to provide a number in the South-East, because they have been allocated by the federal government.

This year we are expecting a significant increase in the number of low care, aged care beds funded by the federal government. The figure looks to be about 650, as well as a significant number of packages on top of that. I am sure that, if you want more details on that, minister Lawson can provide them tonight.

Mr MEIER: It was interesting to hear the minister say that country residents generally felt they were receiving good value for money with their health services. The federal minister referred to a survey which asked people which country they felt provided the worst value for money in health care. Out of the 24, Australia ranked twenty-second—in other words, we are about the best value for money in the world—and America was number one, representing worst value for money. It is interesting that you should comment along exactly the same lines, and continuing provision is obviously helping that.

The minister also mentioned Aboriginal mental health services, and I would like to pursue that further. Output class 41 on page 6.14 of the Portfolio Statements relates to Aboriginal services. Will the minister advise of current and planned mental health services for Aboriginal communities?

The Hon. Dean Brown: With Aboriginal communities we often have more complex problems, because of some of the substance abuse that has occurred. They have had petrol sniffing, which causes brain damage, but that is not classified as a mental health problem. You also see alcohol abuse, which again is not classified as a mental health problem. So, there are people with what I would call complex brain damage and complex needs, and these are the people who in the past have sometimes fallen through the gaps. The Coroner has commented in a number of his reports on the fact that the mental health system will not help these people, because they are not classed as having a mental illness, and the rest of the system is not designed to cope with those sorts of complex needs. We are trying to cope with that.

One of the announcements I made last week was to set up an Aboriginal men's health centre for people with complex needs and brain damage. It will be more than just a mental health service: it will cover those with severe disabilities and brain damage through petrol sniffing, and there will also be one for women. They will be in the metropolitan area. In some of our other supported accommodation facilities we are providing for people with complex needs. They may be mental health patients or people with severe disabilities, or they may have pretty severe but ongoing chronic health problems. We are hoping to help those people as well.

That is why it is important that we do not try to put people into categories. Often the programs have been built around what I would call 'silos'; and people who do not meet the criteria for those programs have therefore not received the help they need. We are trying to overcome that. We are now very aware of that. Many of the coronial inquiry cases go back three or four years, and I think we have moved some distance in that period. The measures announced last week are probably the biggest change of all.

The Hon. M.D. RANN: To recap on the Billa Kalina issue, there seems to be some confusion—and I am not having a go at the minister about this. We have been told by the Premier that South Australia has vigorously opposed the collocation of the nuclear waste dumps here in South Australia. We have been told by the federal government in a public statement by a minister that South Australia supported the collocation on the committee. We have been told by the Premier that there was no consultation whatsoever between the federal government and the South Australian government.

We have been told that there is a letter from the Prime Minister to the Premier and a response from the Premier on this issue of collocation that was dated February 1998. We have asked for the release of those letters. The Premier has yet to release them under FOI but says he will. We under-

stand that that may occur on the day that he goes overseas. We have also been told by the minister that the Department of Human Services does have a member on the committee but, despite the rules of the committee that it must report under law to the minister, that this occurs to the Premier and not to him. Again it comes down to when our representatives on the committee first told the committee that they had changed from supporting to opposing the medium level dump being in South Australia.

The minister quite clearly has said that it is in the Premier's area, but in the area of safeguarding South Australia's health and the clear responsibilities he has as minister in terms of radioactive material, I guess he would be aware of a report in the national press on Monday that an Argentinian firm, INVAP, has been selected as the preferred tenderer to build the reactor being planned to replace the one that currently exists at Lucas Heights. The report said that little is known about what fuel the reactor will use, what sort of waste it will be produce, whether the waste can be reprocessed or whether it may even produce high level waste that requires storage.

The original proposal for Billa Kalina was that the spent fuel rods from the replacement reactor at Lucas Heights would be sent to France to be reprocessed, to be vitrified in glass, stored for 50 years, then brought back and deposited in South Australia where it would remain radioactive for hundreds of thousands of years. Now, because the federal government has chosen an Argentinian firm rather than a French firm, I understand the French government (through its ambassador) has indicated that France may not take the waste and reprocess it. The whole issue of Billa Kalina and what it will do in terms of what it has to handle is still unresolved. In terms of the minister's responsibilities, is he aware or has he been informed by his representatives on the committee of the precise detail of what the commonwealth is planning to dump at Billa Kalina in terms of medium or intermediate level waste?

The Hon. Dean Brown: The Leader of the Opposition raised a lot of matters and, as I pointed out to this committee previously, none of those matters come under my responsibility. If he has a concern about my personal stance both as Premier and as Minister for Human Services, I point out that I have always strongly opposed the use of South Australia as a medium level and high level dump, and I very strongly oppose the way in which the federal government when I was Premier decided to transport low level radioactive material to Woomera. The leader may recall that I opposed it on numerous occasions.

In many cases, the federal government was not even consulting with the state government, and it was required to consult only in terms of transportation across state land. Unfortunately, as it was commonwealth property, we had no say in it whatsoever, but we still voiced our strong opposition to both the then federal Labor government and the Liberal Government. I think most of the material was transported to Woomera under the former Labor government, but I made it very clear to both governments that we would not accept South Australia as a medium and high level radioactive dump.

The leader has raised a very specific question about the possibility of radioactive material and spent rods eventually being stored in South Australia and the health aspects of that. I will need to take expert advice on that specific issue, as I would always do.

The Hon. M.D. RANN: By way of a supplementary before I move on to another issue—

Mr SCALZI: Mr Acting Chairman, I have a point of order. Is there not a bill before the House of Assembly regarding radioactive waste?

The ACTING CHAIRMAN: Whether or not there is, the proceedings of the committee do not preclude any inquiry about funding implications for the budget. I do not think there is a point of order. The Leader of the Opposition cannot be precluded from asking questions as long as they relate to money and not policy.

The Hon. M.D. RANN: That is right. My question relates to the expenditure of money because obviously, in terms of monitoring and in terms of providing an officer of the minister's department on this committee and the requirements to travel to Canberra to attend those meetings, expenditure is involved. The minister has a technical representative on the committee but, apart from advising the Premier as is required by law—and even though it appears that he or she supported the collocation in November 1997—I would have thought it would be useful for the minister, in terms of his clear responsibilities for the health of the state and in terms of radioactive substances, to obtain a technical briefing from his own officer on the committee.

I think it would also be useful to ascertain whether the minister was aware from his representative on the committee of the nature, extent and contents of the letter from the Prime Minister and the reply from the Premier regarding collocation in February 1998. Is the minister aware of those letters and the contents of those letters?

The ACTING CHAIRMAN: The leader will address his remarks through the chair.

The Hon. M.D. RANN: I am sorry, sir.

The Hon. Dean Brown: Where you have correspondence between the Prime Minister and the Premier relating to a consultative committee under the control of the Premier and the Prime Minister, they do not consult with the ministers because it is a lead minister responsibility.

The Hon. M.D. RANN: Even though it deals with health matters and your own representative on the committee?

The Hon. Dean Brown: They can seek technical advice from the Department of Human Services—they do—and, any time I wish to ensure that I have appropriate advice on matters such as the one the leader has just raised, I seek it, and I do so from the appropriate people involved.

The Hon. M.D. RANN: But have you seen the letters?

The ACTING CHAIRMAN: Order! I make it plain that all communication must be addressed through the chair to avoid the risk of quarrels developing between members of the committee and the witnesses at the table. Members must refer to each other by their titles and address their remarks through the chair such that, if you wish to make a remark about what the minister has just said, then say so. I am listening and it is my duty on behalf of the committee to hear what you are saying and allow the minister to respond to that, and he, too, must address his response through the chair.

The Hon. Dean Brown: I made the point that correspondence between the Premier and the Prime Minister does not come to me. The only grounds on which it would come to me would be if it was a specific health issue, such as signing of the Australian health care agreement. In that case correspondence would naturally come to me because I am the lead minister for the state. Matters are not referred to me if I am not the lead minister.

The Hon. M.D. RANN: My next question relates to the GST and FBT costs in terms of patient services. In spite of the Premier's promises of social dividends from the sale of ETSA—and we all remember that an extra $2 million a day would be spent on outpatient services, of thousands extra a day and of extra surgery of thousands per week—for health and more money for hospitals, in fact hospital funding has fallen in real terms and the GST compliance costs and new limits on FBT benefits have put new cost pressures on public hospitals.

On 23 February this year, the minister told a senate committee that GST compliance costs for the first year would be about $20 million. The minister was forthright, and he received a great deal of publicity saying that the cost to our hospital system would be about $20 million in terms of complying with the GST. According to budget paper 4, volume 2, page 6.4, implementation of the GST will cost $9.8 million in 2000-01 and $3 million per year thereafter. Will the minister clear up the discrepancy between his evidence to the senate committee and what appears in the budget papers in terms of compliance costs?

The Hon. Dean Brown: We sought expert accounting advice from outside the department—in fact, outside the government. This was preliminary advice on what the cost would be, and that advice was that the $20 million figure was at the bottom end of the scale. They anticipated that it could probably run up to $25 million. That was the advice that we received last year. It was asked for fairly quickly because we were trying to work out some of the issues with the federal government. We decided with Treasury to do a much more detailed study. After much more extensive assessment, that figure came in at $12.8 million.

The Hon. M.D. RANN: So, $12.8 million is the cost to our hospitals of complying with the GST?

The Hon. Dean Brown: For implementing the GST, $12.8 million was what the consultant assessed. That is spread over the following areas: project and change management, $8.5 million; and upgrading the systems, $4.3 million. These figures are for the department, and the figure that I gave the Senate inquiry was for the department.

The Hon. M.D. RANN: So, right across Human Services, it is $12.8 million?

The Hon. Dean Brown: Yes. I told the Senate inquiry that we would be getting a more detailed assessment, but I gave it the preliminary figure that was available at the time.

The Hon. M.D. RANN: Will that mean further cuts in patient services?

The Hon. Dean Brown: We will receive $12.8 million extra from Treasury specifically to cover the costs of implementation. So, it does not directly impact on the—

Ms STEVENS: That's all you'll need—ever: $12.8 million for the GST?

The Hon. Dean Brown: No. We will get $12.8 million. Let me explain. There are implementation costs associated with the GST to set up the system and get it working—Treasury is covering our costs in that area; there are compliance costs of $7.5 million a year; and, on top of that, there are savings that we have to make in what is termed 'embedded wholesale sales tax'. We have to make savings across the whole of the agencies.

The Hon. M.D. RANN: What impact will that have on patient services?

The ACTING CHAIRMAN: Order!

The Hon. Dean Brown: It is money that we do not receive. We have money taken away, because there should be a reduction in costs as a result of the removal of wholesale sales tax. This is done under the Econtech model. That has been worked out for different areas of government. Based on the Econtech model, we have been given a figure of $7.8 million in savings which we must achieve this year.

The Hon. M.D. RANN: So, that will come out of hospitals?

The Hon. Dean Brown: It will be difficult to achieve because we have to negotiate down contracts and identify where reductions in costs have been made. I indicated earlier—the honourable member was not present—that, in the actual budgets, the figure we have allocated to hospitals this year for casemix to cover actual services in hospitals has increased by $39.3 million compared with last year. The figures I quoted earlier were for across the whole of the agencies: housing, the aged, disabilities and family and community welfare as well as health. The figures I am giving you in terms of hospital services are just for health. There is $39.3 million, and that figure takes into account any embedded wholesale sales tax.

FBT is an issue. As the honourable member would know, much to our disappointment, the Senate, with some modification, supported the imposition of FBT for public hospitals. Despite lobbying by the health ministers of all the parties involved (Liberal, Labor and the Democrats), the Senate passed it. That will have an impact in that additional costs will be involved in paying the fringe benefits tax. The federal government has allocated compensation of, I think, $88 million for the whole of Australia for this coming year. That amount will drop to about $80 million next year and, I think, $70 million in the third year. I think those are the figures for the whole of Australia.

How that money is to be broken up between the states is still being worked out by the federal government. We are arguing and hoping for—and I think we have a chance of securing it depending on how much salary sacrifice has taken place in the public hospital systems—the direct imposition of the FBT being reimbursed between the states according to what we are actually paying. If that is the case, South Australia will get a higher proportion than the other states of Australia (on a per capita basis) because we have experienced a higher level of salary sacrifice.

That does not mean that there will not be a cost impact. There will be a cost impact, but it will be several months before we finally know the level of compensation that we will receive. As I have indicated, that level of compensation is gradually reducing and therefore will tend to bite in progressive years the further out you go. We are negotiating with the salaried medical officers in terms of how we will handle that.

I think we are still in negotiations on that, but we have put an offer to the salaried medical officers and I hope that we can work out a satisfactory outcome. We have enterprise bargaining that runs through to 30 November, and we will pay the fringe benefits tax on the existing packages to that date. The cost of that will be about $9.9 million, but we are expecting compensation for a large part of that from the federal government. Around the whole of Australia the fringe benefits tax will be a further impost on the public hospital system.

Mrs MAYWALD: My question relates to rural aged care. I thank the minister and the department for their efforts in my electorate of Chaffey where, at Waikerie, a $2 million 25-bed aged care facility is being built. It seems to me that right across the country regional hospitals are increasingly becoming responsible for managing aged care, and that the

state government has been filling in some of the gaps in what is primarily a federal government responsibility.

Can the minister outline state spending in regional areas and indicate where it is expanding these services in country hospitals? I cite the recent publicity about the Waikerie facility where current funding is for 20 beds but we have a 25 bed facility, and the community's concern that we may not be able to open all 25 beds?

The Hon. Dean Brown: Due to the lobbying of the honourable member and a perceived need in the area, we have provided new aged care beds at Waikerie. They were needed because of the current inadequate facilities in the northern wing of the Waikerie hospital, which did not have en suites and had fairly small rooms; they certainly did not comply with the federal government's requirements.

Therefore, we spent about $1.5 million on building a new aged care facility at Waikerie, as the honourable member knows—because she was present for the announcement of it. On the way to a cabinet meeting on Sunday I looked at how advanced it was: it is very close to completion. I am delighted to see the quality of the facilities; it will be an enormous lift to the Waikerie region.

As the honourable member has indicated, 20 of those are state-funded beds. As I indicated a moment ago, the federal government is allocating additional low-care beds to South Australia and, by the end of this year, I hope that we might be able to secure five extra federally funded aged care beds for Waikerie. In the meantime, so that these beds are used, we will be making a special allocation of $100 000 to the Riverland Health Authority, and that $100 000 will be specifically to ensure that these beds are occupied up to the end of the year.

I am sure the honourable member will be very pleased that those beds will not be vacant, having been completed, and she will be able to tell her community that we will be funding 25 beds for the remainder of this calendar year. We expect to then pick up the five federally funded beds, so that facility should be fully funded from then on.

Mrs MAYWALD: The Waikerie community will be extremely grateful that the state and the department have seen their way clear to provide that funding. It is an important thing for the community and in particular for aged people who are put in a position where they have to travel to other regions to take up opportunities of aged care beds. It puts the families and particularly long-term residents of the region in a very difficult situation and in a highly emotional situation when they have to move out of their community. It is certainly a tremendous effort on your behalf: thank you very much minister, and I am sure my community will be thrilled to hear that.

The Hon. Dean Brown: I can provide supplementary information. The honourable member talked about the Waikerie hospital: a similar situation existed at Jamestown, where there are state funded beds. Again, we are carrying out construction work there and additional beds and facilities will be finished. Again, because we do not want them to lie idle, it is hoped that there will be federal funding for additional beds at Jamestown: we will provide up to $200 000 to ensure that those beds are fully occupied until we get federally funded beds. It is a bit more difficult and complex than the situation at Waikerie, and that is the reason for the higher funding. I stress that that will be an additional allocation of money to those regions.

Mrs MAYWALD: I thank the minister for that response and for supporting the communities. It is a vital service in country communities, and country hospitals are increasingly required to increase their responsibility to manage aged care. We thank the minister and his department for their support in that area.

Recently the cabinet met in the Riverland and I was fortunate enough to be involved in a meeting with the minister and the department with the regional chairs and the regional CEOs of each of the hospitals and the Riverland Health Authority (RHA) chair and CEO. We spoke at that meeting about the importance of information systems. Referring to page 16 of the capital works statement, can the minister say what consideration is being given to linking GPs to the health system through information technology?

The Hon. Dean Brown: That is a huge topic, and I will try to cover it quickly before the break. We are trying to roll out, across the 300 or so sites that we have in human services, a network of computers and therefore a network under which we can have full exchange of information between the different human services offices. Only about 50 of those offices are connected at present and it is the country areas that I am concerned about. Once we have that, as we roll it out, we ought to be able to improve things such as email services within the health units. That would allow doctors to communicate with the hospitals and other health workers.

A lot of these health workers would be at a community health centre and a mental health nurse may need information that a certain patient has been to see a GP and the GP might have recommended certain treatment or admitted the patient: that information should go through. In fact, I was at a meeting at Victor Harbor on Friday night which highlighted the need to make sure that we upgraded urgently the email services between all the offices involved in human services, particularly in the health area, so that we have better linking and exchange of information between GPs and the department.

We are rolling out an OACIS system initially in the metropolitan area. That is a computerised patient clinical information system. Therefore, all the information about a patient will eventually be recorded by computer and readily exchanged in the public hospital system.

We are working on access regimes involving other health providers such as GPs and private specialists, and we have spent quite some time making sure we have the right framework and, therefore, trying to develop an IT system that embraces everyone providing health services. We will achieve a much more comprehensive system and one that is fully compatible.

Because we are further behind in Australia in health than some other countries such as the USA and because health is behind other industries, we have a lot of catch up to do, but at the same time we have the chance to do it correctly and we are putting a lot of effort into it.

It is a subject I could talk on for some hours but I stress that we have a program to adopt OACIS and we have a program to try to roll out IT and a wide area network across all our human services offices. We have already trialled a network system in the Housing Trust which has 600 computers connected to it, about 400 of which are dumb terminals. All the software resides on the mainframe and is downloaded to the dumb terminal every time someone wants to access something. We have thereby reduced our software and installation costs and we are achieving a very high level of reliability. I understand we are now an international reference point for a computerised network using dumb terminals. Those people who need a PC can still link into the system: there are about 200 PCs on that network.

[Sitting suspended from 1.01 to 2 p.m.]

Membership:

Mr De Laine substituted for the Hon. M.D. Rann.

Ms STEVENS: Minister, I seek clarification in relation to a question you answered earlier about $39.3 million extra for Casemix allocation, compared with last year. Can the minister show me where in the budget papers this is actually shown in terms of hospital based treatment services? I draw the minister's attention to the Outputs Net Expenditure Summary table, which is on page 6.23. I refer there to Output Class 6: Hospital Based Treatment Services. I can see nowhere there an indication that there is an increase of $39.3 million to hospital services. My perusal of this table shows that there is an increase of $5.8 million, so I would be pleased if the minister could tell me where this $39.3 million is reflected in the figures?

The Hon. Dean Brown: The Output Class 6 figure there for 1999-2000 is qualified by the points to which I referred earlier, on pages 6.44 and 6.45. If you are going to do a comparison between years, you have to make an adjustment for things like the $36 million expenditure on insurance, which is not a cash issue at all. There is no cash exchanged; it is simply an accounting procedure. You also have to take account of the fact that there were 26 pay periods last year and 25 this year—and a myriad of other items, some of which are listed there.

Ms STEVENS: I can see that; I have page 6.44 open.

The Hon. Dean Brown: Therefore, if you are doing this you are making a comparison of grapes to apples from one year to the next. The best way of doing that comparison is to use the Casemix funding model, because that is what we actually use to buy hospital services. So, there is the exact amount in terms of what was spent last year in Casemix funding. We know from the budgets that have been worked out on each of the hospitals what the allocation is and we know what we have allocated to the hospitals this year. As I have pointed out, in the metropolitan area it is an extra $29.6 million under Casemix funding this year, compared to last year, and in the country, $9.7 million: put them together and you have $39.3 million extra. For instance, if you look at the insurance and the one-off items—

Ms STEVENS: Which page are you looking at? I cannot follow you.

The Hon. Dean Brown: This is on a briefing I have. We are taking the figures referred to here on page 6.44 and the one-off items that are raised, and the difference between the two is $68.5 million.

Ms STEVENS: Can you explain that to me please?

The Hon. Dean Brown: What I am saying is that if you are going to do a comparison, a like by like comparison, you would need to take $68.5 million off last year's figures, because they had these different accounting procedures and they had some one-off items there such as the money that was put into the car park at the Royal Adelaide Hospital. We have sent the letters out to hospitals recently in terms of their funding. If you are going to make a comparison one year to the next you have to look at the series of qualifications, as you have at the bottom of any notes, and these are the qualifications, and you have to take them into account. After you adjust for that you can see that there is quite a difference. So I am trying to help the honourable member take into account all those sorts of qualifications and give her the basis on which to make a fair judgment. Whether you think the figure is enough or not, the Casemix model is the best way of doing the comparison, and the increase is $39.3 million in Casemix funding.

Ms STEVENS: Thank you for your explanation. I will not pursue it any further. I think we need to pursue it with the Treasurer. I am really concerned that the table on page 6.23 is so misleading.

The Hon. Dean Brown: It is not misleading. You put figures down and then you qualify those figures.

Ms STEVENS: Let's leave it at that and go on.

The Hon. Dean Brown: This is even under output reconciliation. If you go back to the table you referred to on page 6.23, Output Class 6: Hospital Based Treatment Services, there are some raw figures there, then you need to go to the place where those raw figures are qualified, and that is page 6.44. If you look there you will see the variation.

Ms STEVENS: Clear as mud!

The ACTING CHAIRMAN: It might help to leave the matter at that.

Ms STEVENS: I am quite happy to leave the matter.

The ACTING CHAIRMAN: It does not help the committee, can I remind the member for Elizabeth, to make rejoinders which invite the minister to respond, and I therefore ask you to move on to the next matter to which you wish the committee to address itself.

Ms STEVENS: Minister, your own press release as a result of the budget said that the funding for the next financial year would mean a continuation of pressure on hospitals. Can the minister provide the committee with details of the current financial position of each of the major metropolitan hospitals in relation to budget deficits for 1999-2000 and the accumulated debt being carried by each hospital?

The Hon. Dean Brown: As you would appreciate, we have not finalised the accounting for the hospitals for 1999-2000. The honourable member has asked what is the outcome for this year and really at this stage, rather than try to come up with a guess or an estimate, I would rather take that part of the question on notice. I can give the carry-over debt from 1998-99, which is the other part of the question.

Ms STEVENS: I would like details of the carry-over debt, and I would like the exact figures when you get them.

The Hon. Dean Brown: Certainly; we will make the figures available when we get them.

Ms STEVENS: It is just that the hospitals have their own estimates of where they will be in relation to their deficit.

The Hon. Dean Brown: The carry over for 1998-99 is as follows: Flinders Medical Centre, $1.9 million; Lyell McEwin Health Service, $2 million; Queen Elizabeth Hospital, $886 000 (making a combined figure for northwest area health service of $2.9 million); Repatriation Hospital, $2.9 million; Royal Adelaide Hospital, nil; Women's and Children's Hospital, $374 000; and, Noarlunga Hospital, $248 000.

Ms STEVENS: That was for 1998-99?

The Hon. Dean Brown: Yes. In terms of previous debts, Lyell McEwin was $3.2 million and the Queen Elizabeth was $7.7 million, giving a total of about $10.8 million.

Ms STEVENS: None of the areas had anything else?

The Hon. Dean Brown: From previous debt, no.

Ms STEVENS: What is happening in relation to retiring that debt?

The Hon. Dean Brown: We are still working through it with the individual hospitals.

Ms STEVENS: Individual arrangements, you are saying?

The Hon. Dean Brown: The hospitals have created a debt and are responsible for that debt. We are still working with them on how they handle that debt. I point out that, if we suddenly forgive all the debt, they will create a debt every year.

Ms STEVENS: I understand the dilemma—I am just wondering how you will deal with it.

The Hon. Dean Brown: The department itself carries the cash deficit, but the debt is still on the books of the hospitals concerned. For cash reasons we carry it, otherwise they would run out of cash.

Ms STEVENS: This year's Budget at a Glance publication states that the estimated expenditure result for 1999-2000 is $2.633 billion. Last year's Budget at a Glance indicates that the budget for 1999-2000 for Human Services was $2.129 billion. It suggests that there has been an increase in expenditure of $504 million.

The Hon. Dean Brown: I do not think we have had a $500 million increase in expenditure.

Ms STEVENS: I refer the minister to page 5 of Budget at a Glance for this year and last year in respect of expenditure on outputs.

The Hon. Dean Brown: This year's publication provides an estimated figure for last year. It would appear that something has been included this year that was not included last year.

Ms STEVENS: It is an amazing amount of money.

The Hon. Dean Brown: We put down in Budget at a Glance an estimated figure for last year. There is an estimated result for 1999-2000 and a budget for 2000-01.

Ms STEVENS: Yes, but if you look at the estimated result from this year—$2.633 billion—and the outlays projected from last year—$2.129 billion—it suggests that the expenditure is $500 million over what was projected last year.

The Hon. Dean Brown: I assure the honourable member that that is not the case. We did not end up spending $500 million more than we were allocated, and equally we have not received $500 million more this year. I will obtain a detailed explanation, but we have gone from cash accounting to accrual accounting, which I suspect is the reason for the variation.

Mr SCALZI: Following on from the question on health funds, I welcome the $3.2 million increase in the dental area, which will benefit my ageing constituents. I have had lots of comments about the incentive to join a health fund before 30 June. Will the minister comment on the private health funds' commitment to providing health cover for the elderly as the health funds expect someone on a pension or a self-funded retiree on superannuation to pay the same rate for the same cover regardless of income? If someone has contributed to a fund for 20 or 30 years, when they reach retirement age they would expect to pay a premium of $2 400, as I or any other member in this place would pay; and someone earning $12 000 to $15 000 would expect to pay the same amount for the cover they have been used to paying for 20 or 30 years. If we are talking of incentives, should not the health funds take that into account?

The Hon. Dean Brown: The honourable member has given a lot of thought to this area. That point has always concerned me. When you are younger, fitter and use fewer health services than when you are older, when you are employed and have the ability to pay, you may be a member of a health fund for 30 or 40 years. Having paid all your life and having really not used the services a great deal, now you are retired and suddenly your demand on the health services tends to increase. Up until now the health funds have not been able to vary that between age groups. I understand that that will be possible under the new arrangements after 1 July, but it is still one of the anomalies that you are not recognised for long-term membership of a health fund, and therefore the fact that you paid to be a member when you were not using the service a great deal is not recognised by the health funds. When you are older and really need it, you cannot afford to pay the premiums they charge.

That is why I favour a health superannuation scheme, because with such a scheme you pay when you can afford to when you have a job, and it should be putting money away on a superannuated basis for when you are older and can less afford the premiums but need the services. That is why two or three countries are now looking at that proposal, including Greece and one or two of the Scandinavian countries and possibly Japan. Developed countries with an ageing population need to do so, otherwise they will find that their health care costs associated with their ageing population will escalate dramatically and they will not be able to afford it. That is a very good observation. In the meantime, after 1 July the health funds will be in a position to recognise age differences. I am not sure whether loyalty of membership will be recognised: the member will have to take up that issue with the private health funds. Certainly, it is a matter I will look into, because I think it is a good suggestion.

Mr SCALZI: I refer to 'Output Class, health promotion' at page 14: there is a reference to sponsored organisations. How are sponsorships used to disseminate healthy messages to South Australians?

The Hon. Dean Brown: A range of different groups are being used as a means of promoting nine key messages, in particular, in sport, recreation and the arts. There is a smoke free program to encourage people to give up smoking and a number of stadiums are now smoke free, such as Football Park, Adelaide Oval and the netball stadium. Dozens of facilities are smoke free. Particularly with young people, the message is 'Alcohol—go easy', and a number of functions have been organised in that area. Sports injury prevention is promoted within sporting clubs with what we call 'Smart play'. There is an asthma and diabetes awareness program. There is a positive mental health program called 'Positive minds attract', and a program called 'Move it or lose it' to encourage ongoing movement for people with arthritis. There is a healthy food choice program called 'Smart choice' which is backed up by another program called 'Eat well South Australia'—the member may have seen the recent promotion on that. I know he has had contact with the wholesale fruit and vegetable market and has been involved in delivering fruit and vegetables to schools and communities to encourage healthy eating.

Mr SCALZI: I deliver fruit and vegetables part time.

The Hon. Dean Brown: The member drives the truck and delivers the fruit and vegetables—good on him.

Mr Scalzi interjecting:

The Hon. Dean Brown: 'Eat well SA' is one of those programs and another is the skin cancer prevention program 'Sun smart'. High profile events such as the Telstra Adelaide Festival 2000 and the Fringe Festival were targeted and both were 100 per cent smoke free. The department is now looking at developing programs in the areas of physical activity and health promotion in schools. Another is good nutrition, particularly in the indigenous community. Obesity prevention, mental health programs for older people and people with a gambling addiction are other programs.

Mr SCALZI: Notwithstanding recent media reports concerning the effects of smoking on health, particularly in relation to the recent worldwide Tobacco Day and the focus on the impact of smoking on the lungs, brain and aorta and, most recently, the launching of the tar-lung and mascular degeneration advertisements, it appears nothing focuses on the impact of smoking on pregnant women. Output Class 1 at page 6.5 states:

> State tobacco strategy began with specific strategies directed towards reduction in the prevalence of smoking by young people.

Is anything being done in this area?

The Hon. Dean Brown: The answer is 'Yes, there is.' We have set up this anti-tobacco ministerial advisory task force, and I have been very pleased with how that has given a sharp focus to tobacco smoking in the community and how to prevent it. Funding has been provided to the Women's and Children's Hospital to extend its pilot program of stopping smoking among pregnant women. Initial funding was provided in late 1998, and that has now been extended. There was evidence that, unfortunately, about 60 per cent of women take up smoking after pregnancy. We would want women—in fact, all adults—to understand that there is certainly a danger in smoking during pregnancy, because the risk of premature and light-weight births is increased significantly if the mother is a smoker.

There is also a risk if you have young children and you tend to smoke in confined spaces such as the home or the car, with those young children present. In many ways they are innocent victims of a careless adult who may not understand the consequences; but, through passive smoking, those children can suffer from a number of health risks. Those include increased likelihood of heart disease, asthma and cancers; and new evidence coming through even suggests that adolescent women who are passively smoking are likely to suffer from a higher risk of breast cancer. People who are smokers need to understand the direct impact they have on other people through passive smoking.

A detailed and pretty controversial study was carried out by the National Health and Medical Research Council, which collated all the research from around the world which showed that there was a direct relationship between passive smoking and increased health risks for all those sorts of illnesses I have talked about. I have since seen some international work that has backed that up. The important thing to understand is that it is not as if you need an extremely high level of passive smoking to start to suffer an increase in health risks; even moderately low levels of passive smoking will do that. So, almost anyone who is subject to passive smoking will immediately put their health at risk.

I should indicate that the extended program that is being put in place now for pregnant women who are smoking will cover 300 women. It is working with the GPs who look after the women during their pregnancy. The GPs will give the women ongoing advice and encouragement to give up smoking, and to do so on a permanent basis. That will be coordinated through the women's and babies division of the Women's and Children's Hospital. Work is also being done on the impact of smoking on the foetus and the outcome of pregnancy. Women are putting even their own health at risk if they smoke during pregnancy.

Ms STEVENS: On the issue of smoking, as you know, the state government set a target to reduce the prevalence of smoking, especially among young people, by 20 per cent over the next five years. You announced the tobacco control council on 28 May 1998 and it is now two years later. What is the current prevalence of tobacco smoking compared to the prevalence at the start of the program; and is the strategy on track to meet the designated target after five years?

The Hon. Dean Brown: We may have to take that question on notice. The program was to reduce the incidence of smoking in the community overall by 20 per cent over a five year period. There is evidence that suggests that among the older and middle age groups we have been successful, but there is a disturbing sign that those in the younger age groups are continuing to smoke and to say, 'To hell with the risk.' I will try to get some figures, and to get some specifically for South Australia, because that is where it is being applied. I think there is evidence that we are reducing it successfully in older and middle age groups, but not in younger age groups. That is why we are concerned about the point of sale availability of cigarettes to minors—

Mrs Geraghty interjecting:

The Hon. Dean Brown: —and herbal cigarettes, in answer to the member for Torrens. We have spoken to Living Health, which is out there in a strong promotion campaign, particularly among primary and secondary students, with its trailers and caravans. It is picking up on the smoking message very strongly. We have put extra money into that in the past year, and it will be maintained this year. It is a real challenge. We do not quite understand what is driving 15, 16 and 17 year olds to take up smoking, but the prevalence in that age group seems to be on the increase, yet in other age groups it is on the decrease.

Ms STEVENS: I have a supplementary question. The thrust and focus of my question relates to your measurement of outcomes. The $3.9 million (and I remember very well how that came about in the term of the last government) approaches the per capita funding levels that now exist in California, which has seen success in reducing smoking levels across the community. I want to be sure that you have the benchmarks, you know where we started from and you are tracking that, because at the end of five years people will be making decisions about the success or otherwise of the strategy. I am surprised that you do not have the information available, because it seems to me that such information is really basic: the benchmarks, the prevalence studies, where we have reached at this point and whether we are on track.

The Hon. Dean Brown: I understand that it is tracked. I do not have the figures here, but I will get them. One of the encouraging things is that in the past year, because of the ban, we have achieved a huge reduction in terms of smoking in eating areas.

Ms STEVENS: Isn't that smoking levels across the community?

The Hon. Dean Brown: There are various ways of measuring this: one is how many people are actually smoking, and there are other measurements. It is reducing the amount of smoking in enclosed areas and therefore the impact of smoking on other people. We have reduced that, particularly in dining areas, and we have expanded the number of sporting venues at which we now have a ban on smoking. Those signs are positive, but I will get some figures in respect of overall results. I think we have had some successes, but there are some areas of real concern regarding young people.

Mrs GERAGHTY: As a supplementary question: what progress has been made in putting out the appropriate signage through the shops and stores that sell herbal cigarettes? When you go into shops and stores you see the sign stating that it is an offence to sell cigarettes to minors. What progress has

been made in putting out the signage that also indicates that it is an offence to sell herbal cigarettes to minors? I have not noticed any of them around.

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

Ms STEVENS: I want to talk about the minister's press release this morning on dental funding. First, I must say that the first sentence is a little misleading in that the state government has approved an extra $3.2 million—this is just for the benefit of the member for Hartley so that he gets it right with his electorate—when we all know that $1.2 million of that will come from co-payments that the minister announced previously. However, putting that aside, I would like an explanation on how this will work. I presume the co-payments that the minister talked about previously—that is, the $10 for a pensioner or 15 per cent of the standard cost of a service co-payment—still stand, and then we have a different scheme with a different set of co-payments. Does that mean that pensioners, if they access the new scheme, have to pay the new co-payments or do they still pay the $10 and the 15 per cent co-payment that the minister announced previously? Will the minister explain that?

The Hon. Dean Brown: In recent years in South Australia we have had two groups. One is the free public dental service, where it was available, which was available for all people under certain eligibility criteria: approximately 430 000 people in South Australia are eligible. In country areas where there were private dentists and where the dental service was not available, those people could go to a private dentist and pay 15 per cent. The rate that the dentist was paid as a fee for the service was very similar to the DVA (Department of Veterans Affairs) rate, which is a published rate. They paid that co-payment to the private dentist and, in some cases, I might add, the private dentists negotiated not to receive the co-payment if they thought the person could not afford it and urgently needed treatment.

Under this scheme, we have negotiated with the Australian Dental Association (SA Branch) whereby dentists will provide services for public patients for very similar to the DVA rate. There will be a co-payment, again similar to that paid in the country—about 15 per cent of the fee—and people will be referred to the private dentist by the South Australian Dental Service.

Ms STEVENS: Does that mean—

The ACTING CHAIRMAN: Order! I think the member has asked three questions.

Ms STEVENS: This is a supplementary, sir. It really does need to be explained a little more. Does that mean that a pensioner in the city can go to the South Australian Dental Service and pay $10—

The Hon. Dean Brown: That is a full pensioner for certain services—it depends on the nature of the service.

Ms STEVENS: That same full pensioner in the city going to a private dentist would pay up to $22.50; is that right?

The Hon. Dean Brown: The people who are likely to be referred by the South Australian Dental Service to a private dentist are likely to be people not on a full pension but on a part pension—in other words, a higher level of income—and they will pay the slightly higher rate. However, if a full pensioner was referred to the private dentist, they would still only have to pay $10.

Ms STEVENS: Is that the same in the country as well?

The ACTING CHAIRMAN: Through the chair, please.

The Hon. Dean Brown: I think that varies. As I said—

Ms STEVENS: It is hardly fair to the people.

The ACTING CHAIRMAN: Order!

The Hon. Dean Brown: I think it varies because, as I understand it, in the country they have a 15 per cent rate and I have already indicated earlier that many of the dentists forgo or reduce that 15 per cent rate for full pensioners.

Ms STEVENS: But it is for the dentist to make that decision, is it not?

The ACTING CHAIRMAN: Order!

The Hon. Dean Brown: In the country, yes.

The ACTING CHAIRMAN: Questions must be directed through the chair.

The Hon. Dean Brown: Country people are still eligible to go to a city or to a regional centre—because there are dental services in most of the regional areas—and get the same treatment. Generally, from what I have seen, they have been very happy with the service that has been provided where they get the DVA rate and a co-payment.

Mrs MAYWALD: My question refers to page 6.5 of the Portfolio Statements and the reference to the promotion and protection of health and well-being. Gene technology and specifically genetically modified food has captured a lot of media and certainly a lot of consumer interest lately. Will the minister provide an update of where the issue of labelling of genetically modified food is up to?

The Hon. Dean Brown: It has been a subject of some public controversy in the last few weeks. Going back to December 1998, the health ministers decided to put in place a mandatory labelling requirement, but the details of that needed to be worked through. Since then, a lot of work has been done, first, on the what we call the protocol—that means how you handle things such as additives, processing aids and highly refined products such as sugar that may come out of a genetically modified crop but where there should not be any protein or oils present, and how you handle what we call adventitious contamination. Adventitious contamination means you have grown a genetically free crop, it goes into a silo, but there is a certain amount of grain still in the bottom of the silo and it goes into a truck that had previously had some genetically modified grain in it, and so you have a very low level of contamination, if you like, with the genetically modified grain.

We worked through the protocol procedures. Then, on a national basis we commissioned a cost study, which was finished in November last year. We looked at the cost study and, frankly, the consultant had not done what he had been asked to do—and he was told that in no uncertain terms. He had done some work and some of that work was quite valuable, but he had not followed the protocol procedure we had put down and we ended up with a very expensive model. Submissions were called for again and they were asked to come up with a costing model that followed what the health ministers had put down. That has certainly reduced the costs very substantially.

As a result of that, health ministers were due to meet in May. That was deferred, because the task force was not ready to make final recommendations to the states. At the beginning of June (approximately) those recommendations went to the states. Each of the states and territories, the federal government and the New Zealand government were asked to put it through their cabinets so that we can finalise that at the health ministers' meeting in the last week of July. That process is proceeding. I spoke to the other health ministers and I think the recommendations of the task force under ANZFA's control are now before the respective governments.

As is now widely known, the Prime Minister wrote to premiers and chief ministers asking that this matter be considered by governments by the end of June and then taken up by premiers with the Prime Minister at heads of government level. I do not know what the Prime Minister exactly has in mind. In the first part of his letter, he said that labelling was not the appropriate way of going about it and that it should be done through point of sale information, but later he referred to a 1 per cent threshold level.

Assuming that the second part of the letter is what the Prime Minister supports, that would put him in a different position from health ministers at present. I could explain this best with a table, but I do not have one in front of me. The Australian position, which has been supported by the federal health minister, needs some modification because of complications with matters such as processing aides that are used to make cheese, because there should be no protein in the final product. So, debate is still going on about what I would refer to as minor issues, but in last week's discussions the health ministers upheld their decision to support mandatory labelling with no general threshold but with some recognition for the special circumstances of the other areas that I have mentioned.

I think it is important to maintain a high standard of labelling, because that is what the European Community requires. If Australian food manufacturers want to get their products onto the European markets they will have to comply with this European standard. If they comply only in terms of export product, the extra cost of that will be very high, whereas, if it is part of the much broader system of genetically modified food material within Australia, the cost of exporting to Europe will be no greater than the cost of producing for other domestic markets.

I believe that this regime meets the requirement of consumers that they have a right to know. The survey shows that about 90 per cent of consumers believe that they should know from the labelling whether or not they are eating genetically modified food. At this stage, health ministers stress that there is no evidence that genetically modified food is a health risk. If it was, it would be taken off the shelves, but that does not mean that, as health ministers, we do not believe that consumers have the right to know.

For any food product, it is currently required that ingredients be listed on the label. Not all of those ingredients relate to health matters. Appropriate information is simply being provided to consumers when they buy food products. In some cases, such as peanuts, a health warning should be on the label. All I can say is that this is still in a state of transition. We expect to finalise the matter at the health ministers' meeting next month.

I find this delay unsatisfactory and frustrating. This matter has dragged on for 19 months despite the efforts of health ministers to get it resolved as quickly as possible. The federal government keeps changing its stance, and I find that frustrating. Australia needs to get its labelling requirements in place as quickly as possible for the benefit of both consumers and food exporters.

Mrs MAYWALD: I thank the minister for that comprehensive answer. I look forward to the outcome of the meeting in July. Hopefully, we can move forward and provide the community with the confidence that it seeks regarding the labelling of GMO products.

My next question relates to Output 1.2 on page 6.6 of the Portfolio Statements, which relates to disease prevention and management. What action is being taken in relation to clean needles and syringes, which I understand is important in preventing the transmission of HIV and hepatitis?

The Hon. Dean Brown: We have conducted a major review of the clean needle program. Originally, this was called the needle exchange program, but I think we must be honest and recognise that it is a clean needle program. As the survey shows, there is a reasonably high level of return. This is all about making sure that intravenous drug users do not share needles and syringes and use a clean needle and syringe each time. This is a public health issue; it has nothing to do with encouraging drug use in the community.

The incidence of HIV amongst intravenous drug users in the community is about 2 to 3 per cent. In countries which do not have a clean needle program, the incidence is about 50 per cent—and that is a huge difference. This program has been set up to protect the broader community. If 50 per cent of intravenous drug users have HIV, the risk of that being transmitted outside the drug using community is quite high, whereas if it is kept down to 2 per cent the risk is very low.

I believe that one of the reasons we have been able to stabilise and start to reduce the instance of HIV in our community is this type of program. There is a cost involved. There is the cost of providing clean needles. Unfortunately, intravenous drug users invariably do not behave rationally or sensibly after injecting themselves. They have approximately 40 seconds in which to safely disposal of the needle. If someone injects, say, heroin into their vein, within a short time they have to try to stop the bleeding and safely dispose of the needle.

We have a needle disposal problem on which we are working together with local councils around the state. We are trying to identify where these needles are being discarded so that we can place suitable containers there. We have a special 'fit pack' which is provided with the needle to encourage automatic disposal. We hope that a user will take the needle off and push it straight into the fit pack, thus disposing of the needle safely.

We have set up a 24 hour hotline. Anyone who sees a discarded needle lying around can ring this hotline and arrangements will be made through local government to have it picked up. In the case of public stick injuries—that is, a person is pricked by a discarded needle in a public place—we also have an information hotline for them to obtain suitable information about what they should do. It may be that they should immediately have a vaccination for hepatitis if they have not already had one.

I stress to the public that there is no known incident anywhere in the world of someone contracting HIV from a discarded needle in a public place. It appears, therefore, that the life of the virus in a needle is very short indeed. The virus is transmitted by a user using a needle immediately after another, but there is no reported case of HIV being contracted through a stick injury from a discarded needle in a public place.

Ideally, we would like to have a retractable syringe. There are retractable syringes for 10ml and 5ml needles, and the other day I saw one for a 3ml needle. I understand that a drug user injects about half a millilitre. The risk of overdose is very high using a 3ml needle because you are far less accurate in what you can inject compared to a 1ml needle. The other risk is that people who use 3ml needles, if they fill it up, might pass it to someone else for the next injection and transmit HIV. I would like to see a retractable needle; it would be more expensive but it would remove the public fear of discarded needles that exists at present in our community.

But we are continuing to work. We have put some extra funding into it this year because the demand has been very high. I think I am right in saying that we have had an increase of about 40 per cent in needle use or demand for needles in about a four year period, and the extra funds this year take account of that increase in demand to provide the additional needles required. We received some extra money part way through last year under the Prime Minister's drug initiative. This year it has been funded as part of the budget for a whole of year supply.

The ACTING CHAIRMAN: Could you tell the committee why it is believed that it does not encourage an expansion in intravenous drug abuse if there is an increase in the number of needles that are being used over the period of four years or whatever?

The Hon. Dean Brown: I think I am accurately reporting the police here, even though it does not come under my responsibility. The police have indicated that they believe that that is due to a reduction in the price of heroin on the streets, and that has resulted in increased use. There is no evidence that whether you supply clean needles or not that has any impact on the level of use of injectable heroin.

The ACTING CHAIRMAN: Is that a statistically valid study that has been done by epidemiologists?

The Hon. Dean Brown: Apparently it is a well established fact that the supply of clean needles does not encourage the increased use of injectable drugs.

The ACTING CHAIRMAN: So, there is an epidemiological study and statistics that back that?

The Hon. Dean Brown: We can get that material for you.

Mrs MAYWALD: Following up on the problem of addiction within the community, the member for Elizabeth and I were part of a select committee that looked into the possibility of heroin trials, and it was a big eye-opener to both of us in relation to the issues facing addicts. The statistics that we were presented with indicated that it is likely that there are around 5 000 addicts in the community in South Australia who at any time could be seeking assistance or treatment for their addiction, but there are places available for only about 2 500 people within the state to get treatment. What is happening to increase this, and what initiatives are being put in place to assist those addicts who are unable to receive treatment at the time they request it?

The Hon. Dean Brown: I share the concern of the honourable member in terms of what effective treatments are being provided for heroin addicts in South Australia. You are quite right; in fact, they were Drug and Alcohol Services Council figures that were supplied to the select committee. There are about 5 000 people with a heroin addiction, and there are about 16 000 occasional heroin users. That 5 000 is part of the 16 000, so you have a graduation of people who use the drug. The state budget includes $2.6 million recurrent funding for illicit drug programs in 1999-2000, and an additional $2 million recurrent funding for 2000-01. We hope to increase the number of people who receive effective rehabilitation and treatment because, after all, that is important. If you have 5 000 people with an addiction, you need to be treating, if possible, all 5 000 of them.

Most of those people who are being treated at present are on the methadone program. We are trialing some new methods, as the select committee was notified. I am a keen supporter of naltrexone, and I have spoken to a number of people who have gone through the withdrawal phase using naltrexone, and I think the outcome is very good, providing they receive ongoing social and community support for up to 12 months after their withdrawal period. Taking them through withdrawal and just putting them on to naltrexone and then back in their old environment where they will mix with intravenous drug users is a real risk because the likelihood is that they will overdose.

We are trying to increase the range of rehabilitation services offered and the range of treatments. We are trying to provide ongoing community support. There is one excellent program in Drug Beat where we have helped provide a house in the northern suburbs, and we have earmarked another house. I am not sure whether they are in the second house or not. It is a bigger area. I think they have asked for some recurrent expenditure as well, and we are trying to provide that.

I will not go into all the other treatments available, but I point out that we have now finished our naltrexone trial. We carried out the first major trial here in South Australia where we put people under rapid detoxification and then on to naltrexone, and we also put another group of people through a normal detoxification and then on to naltrexone. The first results of that trial are likely to become available in a couple of months. I am sorry but I have no idea of the outcome of the trial at this stage. I hope the trial will give us a better idea of how to use a facilitating drug such as naltrexone to encourage more people to undergo rehabilitation, because there is certainly a need for it.

The ACTING CHAIRMAN: Can you provide the committee with the number of users and addicts in those two categories that you believed to be in existence in 1979, 1989 and 1999; how many deaths were there from drug overdoses in each of those three years; how many deaths were there from diseases that are commonly transmitted amongst intravenous drug users in each of those three years; and how many addicts were there in each of those three years seeking treatment or rehabilitation from addiction to intravenous drug use?

The Hon. Dean Brown: As you would appreciate, I do not have that information here, but I will certainly get it. I have seen the figures. A number of different surveys look at the number of intravenous drug users state by state around Australia. I have seen some of those figures. Although they suggest an increase here in South Australia, I think it is less than what has been occurring interstate. I think you will find on a per capita basis that we tend to be behind most of the other states of Australia, and certainly we are behind Melbourne and Sydney. I will get that information about the deaths both from drug overdose, I presume you are referring to, and also deaths from diseases such as HIV.

The ACTING CHAIRMAN: And hepatitis and whatever may be transmitted.

The Hon. Dean Brown: Hepatitis C unfortunately is a long-term debilitating disease which is unlikely to lead to death: you are more likely to have liver cancer and eventually chronic liver failure. It is one area we are very concerned about because, whilst the clean needle program has been effective in reducing HIV, it has not been so successful in reducing the incidence of hepatitis C. One of the reasons for that is that it appears that hepatitis C has a longer life outside the body and is more easily transmitted than HIV.

I think I am right in saying that, by injecting and contaminating the spoon with the needle, it is possible to transmit hepatitis C. There is still a high incidence of hepatitis C. Therefore, with the clean needle program we are now providing advice on how to reduce the transmission of

hepatitis C, and we are putting more effort as part of this national drug strategy into the education program.

The ACTING CHAIRMAN: Could you add in one other year besides 1979, 1989 and 1999, and that is the year that we started handing out party packs—that is, free condoms and free syringes and needles, and so on? That is what everybody calls them; let's not beat about the bush.

The Hon. Dean Brown: We will certainly try to get some of that information. I think, though, you are looking at two different programs there.

The ACTING CHAIRMAN: I am interested to know what the levels of addiction were at the time that the party packs were introduced, compared to what they are now, and what they might have been in 1989. I cannot remember when we started handing out these clean needles.

The Hon. Dean Brown: I think it goes back to about 1995. Christine Charles has indicated that apparently we have had the lowest incidence of transmission of HIV of any state in Australia.

Mrs GERAGHTY: I understand that the federal government is very close to announcing a trial in South Australia on retractable syringes. I heard it mentioned on the radio last week. Has your department had any input into that?

The Hon. Dean Brown: First, I have taken up the issue nationally. I wrote to the federal minister. I took it up through the HIV Council Australia-wide with the chairman. I have urged that there be a national approach, because it is not the sort of thing you can develop in one state. If you are going to have a suitable retractable needle it should be a national project. The costs of developing that, which could be quite high, should be shared nationally, and we want to make sure that we purchase very large quantities, to reduce the costs and get the benefit of that. There is someone here in South Australia who has developed a retractable needle and we are looking at testing that needle. There is a new retractable needle out of the United States of America, but that is 3 mls and to my knowledge no-one anywhere in the world has yet developed a 1 ml retractable needle that is functional.

I have seen various models and modes of these retractable needles, including one which I think was 3 ml, and you have to be aware of how complex it is. Here is someone who has just injected themselves, the drug is starting to take effect, and they are not going to go through a whole series of manoeuvres that a person normally could do to effectively dispose of that needle. The best and most effective is that, as you actually inject it, at the appropriate point the needle suddenly disappears up the syringe. That is ideally how it should be.

I will get for you the other information that we talked about earlier, but I can indicate to you on the matter of the prevalence of HIV attributable to drug injection that between 1992 and 1998 it is believed that in South Australia only nine cases of HIV were transmitted through the needle program, or through people who were intravenous drug users. So you can see that the incidence has been very low; nine people only in that six year period, and that is the way I hope we can keep it, and that is why I think it is justifiable to maintain the clean needle program.

To clarify a point, at the beginning of this afternoon the member for Elizabeth raised the issue about Budget at a Glance. I urge that she look at the Portfolio Statements, because it has the complete figures for last year and this year. Budget at a Glance certainly shows a big difference between what was put down last year and this year. They are Treasury figures and we take no responsibility for Treasury figures at all. It would appear that Treasury put the figures in there on quite a different basis.

Ms Stevens interjecting:

The Hon. Dean Brown: If they gave me $500 million I would accept it.

The ACTING CHAIRMAN: I have a brief question. I refer to the Insurance Services Unit in the Department of Human Services and the likely cost that was incurred by the gun control coalition when a member of the coalition, Elizabeth King, as I told parliament 13 April, sought to be represented by the Crown under the terms of the arrangement that was relevant to the Injury Prevention SA Incorporated unit with which she is involved. Can the minister tell the committee what was the likely cost of that defence to the taxpayer, if any, and why the people who claim they were defamed by Ms King's remarks had to meet their own legal costs while hers were met by the Crown.

The Hon. Dean Brown: When the member first raised this matter in the parliament I was not aware of the incident at all. I have made a number of investigations since and have now furnished a reply. As you raised the matter in the parliament, it is appropriate that I put down formally what I found. I found that the Department of Human Services for a number of years has been providing public liability insurance for a number of organisations that we fund, and these are invariably small organisations. We deal with and fund about 450 organisations each year for various community services. These are invariably not for profit organisations and, because they are so small, to go out individually and try to take out public liability insurance would be very expensive. We can do it and provide that coverage and, therefore, when we give them money, not have them spending our money on public liability insurance but instead on delivering the services we want them to deliver, thereby saving costs.

Injury Prevention SA was one of those organisations that received public liability insurance. Ms King worked for Injury Prevention SA. I found that going back to May 1999, over a year ago, there was a claim against the insurance policy held by Injury Prevention SA, and that is a SAICORP insurance policy—the government's insurance policy. The Treasurer is responsible for SAICORP. A claim was made in May 1999. Injury Prevention SA had been comprehensively insured by the South Australian government since 1997. The claim was for defamation against an employee of Injury Prevention SA, Ms King, who was involved in activities which her employer believed would lead to a reduction in injuries caused by firearms and similar weapons.

Although we were funding Injury Prevention SA for a number of activities, mainly in terms of reducing injuries in the home for older people, and we had a specific program we were funding it to do, the activities Ms King was involved in were not part of the funding. However, our insurance policy was used as a blanket policy by Injury Prevention SA. The defamation claim was made against SAICORP. The Crown Solicitor was acting for SAICORP and not for Ms King. At no stage did the Crown Solicitor act for Ms King. The role of the Crown Solicitor in this matter was to act on behalf of SAICORP because the insurance policy claim had been made against SAICORP.

We reimburse the Crown Solicitor's office for the time of the legal officer on an on-going basis, but I stress that, although the legal officer sits in the Department of Human Services (and that has been a custom for some time), the person actually works for the Crown Solicitor, and on this occasion was working for it against this claim. As a result of

that, the arrangements were unsatisfactory. I have therefore asked for a review to be conducted in conjunction with the Treasurer, because he is responsible for SAICORP. If we are to continue providing a public liability or a comprehensive insurance policy for some of these small organisations, it should only be in relation to the activities for which we fund them and not in relation to other activities for which we do not fund them.

We would have solved this problem in two areas. If Ms King was working for Injury Prevention SA but doing other work, she would not have received protection under our policy, but we are reviewing under what circumstances we even insure these non-government organisations. It does not mean we will cease that, but it may involve only activities for which we fund them.

The ACTING CHAIRMAN: It could be restricted to the areas of property damage and personal injury rather than extending it to defamation and so on: in other words, they should do their job and mind their tongue.

The Hon. Dean Brown: We would have to look at that. They are not making statements on behalf of the government and I do not see why they should be funded. If they were making statements on behalf of the government and were authorised to make such statements, that becomes another matter.

Mr De LAINE: My questions relate to the Queen Elizabeth Hospital obstetrics services. All the minister's statements in the parliament about the clinical review into obstetrics at the QEH have been pushed aside by an announcement by the Acting Chief Executive Officer that the service is to be down-graded to level one. All the minister's undertakings that clinicians and the public would be consulted about the needs of women in the western suburbs apparently now mean nothing. The Northwest Adelaide Health Service says:

> The hospital has recently had difficulty providing specialist staff, therefore 'Bingo!' the service is to be down-graded.

Given the minister's statement to the parliament on 18 February 1999 that he was concerned that the hospital system had a clear vision about where it was heading over the next 20 years, when was the minister first told by the Northwest Adelaide Health Service that it could not recruit enough specialist staff and wanted to down-grade obstetrics, and what options were considered by the minister before agreeing?

The Hon. Dean Brown: In terms of the action taken by the Queen Elizabeth Hospital, I believe I found out about it on the day the announcement was made. As to the broader consultative process being carried out by Dr Kathy Alexander, we are working through that. The clinical review has been carried out and the two are being brought together, so it is expected that the issue will be resolved very shortly.

The situation at the Queen Elizabeth Hospital was an immediate safety issue. When it comes to safety issues, I believe it is up to the individual hospitals to make those decisions. It is not appropriate for the minister to be consulted on issues of public safety. Ministers set the broad policy to ensure that there is effective administration. I assure the member that the department is working through that, and the member would have to agree that there has been very wide consultation with the community, local government and the hospital staff. I have received correspondence which expresses appreciation for giving them the opportunity to express their views to Dr Kathy Alexander. The broader clinical review is nearing completion and a departmental mental health response is being prepared.

Mr De LAINE: When will the findings of that review be released?

The Hon. Dean Brown: The findings will be released when the departmental response is finalised. It must be appreciated that there has been broad consultation putting forward the differing views of the community and a clinical review, and now it is important that all this is brought together so that there can be a departmental response. When that has been done, we will bring a group of people together to discuss the outcomes, and I would be delighted if the member was part of that as a representative for the western suburbs.

Mr De LAINE: Will the findings be released voluntarily by the minister?

The Hon. Dean Brown: Yes, they will.

Mr De LAINE: Given the minister's undertakings regarding public consultation, why did he not announce the downgrading?

The Hon. Dean Brown: It is a safety issue and, as I have said throughout, when it concerns safety issues in hospitals that is the responsibility of the medical staff and the administrators of the hospital. It is not possible for ministers to be involved in the fine detail of safety issues on a day-to-day basis. If that was the case, hospitals would be compromising safety.

Mr De LAINE: Over the years, patient satisfaction has been very high with maternity services being delivered by the QEH. In 1997, the QEH was the first maternity unit in Australia to be awarded baby-friendly accreditation. One highly regarded service was the program to support patients with a non-English speaking background—particularly, Vietnamese and Aboriginal women who appreciated the culturally-sensitive services provided. Is this excellent service still available and, if so, will the minister guarantee that it will continue to be provided?

The Hon. Dean Brown: Yes, I am able to give a guarantee that that excellent service will continue.

Ms STEVENS: The Brennan report released by the minister with great fanfare last week, together with a departmental implementation plan, is an indictment of the Olsen government, the minister and the Chief Executive of the Department of Human Services. The report states that there has been a lack of vision and leadership and that, after a decade of rolling reviews, failure to act will produce another decade of disillusionment. It also states that mental health needs a director and that the system has failed the staff, not to mention people with a mental illness and their families. The report goes on to say that previous reports failed to achieve the required change; that the 1996 realignment resulted in a fragmented system without strategic direction; that regional services have different policies and different mission criteria; that the mental health unit has become dysfunctional; and that the system has failed. As the minister would know, that is not the end of the list of concerns that came out of that report.

The report stresses the need to move forward but, surely, there is a case to address the apparent incompetence which led to this situation. The report highlights how South Australian resources are skewed towards institutionalised acute beds and draws on the fact that the number of acute institutional beds in South Australia is greater than the national average. It also alleges that resources in South Australia are skewed towards stand-alone psychiatric

facilities (this is backed up by the fact that expenditure on stand-alone psychiatric facilities in South Australia is 80 per cent above the national average).

The implementation plan states that decentralisation from metropolitan to rural areas will continue and will be addressed over five to 10 years. All of these things are not new. The question not answered by the implementation plan is how the structural budget changes needed to address the skewing of resources are to be achieved. For example, how will the restructure address the need for greater expenditure on non-institutional residential facilities? As the minister would know, the figures from the 1997 Mental Health Report indicate that, in Victoria, per capita expenditure on non-institutional residential facilities is $11.60, and in the ACT it is $12.42, compared with 27 cents in South Australia.

It is disappointing that it took a summit, two years of reviews and the Brennan report for the minister to realise that mental health needed a director, a policy, and a way of achieving the resources required to put that policy into practice. One would have thought that the minister would have worked that one out a little sooner. Will the minister explain why he and his department failed to recognise and address the failures of mental health services management which Brennan has alleged contributed to the service failure commented on by the Coroner on several occasions?

The Hon. Dean Brown: The member has made a highly political statement which is out of context with what Brennan himself says in his report. From the very outset, I must say that I find it disappointing that the member has reverted to a political attack on me. I do not mind political attacks on me, but think it is inappropriate to politically attack the CEO of the department, particularly as Brennan was talking about a period going back to the 1980s.

A Labor government was in office for about four or five years of the period addressed by Brennan. I have been minister, with Ms Charles as CEO, for a period of just over 2½ years, and during that time—in fact, within a month or so of being appointed minister and Ms Charles being appointed CEO of the department—we set up the Mental Health Summit. That was the whole basis of what we have now announced. It was an appropriate way of going back and looking at what the consumers wanted, recognising the problems there and working them through with the mental health summit.

I am very supportive of the mental health summit, and so are many of the consumers and carers in the mental health area. It is happening. So, the first thing was to have the summit, which set down the broad objectives of what we wanted to achieve. The clinical review was initiated last year, and at the same time we brought in Brennan to work out how to implement the findings of the clinical review and how to achieve the objectives set down by the mental health summit. That was a perfectly reasonable way to do it. As a result of that, we have what I would argue is the most radical redirection of mental health services that this state has seen.

I know, because I happened to see some of the initial mess when I was Leader of the Opposition; frankly the real problem was the manner in which the institutions were closed down back in 1991-92, and they were closed down without appropriate resources being available in the broader community. We are now putting in place that other half of the picture. A decision was made in 1991-92 (in fact, it went back earlier than that, to the late 1980s) to close the institutions, but the institutions were closed without providing supported accommodation in the community. During my period as Premier and minister, we have put significant resources through SACHA, for instance, into the Port Adelaide mission to start providing supported accommodation in the Port Adelaide area. The honourable member would know the superb work that the Port Adelaide mission is doing. I have been to the openings of three or four of those facilities for the Port Adelaide mission. I praise the Port Adelaide Central Mission, because it more than any other organisation has done work in that area. I have also opened a facility at Glenelg, specifically aimed at those with long-term mental health problems who need support in the community.

Both the CEO and I had a chance to look in detail at the model in Victoria, and we think that the graduated level of support from a high to a middle level of dependency and a lower level of support should be the model that we follow. The Port Adelaide mission is providing the medium and lower level of support, but not always with 24 hour care on site and not always with the clinical input which we think should occur. We have been planning some of these changes for quite some time. From what the honourable member has said, one would get the impression that we have just stood still during the past two years. The facts show that that is not the case.

Ms Stevens interjecting:

The Hon. Dean Brown: If the honourable member would listen, she would hear that we have already put out there the facilities that I have talked about, including the Port Adelaide mission facilities and a number of other South Australian Community Housing Association (SACHA) proposals and a facility at Glenelg.

Brennan looked largely at the clinical side. Brennan did not look at some aspects that we picked up, which was particularly supported accommodation, but we have put them in the departmental response. The departmental response was broader than Brennan and covered a lot of issues that Brennan did not look at, and it picked up the issues that had been raised in the summit. We found that carers and people who had mental health problems and who needed long-term support wanted the support in the community, but they wanted 24 hour support where necessary, and they wanted a clinical input.

So, we are providing those three levels of support. The idea is not that people will go in and stay there: we will try to graduate them down through the levels of support and rehabilitate them back into the community. There are other people with severe mental health and associated behavioural problems who will always need a higher level of support and have a higher level of dependency. We see those people going into a long-term facility in Glenside. Eventually, Glenside will become what we would call a centre of excellence for rehabilitation. It will not be an acute facility.

The acute facilities will be out in dedicated facilities in the hospitals. The idea will be that, when a person leaves an acute hospital, instead of being pushed back into the community and being left, they will able to go into a supported accommodation facility at the appropriate level and slowly be able to rehabilitate themselves back into a normal lifestyle as far as possible. Most people are able to do that. After all, one in four people suffers from some form of mental health problem during their life. I also take some exception to the suggestion that with a great deal of fanfare we announced Brennan last Wednesday.

Ms Stevens interjecting:

The Hon. Dean Brown: It was not with a great deal of fanfare: it was a low key function. The important thing was that we invited 350 people who have been directly involved in the consultation process and who I thought had a real interest and a right to know. I was delighted to see the member for Elizabeth come along as well. She should have said (because she was there and she heard it) that for the first time ever we had the senior psychiatrists in this state stand up and express unanimous support for our direction and what we were planning to do. I have never heard that unanimous support from the psychiatrists before. A number of people have commented to me since how unusual it was, because in the past there has been enormous divided debate. In fact, the President of the Royal College of Psychiatrists came and saw me after the annual general meeting. She brought several senior psychiatrists with her, and she pointed out that they were absolutely unanimous in wanting to see the appointment of a director of mental health. The target for that appointment is a very short time frame—by August 2000.

They wanted to see southern and northern metropolitan networks and a country network; they wanted to see the retention of the rural and remote triaging system at Glenside; they wanted to see Glenside have an ongoing role but as a centre of excellence in rehabilitation for people with mental health problems—that is, long-term care for people with complex needs; and, very importantly, they wanted to see greater supported accommodation in the community. All those matters are being met—that is, the Brennan recommendations and, more importantly, the final adoption and response of the Department of Human Services.

With an issue such as mental health, it is easy to try to make points. I am not defending what has been a lack of an appropriate level of care in the community for an extended period of about 12 or 13 years, but I am delighted that we are putting in a significant commitment. That is the other part of the honourable member's question: what are we putting in? It is not only the additional $2.5 million. I might add that that is on top of the $5 million we committed last year on an ongoing basis. So, that means we are up about $7.5 million compared with where we were two years ago, and that is a substantial real increase.

However, on top of that we propose to inject about $6 million of crisis housing accommodation capital funds—because we are dealing with crisis accommodation—to provide these facilities. We are already well advanced on some of them. The land at Victor Harbor has already been purchased. Victor Harbor was a priority area because two major boarding houses in which many of these people were staying were bulldozed in the past 12 months and it was important to find suitable replacement accommodation for those people as quickly as possible.

We are providing an extra ASIS team in the southern suburbs at Noarlunga. We are providing supported accommodation at Noarlunga and a range of lower level community packages in that area. We are providing a supported accommodation facility in the southern suburbs called 'Millennium Housing'. We are providing two dedicated facilities, which I mentioned earlier today, one for Aboriginal men and one for Aboriginal women in the inner city area. In the Salisbury area we propose a joint project between the South Australian Housing Trust, the North Western Adelaide Mental Health Service, the Port Adelaide Central Mission and the Northern Consumers Advisory Group to provide supported accommodation there as well. So that will be north, north-west—

Mrs Geraghty interjecting:

The Hon. Dean Brown: They are the first six target areas. We indicated that we wanted to extend this to other parts of the metropolitan area and in the country. I see this as an ongoing program that will need to be in place for five or six years to provide all the accommodation needed, but $6 million is a huge start compared with what has been provided up until now. If the honourable member would like to look at a suitable sort of model that we are following, I suggest that she look at the footbridge model in Victoria. Footbridge is for high level dependency, but equally they have these medium and lower levels of support as well.

Ms STEVENS: Thank you for your long answer, minister. I want to say that it is not about political point scoring or being political—it is about accountability. The fact is that the author of the report makes a number of statements, and in particular he says that South Australia has struggled with the national strategy, and I understand that the first strategy was signed in about 1992. The minister mentioned the issue of funding, but on page 9 of the report he says:

> These results point to system failure rather than under investment. It is our overwhelming conclusion that system issues must be addressed first.

I have to say again, on behalf of all the people who see me on a daily basis about the pain and the hopelessness of their predicament in terms of mental illness and family members with mental illness—and I am sure that the minister is aware of this, too—that systems issues are primarily the responsibility of the minister and his department.

The report uses the term 'over all these years'. This government was elected to office on 11 December 1993 and it is now the year 2000. I think fair is fair in terms of a bit of accountability and working out why it went so wrong and whether we will get it right this time or whether we or someone else will be doing this again in a few years.

I would like to talk about the Flinders Medical Centre 50-bed facility. In the 1998-99 budget, the Premier announced the 50-bed $7.5 million health facility at the Flinders Medical Centre. We know that it does not appear in the budget now. Last week I heard the minister say that there were to be 30 new beds at Flinders Medical Centre. I think the minister said that 20 beds were marked as high priority and that there would be 10 additional beds as well. I would like to know the estimated cost of these beds and when they will be operational because, surprisingly, they are not in the capital works program.

The Hon. Dean Brown: Some of these issues or questions were answered at the presentation last week. I think the honourable member may have left by then, but I did answer a number of them at that time. The original proposal was to provide 50 beds at Flinders. That covered three things: acute beds for the south; rural and remote secure acute beds; and adolescent beds. As Brennan has found out—and as we found out at the mental health summit—it is more appropriate to put the adolescent beds into the Women's and Children's Hospital. Therefore, two secure beds will be provided at the Women's and Children's Hospital. I have asked that that work be undertaken as quickly as possible. As I understand it, some of the money which they have raised publicly and which has then been subsidised on a dollar for dollar basis by the state will be used to provide those secure beds as quickly as possible in existing facilities. In other words, we do not need to build a new building: it is a matter of renovating existing buildings.

At Flinders, as I indicated last Wednesday, the preferred option, if possible, is to provide the beds within existing

facilities/buildings at Flinders, and urgent work is being undertaken to try to identify how that can be achieved. That is being done for a couple of reasons: first, it can be done quicker than if you went out to build a new structure; and, secondly, we think it is more appropriate. My chief adviser on psychiatry, Professor Ross Kalucy, indicated to me that he had concerns about where it was proposed to build the original structure which was some distance from the hospital: it was an ideal location in terms of view but not an ideal location in terms of the treatment of patients and reasonable access to the rest of the hospital and certainly accident and emergency. He supports, as does the CEO of the Flinders Medical Centre, trying to find suitable facilities by juggling existing space and making suitable internal operations as necessary.

The other beds that were going to Flinders were some rural and remote beds. It has been decided, as recommended by Brennan, that those rural and remote beds, first, if possible, should be provided in the country hospitals, particularly in the larger regional hospitals, and in the other acute hospital facilities in the metropolitan area so that there would be a range of services. For instance, if someone was coming in from the north, they would be able to use a hospital bed at the Lyell McEwin Hospital rather than travel to Flinders. That accounts for why there is a difference between the 30 beds which I said we wanted to provide at Flinders and which was always the number to cover the acute services in the south, compared with the 50 originally, because adolescent beds and rural beds have now been removed from the Flinders facility.

Ms STEVENS: The two beds at the Women's and Children's Hospital for adolescents—

The Hon. Dean Brown: Two secure beds.

Ms STEVENS: Sorry, two secure beds. Is the minister confident that that will then alleviate the need to place adolescents at Glenside Hospital?

The Hon. Dean Brown: I am told that, generally, that would be the case but, sometimes, violent near adult people with a drug history are involved, and it would be inappropriate to put those people into the Women's and Children's Hospital rather than a secure facility. One cannot be rigid in those cases. On some occasions, I have questioned why a person has been put into Brentwood, and I have been told that, because of the nature of the person involved, on the best clinical advice, they should go into Brentwood, particularly very violent people with a drug related problem, who are almost an adult and who have a history of threatening others. They can be put into Brentwood where they will receive specialist care.

Ms STEVENS: I refer again to minors being placed in Glenside Hospital. A specific case was brought to my attention last week of a 15-year-old boy who was admitted to Glenside Hospital. I do not think he was placed in the Brentwood ward; it might have been the Kurrajong ward. I received a frantic telephone call from his parents who were not allowed to see him. They were incredibly traumatised as well as the boy. That matter has been sorted out following my intervention and intervention by the minister's office last Friday. I spoke to the boy's mother yesterday and he is now at home but, certainly in the beginning, the situation was of concern.

Following some publicity about young people being placed in Glenside, I received a letter. I do not want to reveal the writer's name, but I would like to quote this letter and ask the minister to comment on its contents.

The ACTING CHAIRMAN: Does this letter have anything to do with the budget?

Ms STEVENS: It certainly has. It relates to the mental health services budget on page 6.23.

The Hon. Dean Brown: I would like to respond to the issue raised by the honourable member about the 15-year-old boy. The honourable member contacted my office—something which I encourage members of parliament to do—and the matter was followed up. The clinical advice was that Glenside was the appropriate location for this boy who was about 15 years old. Without going into the details of the patient, he was extremely violent, and Glenside was regarded as the most appropriate location. There was clinical advice to back that up.

I am pleased that the honourable member has said that the matter has been cleared up. I appreciate the cooperation shown by her office and the way the matter was followed through by my office, but I stress the fact that we did not alter anything, we simply provided information about why the person was put into Glenside.

Ms Stevens interjecting:

The Hon. Dean Brown: I am not sure whether that was not the arrangement throughout. When a crisis occurs involving a young person who is violent, the incident is serious and I understand that members of the family become very concerned. In the initial few hours or so, sometimes the action that is taken can be misunderstood. However, in this case, the parents have accepted the explanation. I am glad to hear that the lad is back home and appears to be more stable.

Ms STEVENS: But the issue is that, if children under 18 are going to be put into Glenside Hospital, a different set of processes must be involved. The parents must be involved. Both these parents were around, the lad was not on his own, and the fact that they were cut out was an issue. They did not know what was going on and neither did the child. Perhaps the matter could have been handled better.

The Hon. Dean Brown: Under what we have agreed following Brennan, Glenside will not be used as a short-term acute facility. We are now talking about temporary or transitional positions only. Some of the Glenside facilities are not suitable. I have looked at the facilities and spent some money on urgent repairs because I believed they were substandard. We now have a clear direction for Glenside, and I think that should be welcomed.

Ms STEVENS: I will now refer to the letter. I received this letter on 7 May, a few days after—

The ACTING CHAIRMAN: Does this letter clarify an item of expenditure in the budget?

Ms STEVENS: It relates to mental health services.

The ACTING CHAIRMAN: Does it relate to explicit expenditure?

Ms STEVENS: It relates to expenditure for the running of Glenside Hospital.

The ACTING CHAIRMAN: To what sum does the letter refer?

Ms STEVENS: The letter does not refer to a sum; it relates to issues involving processes at Glenside Hospital.

The ACTING CHAIRMAN: It is probably more appropriate for a grievance debate than the budget estimates in that the budget estimates are for the purpose of obtaining information about funds being appropriated to programs rather than explicit differences over administrative policy.

Ms STEVENS: With respect, sir, many of the questions that have been asked today—

The ACTING CHAIRMAN: Oh, read the letter!

Ms STEVENS: Thank you, sir. The letter states:

> Dear Ms Stevens,
>
> I have written to you previously regarding my concerns for the treatment of young patients at Glenside Hospital. On that occasion it was a teenage girl who had been admitted to a geriatric ward—something denied at the time by the government and senior administration, but still adamantly confirmed by staff to me. Given that reaction, I suppose I shouldn't have expected any better this time. However, I noted with great disappointment the response of the minister, Dean Brown, to more recent claims that teenagers as young as 14 have been placed in wards with violent adult patients. His denial was interesting in that it only dealt with the claim that these young patients had been in wards with convicted criminals. What he failed to address is the ongoing fact that young patients are constantly placed in wards such as Brentwood with violent adult patients (not necessarily criminals) and that this is not a suitable place for them to be treated.
>
> It has recently come to my attention that Brentwood staff have over several months been keeping detailed incident reports on the number of young patients held in their wards and dangerous or violent incidents involving them. In a recent meeting with hospital administration to address their concerns, the staff were informed that all of the incident reports regarding these young people had been 'lost' and that, since there was no record of any incidents, nothing could be done.
>
> What I want to know is how, in a supposedly professional administration, is it possible to lose every single incident report concerning young people over the past several months? It is either appalling incompetence or a deliberate cover-up.

The letter continues:

> The fact is that young people are being constantly placed at risk in Glenside and neither the government nor the administration have the will to respond in anything but a negative 'shoot the messenger' way.

I will leave it at that, because that is all of the letter that relates to young people at Glenside. Is the minister aware of the matters to which I have just referred and, if so, will he provide an explanation?

The Hon. Dean Brown: Am I aware of what?

Ms STEVENS: The loss of all the incident reports.

The Hon. Dean Brown: No, and we will investigate the matter. To say that the government is sitting there and not responding is not correct. What more can one do? We have had a comprehensive summit. We brought in Brennan and told him to outline it exactly as it is and to make recommendations. In the space of a month, we have come out with a departmental response.

Any issue about Glenside being used for acute patients is an interim provision only until we are able to provide other in-hospital accommodation. Let us be frank. The longest delay in providing that accommodation is with the Royal Adelaide Hospital, because we need to go through stage 2 and stage 3A before we can provide on-site acute beds at that hospital. It is simply a physical problem of being able to provide the space.

I have seen the plans as to where the acute facilities are to go. I think it is under stage 4, if I remember rightly, of the Royal Adelaide Hospital that the acute psychiatric facility is provided. But it is part of the planning. I would hope to move the Flinders beds and provide the acute beds at the Women's and Children's Hospital as quickly as possible. We have given many of these issues the time frame of only two or three weeks to come up with broad planning issues about where to put the facilities and how to commence the detailed design work.

Membership:

The Hon. M.D. Rann substituted for Mr De Laine.

The ACTING CHAIRMAN: Recently, the Public Works Committee received submissions on the capital works program to be undertaken to upgrade the Queen Elizabeth Hospital and in the course of stage 1 of those works no mention was made about the retention or otherwise of research facilities on that campus, even though the research facilities structures, or at least the buildings in which the research facilities are housed, are to be demolished. Is it the intention of the government to remove the research programs from the Queen Elizabeth Hospital campus at any time in the next five years?

The Hon. Dean Brown: The answer is that it is not proposed to close down research at the Queen Elizabeth Hospital. As chair of the Public Works Committee, you, Mr Acting Chairman, would be aware that the government has so far put up a proposal to construct 200 new beds to replace 200 old beds. My understanding is that the proposal does not affect the building where the current research is being carried out: it affects the old administration wing at the back, which will be demolished. I think work is due to start on that very shortly. It does not affect the medical research building. However, the longer term plans for the hospital do. If you go through to the final development of the hospital, you see that it is planned to replace or demolish that building which is currently the research wing.

A senior staff member from the hospital has been to see me fairly recently and has raised a number of possibilities about where the future research might be housed. Those matters will be looked at as part of the further stages, but the stage that has been referred to the Public Works Committee does not affect the research facilities.

In terms of the type of research carried on at the various hospitals, the clinical reviews that are under way have a big impact on that, because we want to build up centres of excellence across the metropolitan area. We are developing networks. In reality, in the past all the hospitals have tried to stand alone and offer the same services—to be all things to all people. We have more teaching hospitals in this city—six of them, I think—whereas most other cities of equal size in the world probably have one teaching hospital. We do not want to close down the teaching facilities but we want to make sure they have their centres of excellence, and they cannot all be centres of excellence in all areas of medicine. So there will be some changes made as a result of the clinical reviews between the hospitals but I think that is simply part of the change in technology, the extent to which it is more expensive to provide much of that technology and making sure you build realistic centres of excellence rather than scattering your research so widely that it has minimal impact.

That is a broad statement about research in our hospitals and there will be changes, but that should not imply that the nature of research in any particular hospital is about to change.

Mr MEIER: The regional statement (page 6) states that 'the government is committed to enhancing and improving regional access to health services'. The minister highlighted some of those aspects earlier today. Given this commitment, how are telemedicine and tele-education enhancing rural services.

The Hon. Dean Brown: Telemedicine was first used, and has been used for a number of years, in telepsychiatry, and I think there are now 18 hospitals in rural parts of South Australia that have telepsychiatry. We are trying to increase that number. In some cases, it depends on the quality of the telecommunications link. I spent Friday night in a country

area: the GPs, the mental health workers, the mental health admissions nurse for the hospital and some rural and remote psychiatrists—the whole team of about 30 people—sat around all night talking about how more effectively to integrate mental health services, particularly in country areas. I was pleased to hear the extent to which telepsychiatry services is a very valuable tool indeed. We intend to expand the role of telepsychiatry based at Glenside and to make sure that there is a centre of excellence there. We have some of our own psychiatrists but also visiting psychiatrists who come in and provide a service.

We have a telemedicine service in terms of the renal service at the Queen Elizabeth Hospital, and I have seen that in operation. Patients in country areas have a video link with the hospital and each day as the patient goes onto dialysis they hook up, talk to the appropriate specialist nurse involved and she checks on the patient to see that the parameters on the machine are set correctly. They come back perhaps half way through the three hour dialysis session and then again at the end. There is the comfort of knowing that, if at any stage they urgently need an expert opinion as part of the dialysis process, they are able to get it. That occurred at Moonta Bay in your electorate. The person who accessed that service had previously been spending a lot of time in Adelaide and commented that it was a great relief to be able to stay at home, to live within the community, to live with his wife and to be provided with home dialysis.

That is another classic example. I have seen it operating in terms of education. We have a specialist at Mount Gambier and each Friday he comes on and is hooked into training sessions at the Women's and Children's Hospital. He is training for higher qualifications in a field of specialisation.

We have a tele-oncology service at the Royal Adelaide Hospital, and there is a weekly video-conferencing hook-up between the Royal Adelaide and the Royal Darwin hospitals. People with cancers are initially treated in Darwin and when they come to the point where they need a higher level of care and a higher level of intervention which cannot be provided in Darwin they come down here. But there is a continuity through this tele-conferencing facility, so the specialists down here have been part of the treatment plan for weeks or perhaps months prior to the patient coming down here.

Julia Farr Centre has a support mechanism in country hospitals for people with brain injury. There are video-conferencing facilities, and in the Riverland in particular all of the hospitals now have a joint conferencing facility, so instead of them all having to drive to one town to sit down and have a meeting they can hook up amongst themselves on the video-conferencing and receive and participate in a conference. The Women's and Children's Hospital has video imaging facilities. It also has a networking system, which has been funded to the extent of $700 000 by the federal government, as part of a national program.

Mr MEIER: I thank the minister for that answer. Certainly it is of great assistance to hospitals in my area and, hopefully, it will continue to expand, as the minister has indicated it will. I refer to page 6.6 of the Portfolio Statements, where disease prevention and management appears as a portfolio output. Can the minister give me an up-date on how the breast screening program is progressing?

The Hon. Dean Brown: The breast screening program here in South Australia is regarded as probably the best in the country. We certainly have a higher percentage of participants in the target group of women involved in that program. They have seven fixed-screen clinics, six in the metropolitan area and one in the Riverland, based at Berri Hospital. There are two mobile X-ray units that work in rural and remote areas, and I think there is now a caravan also that operates in the metropolitan area to service women in their localised communities who otherwise may not travel to a hospital or a clinic to receive treatment. At the end of last year about 65.4 per cent of South Australian women between the age of 50 and 69, which is the target group, had participated in the screening over the previous 27-month period, which, as I said, is a very high percentage indeed. It aims to try to achieve 70 per cent of women in this age group every two years.

The target for this last year was 65 000 screens. We are trying to increase that for this coming year to 68 000 screens, so an extra 3 000 people. A new mobile unit was commissioned for the metropolitan area in February this year. The Marion clinic has recently been renovated and expanded with increased capacity. I was down there for that opening and I was very impressed indeed. From January the clinic has been providing 80 screens a day, and when it is at full capacity, by the end of June, it hopes to be able to treat about 120 women a day. So we can see that there is a significant increase in the number of people involved in the services being provided.

I can recall that at about this time last year I was asked to go on air to counteract claims that were being made publicly that I was about to abolish Breast Screen SA, that despite the excellent record that it had achieved and the service it was providing I was not a supporter of it and was about to dismantle it. I would just say: the evidence stands.

Membership:

Ms Thompson substituted for Mrs Geraghty.

Mr MEIER: My next question relates to the regional health boards. I guess, minister, it would be some five years since we implemented regional health boards in South Australia. As I said earlier, to the best of my knowledge, no public hospital has closed since we brought in that policy. Can the minister identify at this stage some of the positives of the regionalisation of health, as against the centralisation of health which we used to have, and perhaps he has other comments on how it helps make the expenditure on health even more efficient in this state?

The Hon. Dean Brown: Thank you very much. I am glad the honourable member has raised this issue, because I suppose there are those who have been detractors of regionalisation in health. Having had a chance now to move around and talk to the people involved and even see a further improvement over the past two and a half years, I am a keen enthusiast for the regional structure we have set up. I think it has worked very well. In some areas it has worked better than others; some areas got in there a little more quickly than others and adopted the true principles and concepts of regionalisation. But I think all of them have improved in the past couple of years. It has a lot of benefits.

First, the decisions are being made much closer to the community. It has helped breakdown this feeling that every town had to offer every health service that it possibly could, and if they did not there was something wrong with their hospital. That was the sort of inference. We have developed very strong networks through those regions and you now see a level of cooperation, and, let's face it, some of these hospitals are relatively small hospitals and interstate they would have been closed down six years ago, but back in 1993

I gave a commitment not to close any public hospitals in the country, or in the city, and we have stuck to that.

We have broadened our role into aged health care and community care. I think it has been an excellent model and people interstate have said to me, 'If only we had followed the model that you have in South Australia.' That has turned out to be much more effective than, say, the model in New South Wales, which was to close the small hospitals and to set up big regional hospitals, which means that everyone has to travel at least some distance, and in some cases quite reasonable distances, to a bigger regional hospital. It also means that it is then harder to keep the GP services in those towns if there is no hospital, and it is harder to maintain aged care facilities there as well. We have integrated those all together and one supports the other.

I think the other thing that has occurred is that it has allowed them to look at where they should provide some of the services. I have found that there is even an acceptance now by communities who have said, 'In our community we have decided that we will not carry out theatre work.' Even though there is a theatre the community accepts that there will not be theatre work, because it may be a very small hospital and there are not the suitable doctors around, the anaesthetists and others, to provide that service.

One community said that it was delighted to see the sort of flexibility we apply. Its theatre had been closed down for some years but it had opened again because they found an appropriate surgeon. It is not a one way process. Most of those individual hospitals that had some concerns because they felt that their independence was being undermined now believe that the hospital structure and their role in it has been strengthened. What we have been able to achieve by maintaining local boards is that strong link between the hospitals and their local communities, which is absolutely crucial in terms of people feeling that they own the hospital, and as a community they are willing on many occasions to put in a lot of money.

Snowtown recently put almost $1 million into aged care in its hospital. I went to the opening at Booleroo Centre. We did some renovations and the local community raised about $400 000 as part of it. There are plenty of other examples where the community feels that it is their hospital and they want to get in and back it and are very proud of it. In most country hospitals and centres, the hospital is now the centre of activity in the town. If you go to Karoonda you will find more cars around the hospital, even on a Friday night, than probably around the pub. It is a huge boost for those towns. It means that they have kept the jobs, the supplies and the older people in the town.

Ms STEVENS: I have one small health question left before changing over. I refer to mental health and to an initiative announced on Wednesday 6 May 1998. What has happened in relation to it, how many people have used it and how well is it proceeding? I refer to the 24 hour mobile crisis service catering for young people, their families and organisations that assist them. Can the minister provide an update on how it is operating, how many young people it has dealt with and how successful those issues have been through that service?

The Hon. Dean Brown: We will get that information. We do not have the details here.

The ACTING CHAIRMAN: The committee will now deal with Family and Youth Services.

Additional Departmental Advisers:

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

Dr A. Van Deth, Executive Director, Metro Division.

Ms M. Novick, Senior Policy Officer, Executive Services.

Ms STEVENS: I refer to page 6.15, output 4.2 of volume 2, relating to care for children and young people, and particularly in relation to alternative care. One of the quality indicators relates to the percentage of children exiting alternative care after less than 12 months and who have had three placements or less. It is 77 per cent of children this year, and it is the same target for next year. The total number of children in foster care is 1 025. I find it difficult to follow because it seems that there are two different indicators—the less than 12 months and also the three placements or less—both operating together in the one statement. Is the minister able to shed some light on why two things are operating together? With respect to the remaining 23 per cent of children—I think that represents 235 children—are we to presume that those children had many more than three placements or were in foster care for more than 12 months, or both?

The Hon. Dean Brown: The simple answer is that those figures cannot be used in that way. One set of figures applies to 30 June and the other set to a 12-month period.

Ms STEVENS: Which is where, minister?

The Hon. Dean Brown: The member should look a little higher. One set of figures relates to a fixed point of time and the other relates to the total number of children who have been in care over one year. The number of children under care as at 30 June is less than the total number of children under care for the whole year. Therefore, the member cannot use her calculation.

Ms STEVENS: Will the minister provide an alternative calculation? If the minister is talking about 77 per cent of children exiting alternative care after less than 12 months with three placements or fewer, how many children are involved?

The Hon. Dean Brown: I do not have that information but I will provide it.

Ms STEVENS: Thank you. The bigger question concerns the 23 per cent—

The Hon. Dean Brown: I will check the details but I think the member is including in that 23 per cent children residing with relatives.

Ms STEVENS: I am reading from the budget paper, which states that the number of children exiting—

The Hon. Dean Brown: If the member is asking whether that means that 23 per cent of children who are exiting the service had more than three placements, the answer is 'Yes.'

Ms STEVENS: The point I am making is that the quality indicator has two parts to it which, from my point of view, makes it confusing. Does it refer to children who were exiting alternative care after less than 12 months and, as well as that, had three placements or fewer? Does that mean that the 23 per cent exited alternative care after less than 12 months with more than three placements? Did they exit alternative care after 12 months and had three placements or fewer? Or did they exit after 12 months with more than three placements? That is the confusing part.

Mr Proctor: We are talking about a number of those exiting care and we are saying that, of those exiting care, 77 per cent had three or fewer placements and, therefore, by

definition, 23 per cent had more placements than that in the course of that 12 months.

Ms STEVENS: Can you tell me why that is the case? Why were there more than three placements within three months?

Mr Proctor: The issue we are talking about is the degree of stability in children's placements in the alternative care system at the present time. We have numbers which will show that at 30 June 1997 the average number of placements per child was 2.3; at June 1998 it was 2.4; and at June 1999 it was 3.1. Those figures include respite care placement. This is the same issue as you have raised, and I am talking about it from a different perspective. It is important to note that those figures include respite care placements. A number of children in the system have regular respite care as a means of providing support to the long-term placement; that is, the respite care enhances rather than detracts from the stability of the long-term relationship with the foster family.

Those figures suggest that over that period there was a greater degree (marginal, I would argue) of volatility in respect of movements within the system. However, there is another way to look at the numbers, and that is to look at the number of care givers per child in 1997 and 1998, because that is probably a more valid indicator of placement stability. The data we have on the numbers of care givers for children who were in care for each of those calendar years show that, in 1998, 82 per cent of children lived with the same care givers, compared with 87 per cent in 1997. Again, it was a marginal increase in volatility, with slightly less stability, which is clearly undesirable. At the present time the department is engaged in examining the alternative care system, working with service providers to try to deal with this issue and the others that need to be dealt with in the alternative care system.

The Hon. Dean Brown: At the end of last year we had a discussion with the foster carers. They asked us to work with them on a number of key issues, and this is one of the issues. Another issue with the foster carers was that they asked whether I would index them fully, and this budget does that. There is an extra $1.6 million to provide full indexation of all payments to carers. I granted an increase in December, and this now brings up the full CPI adjustment. It had not been adjusted for some time, so they appreciate it. My hope would be that from now on it will be indexed each year; that is the expectation I will create. We must appreciate that there is quite a commitment there.

Some years ago, before I was minister, SACOSS was allocated money that was not spent on the project for which it was allocated. The government and SACOSS have mutually agreed that that money will be put into a trust fund specifically to provide support for foster children, where needed. It may allow them to go on and get some higher education. Out of this I want to make sure that we not only provide foster support for these children but also take a long-term interest in their wellbeing and development.

There are many things that a foster child does not get; for instance, they do not have the same chance as other children to buy a computer. I am keen to maintain something like a trust fund so that if we see a need we can buy a child a computer as part of their education, particularly if they are going on to higher education—or some other support. I want to be flexible here, and SACOSS has also agreed to be flexible. I think it is a unique step that we have set up this trust fund, and the income from that trust fund will go specifically to those foster children. It will not be there for the base provisions: it will be there to help them live a more normal life, as other children would expect to live.

Ms STEVENS: How much is in that trust fund?

The Hon. Dean Brown: I think there is $1.6 million. So, it is a significant amount of money.

Ms STEVENS: My next question relates to alternative care. As the minister would know, the alternative care contract with Anglicare concludes on 30 June—in nine days—after two years and seven months. What were the benchmark indicators to assess the performance of Anglicare in achieving improved outcomes for children in care? What is the extent to which those performance benchmarks have been achieved over the life of the contract?

The Hon. Dean Brown: First, a moment ago I referred to our discussion with foster carers. One thing they asked us to do was to try to achieve as much stability as possible for foster parents and the children themselves. Given the contract service that was introduced before I was minister, the request through Anglicare was that we would not suddenly change who was providing the service, because once again that would cause discontinuity. They said the most important thing of all was to be able to establish an understanding and a link with the alternative carers, the people providing the service and the foster parents to be able to work through some of the difficulties of the foster children with the same person. So, as a result of that, I decided that we would not go out and call new tenders, because that was not in the interests of the foster children involved. Instead, we decided to roll over the Anglicare contract for a two year period and at least get a decent period of continuity, but we wanted to achieve some specific things as part of that.

The service includes increasing the range of care options for children, the introduction of brokerage funds, and providing flexibility to develop individual care packages for young people and families who are unsuited to the existing services, because we feel that a number of children are better treated in other ways. Deeds of arrangement with new service agencies expire at the end of June. They stipulate the total output in the provision of placement services and the number of direct contact hours to be provided. We will get the benchmarks; we do not have them here. Certainly, we are taking up with them a number of issues to try to improve the service and increase flexibility. One thing we have asked for is to try to achieve even greater continuity of the personnel involved in providing the service. We will provide more detailed answers to the honourable member's questions.

Ms STEVENS: I am concerned that we are very clear about the fact that we outsourced this contract for1 alternative care services 2½ years ago. I definitely want to know what the benchmarks were to start with and the degree to which those benchmarks have been achieved, because obviously the government has decided to roll this over and not recall tenders again. I am assuming that the minister must be satisfied with the achievement of those benchmarks.

The Hon. Dean Brown: First, let me say that we saw room for improvement in the service that was being delivered by Anglicare. We have taken that up with it, but we have also balanced that with the need for some continuity of service. For the sake of the children and the families involved, we decided that the best option was to roll the contract over for a two year period, and we have done that. However, that does not mean that it is just rolled over on a constant basis. There is renegotiation of some of the outcomes that we want to achieve under that contract.

In terms of the effectiveness of the new foster care system and the standards for children in foster care, a longitudinal study has been carried out in alternative care by Flinders University. I will outline what the study found. The study represented the first longitudinal study in children in foster care conducted in South Australia. Its findings were important to inform us over the long term how the alternative care system is functioning in meeting the needs of children placed for emergency short-term or long-term care. A major restructure of the placement system took place in 1998-99. The longitudinal study has enabled a comparison to be made of how children faired under the old system and how they fair under the new system.

Despite numerous criticisms being raised about how the new alternative care system is working, the Flinders research indicates that there are encouraging findings about the effectiveness of the new service. One of the key findings involved placement disruption, which has been a longstanding concern. A key feature of the alternative care reform was to reduce the level of placement disruption, that is, unplanned placement moves experienced by children in care. The study indicates that the majority of the placement moves are now planned. Furthermore, most moves from one placement to another are based on the search for better options rather than as a result of the breakdown of the previous placement—and I think that is encouraging. There were small but statistically significant improvements in the overall adjustment of children whilst in alternative care.

There was an overall reduction in conduct disorders, hyperactivity and emotional reaction among the children studied. Most hard drug users had stopped taking drugs once in care and there was a general improvement in the behaviour at school. Whilst for most children there was some stabilising of their behaviour whilst in alternative care, the study indicated that a proportion of children remain difficult to place because of their behaviour and level of need. This subset of children and young people does cause problems for the alternative care system, tying up resources and exhausting the placement options. However, having established where a major blockage is occurring in the system, more appropriate care options can be designed to address the particular needs of the group of children and young people.

The aim of reunifying children with their families, where possible, appears to be on track. The study indicated that 25 per cent of children were reunified with their families in the first four months of being in care. Furthermore, relatively few children who went home returned to care during the study period, providing some indication that the efforts to maintain children in their family environment are succeeding. The results provided a profile of children entering the alternative care system. Children generally fell into two groups: first, younger children aged around eight years or so being placed in out of home care because of neglect and parental incapacity; and, secondly, a group of adolescents with behaviour or mental health problems.

Having a clearer picture of the types of children needing alternative care services enables more effective planning of the service strategies. These latest results from the research program are encouraging and provide an indication that, for the majority of children, the new system is improving the outcomes of children in care. I think that is an encouraging outline. Incidentally, I had not seen that result before.

Ms STEVENS: Will the minister provide details of the author of the report and its date?

The Hon. Dean Brown: Professor Jim Barber was the person responsible for the research and Flinders University was contracted by the Department of Human Services to do it. It is ongoing research. I presume that these are fairly recent findings. It is current research.

Mr SCALZI: Referring to page 6.5 of the Portfolio Statements, I note the aim to provide community support and development: will the minister advise on support and development provided through the charitable and social welfare fund otherwise known as Community Benefit SA?

The Hon. Dean Brown: The community benefit fund, or Community Benefit SA, allocates about $3 million a year annually—that is money taken from poker machines. The program was set up when I was Premier in 1995 and we imposed a supertax on the larger poker machine venues and directed an extra $25 million into community benefits. Since it was established in 1995-96, 2 820 applications have been received and $44.5 million has been requested. Funding has been provided to 982 projects and a total of about $10 million has been allocated. That means that the average per project is about $10 100. Certainly, the broad aims have been achieved.

There are two funding rounds each year, and I know that the latest funding round is ready for sign off now and there will be an announcement on that in the next day or so. In fact, I think letters to the agencies which put in applications and which have been successful have been sent out or are about to be sent out by Community Benefit SA. In the August 1999 round, 409 applications were received requesting just under $6 million: 146 projects were allocated $1.4 million. There were 142 projects under the normal grants, involving $1.16 million. There were four projects under special grants and, in total, $211 was allocated to those projects.

The special grants were for a smaller number of community organisations that at the very beginning had asked for this poker machine revenue to be allocated. They were organisations that had lost significant revenue as a result of the poker machines. They had had bingo nights and various things such as that. These are mainly some of the bigger, well-known charities in South Australia such as MS and others. Cabinet decided that there should be a special allocation for them, particularly looking at ways in which they could build-up their other fundraising activities to replace poker machines. Those special grant lines will eventually be phased out in about two or three years. I have already agreed—and cabinet has given its support to this—to phase them out, because it is inappropriate to have them included on an ongoing basis.

Mr SCALZI: I refer to page 6.6 of the Portfolio Statements—'support for community activities and networks that develop caring and cohesive communities.' Will the minister expand on the department's support of charitable agencies?

The Hon. Dean Brown: Recurrent funding is provided for non-government organisations, which include programs such as the Family and Community Development Program, $7.5 million; and Alternative Care Services, $4.9 million. The Gamblers Rehabilitation Fund for people with a gambling addiction is likely to be increased this year. In the past, we have allocated $1.5 million, largely through hotels and clubs money. This year, the government has put in $500 000 on an ongoing basis. Funds allocated for that purpose will be increased to $2 million. Funds for the Supported Accommodation Program (SAP), which is jointly funded by the commonwealth and state governments, will increase this year from $23 million to $24 million.

I will refer to the bigger agencies that receive recurrent funding. I think I am right in saying that the department works with about 450 agencies, many in this area which provide fairly small services and others which provide much bigger services. It must be appreciated that a large number of organisations is involved. Groups such as the following receive funding: the Aboriginal Family Support Services, $1.5 million; the Adelaide Central Mission, $1.2 million; Anglicare $4.2 million; Anglican Community Care in the South-East, $1.1 million; Centacare, $1.2 million; Lutheran Community Care, $500 000; the Port Adelaide Central Mission, $900 000; the Port Pirie Central Mission, $1.5 million; the Salvation Army, $2.2 million; St John's Youth Service, $1.2 million; and the Wesley Uniting Mission, $600 000. A number of these organisations also receive funding from other areas of the portfolio—through Community Benefit SA or other such areas. The details I read out relate to support received specifically in this area.

Mr SCALZI: 'The establishment of new contracts with non-government organisations' is a portfolio target on page 6.5 of the Portfolio Statements. What contributions do non-government organisations make towards enhancing the health and well-being of South Australians?

The Hon. Dean Brown: Non-government organisations carry out an important role in the family and community services area. Without these organisations, we could not provide the level of care that we currently provide. We give them money, but they also raise money in the community. There is the added benefit that they tend to be closer to their communities and in a position to deliver the services that these communities need.

We allocate about $145 million a year to non-government organisations in this area. That is a substantial amount of money for about 450 organisations. Some are fairly large allocations; many are very small. Many of the organisations involved tend to be very small. SACOSS is involved with some of the allocations that we make. We try to provide ongoing support for these organisations. It is one thing to fund them and to ask them to provide certain types of services. Much of this is done on a non-contested basis. In other words, we will see a group in the community that is providing an important service; this group is already set up, and we provide it with support. We also try to provide these groups with industry and development support.

SACOSS has a budget for best practice of $115 000 to help these organisations. SACOSS also does work to help these organisations to deliver best advice to the people they are trying to help. An allocation of $105 600 has been made for this purpose. Community and neighbourhood houses and centres receive $63 000. The Multicultural Community Council receives $21 000 in this area; Volunteering SA receives $94 500 for best practice and $31 000 for best advice; and the Youth Affairs Council receives $13 100 for best advice and $31 500 for best practice.

Membership:

Ms White substituted for the Hon. M.D. Rann.

Mr SCALZI: What does the department do to ensure that these community organisations are aware of the funds that are available?

The Hon. Dean Brown: Most of them come to us asking for money. Community Benefit SA advertises that applications are available. We advertise in a number of these areas. We might pick out a particular need and invite interested community groups to apply for funds. Some are based on what we perceive to be a need, while others are historically based: they have been funded for a number of years and we continue to fund them. We review what they are delivering and make sure that they continue to deliver what we want. Some are done on a tender basis.

Ms STEVENS: I refer to a report by James Barber, PhD, Professor of Social Administration and Social Work. I am not sure whether this report is the same as the one to which the minister referred. It is entitled *The Slow Demise of Foster Care in South Australia*. It may be that the minister has a second report of which I am not aware. This report does not mention any of the positive things to which the minister referred but, as I said, there may be another report. There are matters of concern in this report of James Barber, to which I will refer. On page 7, he states:

> When all of the tenders were reviewed by the Community Services Division, an independent tender review panel recommended awarding the two metropolitan area services to two different providers. However, after intense lobbying of the then Minister for Family and Community Services by one of the agencies, the decision of the panel was overturned and both metropolitan areas were awarded to that agency. The agency concerned was the welfare arm of the church with which the minister himself was affiliated. Naturally the other non-government agencies viewed the minister's behaviour as a betrayal of trust and the bitterness over the way the contract was ultimately won remains within the sector to this day.
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> A recent evaluation of the restructured system (Barber, Cooper & Delfabbro, 1999) uncovered considerable levels of frustration with the new system across the entire children's services sector. In 16 focus group discussions held throughout the state with users and providers of the service, for example, there was near universal agreement that the quality of the service system was declining and that working relationships within the sector had deteriorated.

He then raises a number of categories of policy and planning failures within the system. The headings include 'The decimation of residential care' and 'The collision between policy and demography'. Essentially, it is about the severe shortage of placements for emotionally disturbed children and adolescents and children with disabilities; and it also indicates that the number of people available to be foster carers is declining.

The next section is entitled 'The funder-purchaser-provider model'. I will read the conclusion, which is entitled 'The bureacratisation of social work practice', because I think it is relevant. It states:

> In summary, then, there is little doubt that South Australia's alternative care system prior to the restructure of December 1997 was inadequate. Moreover, some of the problems were attributable to a moribund, grants-based approach to funding which promoted waste and compromised accountability. Under the grants-based model, the old system contained little incentive to improve performance or experiment with new ideas.
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> Just as certainly, however, the funder-purchaser-provider model that replaced the old approach to funding has created significant problems of its own. If the new model is to have a future, there is a need for what amounts to a psychological shift by 'purchasers' away from a master-servant relationship with its 'providers' towards collaboration and shared responsibility. The situation in South Australia has not been helped by the creation of a new bureaucratic structure interposed between referring social workers and agency support workers and carers.
>
> Most importantly, however, is government cost-cutting which has driven residential care to the brink of irrelevancy. Ironically, this policy is now in the process of destroying foster care as well because increasingly difficult children are being referred to a pool of carers that is collapsing under the weight of contemporary social and demographic forces.

I do not know whether that is the same report you were referring to: it certainly has a different conclusion. Will the minister comment on the matters I have raised?

The Hon. Dean Brown: It is not the same report; I understand that it is an earlier report based on qualitative research where the author asked staff for their views and formed a view based on that. The study to which I referred is more recent and it is based on quantitative analysis which expresses a fairly strong point of view on a funder-purchaser model that was put in place before I became minister. A number of people were critical of it because they had missed out. One of the troubles was that the system tended to pick one winner and all the others missed out.

I am not sure that that was entirely the appropriate way of doing it, but the important thing now is to build on it. That decision was made in 1997 and, as I said, we are working with Anglicare to refine and improve the process. Professor Barber's research and most recent studies show that it is improving the quality of care.

Ms WHITE: I am becoming increasingly distressed by the number of cases that are coming into my electorate office concerning wards of the state who clearly are not being properly cared for by the system. The system—not only your department but also the police and welfare agencies—is letting these children down. The parents and relatives of these children are becoming increasingly distressed by the inability of the state to cope with these children and provide them with the care that they need.

I want to raise two specific cases—one that came into my office only this morning—of minors who are wards of the state. Both involve children at risk who are in desperate need, but the system seems unable to cope with them. I will not mention their names, but I will provide that information to the minister so that he will know who I am talking about.

The first case involves a child who was nine years old when her mother died after a long illness. The child blamed her father for her mother's death. She exhibited severe behavioural problems and was removed from her family. The child is now 13 years of age. In the past two years I believe that the child has lived in about 13 foster homes, but some of that care has ceased because the child started making sexual advances to the male of the household.

I understand that the child is now in state-provided residential care and that the police have had to return her there because she has been soliciting herself. She has been hanging out with a 22 year old male and, at times, living with him. This male is known to police. I am not exactly sure of the history, but it has been intimated to me that it is because of sexual offences against young girls. She is now believed to be hanging out with a 25 year old man. This 13 year old girl needs help. She is often on the streets and is apparently not getting the help she needs. I contacted your department several times in February and March, and none of my phone calls have been returned. Will the minister address this very serious case?

The second case involves a child not quite 4 years old who was removed from the family at the age of 1½ years because of physical abuse by the parents—broken legs, bruising and so on. The child has spent 12 months with the grandparents. There is now a court case over custody of the child, for which the grandparents have paid. They have had to fork out a lot of money and have found this very stressful. The grandparents tell me that this child is in desperate need of counselling, that the child is disturbed, has nightmares and fears being hurt by adults. I am told that officers of your department have told the grandparents that the child would not remember any of this, but clearly the child appears to need counselling. The grandparents have gone to Victims of Crime, FAYS and the police. All these organisations have said that the child needs help.

The grandparents also went to CAMHS. Initially they were told that there was a three month wait, then they were told that there was a two month wait. The child still has not received counselling. The grandparents are at their wits' end. The parents of the child are violent and are in and out of gaol. There have been death threats to the child. The grandparents are very distressed about the situation. They tell me that they do not know how to handle the child. They do not have the skills or the knowledge to address the problems the child is having.

What I am after, minister, is not only action today for these two children, who are very much in need, but also some guarantee that I can convey to the many electors that I have that the system will in future be able to handle the needs of these children better than has been the case.

The Hon. Dean Brown: First, I appreciate the member not giving details of the children; it would be inappropriate to do so. As to the second child, I have written to the grandparents recently, I think; the name is familiar. I think the matter is before the Family Court.

Ms WHITE: The custody is, but what about the support counselling that is needed?

The Hon. Dean Brown: I understand. One issue that needs to be understood here is that in some cases—and I am talking generally; I am not talking about the two cases the member has raised—there are custody issues, there is a broken relationship, you have Family Court disputes, and one party feels that the Family Court is discriminating against them. I think that has to be taken into account. Certainly, I would want to know any details of what we call complex cases. There are a number of them which are very difficult to manage indeed, and I think it sounds as though these two cases are both in that category.

We are trying to provide alternative ways of looking after some of these more complex cases. For instance, one method that is being used in terms of foster care involves the SOS homes down at Seaford. That seems to have gone very well. SOS is a European organisation set up on a voluntary basis and, whilst there are some people who sat back and wanted to see how effective they were, the general comment I get is that they have been very effective indeed. In those cases you have a home mother, and she has three or four foster children whom she looks after, and they are very much trying to establish a family sort of relationship under which they live.

But all I would urge is that you understand that there are often other issues that are not known and there are often more complex issues involving the Family Court. In some of these areas where people have come to me and raised a serious concern I ask for an independent assessment from within the department to make sure that appropriate treatment is being provided, and in some cases I have brought in an outside person to give further assessment of whether or not the appropriate treatment and support is being given and the right decisions made. Some of these are very difficult cases, that is all I can say, but particularly where there are certain needs for the children we would want to give that a priority, and if members could continue to refer those sorts of issues and those needs to me I will try to make sure we are able to deal with them.

Ms WHITE: I have a supplementary question.

The ACTING CHAIRMAN: Yes, although I do not know what appropriation the member is referring to.

Ms WHITE: Minister, I am looking for a guarantee that the four year old will get counselling—she needs it, now—and that the 13 year old will not be roaming the streets prostituting herself, that you would do everything to prevent that. Can you give me those sorts of guarantees? Parents expect them.

The Hon. Dean Brown: I cannot sit here and give a guarantee as to what a 13 year old will do. We will attempt to try to put that child into a situation where the prostitution is stopped, if that is what the child is involved in. We will try to make sure that they get the sort of support and care that they need, but for some of them I stress it is very difficult indeed. Certainly, the four year old is in an entirely different category, and I will ask someone to immediately look at the needs of the child.

Membership:

The Hon. M.D. Rann substituted for Ms Thompson.

The Hon. M.D. RANN: I would like to ask the minister a question about the Cavan youth detention facility. Concerns have been raised with the opposition regarding the loss of revenue to the City of Salisbury from siting a youth detention facility on prime industrial land at Cavan. It is claimed that the council will lose rate revenue of $70 000, as the land has been purchased by government, having previously developed an adjacent access road at a cost of some $350 000, a development which I am advised was largely at the instigation of the then owner of the land. It has also been claimed that State Planning and the State Planning Commission have urged the Minister for Transport and Urban Planning to reject the development but that the minister proceeded to give her consent.

I understand that following advice to the government the Salisbury council was considering mounting a legal challenge. The government offered compensation of $250 000 to the Salisbury council. The government has also advised that no other government owned land is available or suitable for this development. So my questions are as follows, with your concurrence and indulgence, Mr Acting Chairman, because they are in four parts, but I shall ask them this way because I have agreed to depart the building at 6 o'clock.

Why did the planning authorities advise the Minister for Transport and Urban Planning to reject the development, and why was that land ignored? What price did the government pay for the land, and did that price reflect the value added by all or part of the $350 000 paid by the council to develop the area as an industrial estate; for instance, did the then owner make a windfall profit because of the expenditure by the council on developing the land? Why is the nearby SA Water land deemed to be unavailable? For what other purposes has it been reserved? How was the compensation figure of $250 000 arrived at? Has Crown Law provided advice in relation to the legal validity of the claims made by the City of Salisbury?

I think the City of Salisbury feels that it has been dudded over this and that there have been various manoeuvres, that the council is concerned that the planning commission, State Planning, has been overridden by the Minister for Transport. Because I know that it is in your portfolio area, minister, I wonder whether you could respond to the Salisbury council's clear concerns.

The Hon. Dean Brown: First, Crown Law has given an opinion to the department and I think we have also sought a second opinion, so we have two legal opinions on which we are working. So it is not as though we have just blindly gone into this. We believe that we are on very secure grounds legally. We are in the middle of negotiations with the Salisbury council. I think it is inappropriate therefore that I comment in terms of some of the issues you have raised, in the middle of commercial negotiations.

The government bought the land on the open market. It was advertised for sale and the government went and purchased it on the open market. So it is not as though the government has secured the land through compulsory acquisition or anything like that; it was a straight commercial sale. Therefore, being an open commercial purchase, I think it is inappropriate to obtain information on some of those, because some of the questions related to private individuals, and it is not a matter for us to determine what they do in terms of their purchasing of land. We went out and bought it. It was advertised. I personally went out and had a look around to try to find suitable land.

The big advantage of this is that we need to separate it immediately from the existing Cavan site, but close proximity to allow the two sites to operate effectively to share resources, such as vehicles and things like that, is appropriate indeed—or if there is a sudden need to transfer staff from one to the other because of illness or something like that. These two sites are in reasonable proximity. It appeared to me to be an ideal site. It is on good transport routes and, therefore, we believe it is an ideal site. But I really cannot comment further. The leader has asked me questions about the money the Salisbury council had spent. That is part of the commercial negotiations.

The Hon. M.D. RANN: By way of supplementary question, one of the concerns is not only the loss of rate revenue—and we can understand the council's concern about $70 000 in terms of rate revenue loss—but also the fact that it had put in $350 000 to develop access and so on in line with trying to upgrade the site as industrial land. I understand the Salisbury council will be addressing this issue on Monday night at its next council meeting. It would probably be quite useful for the minister to speak with the Mayor, Tony Zappia, to see whether these outstanding concerns can be resolved prior to that meeting.

The Hon. Dean Brown: Well, in fact there are talks tomorrow, so your concern is already answered.

Mr MEIER: I refer to page 613 of the Portfolio Statements. I note a reference to the provision of care for children and young people. Will the minister advise on developments as they relate to alternative care and the longer term prognosis to provide assistance to improve the circumstances of children and young people under guardianship? It follows on from the earlier question asked by the member for Taylor, which was specific in relation to two particular children. Mine is more of a general nature.

The Hon. Dean Brown: We have had some discussion around this area already, and I thank the honourable member for his question. We spent about $4.9 million on alternative care services. That includes $600 000 for SAAP supported accommodation providing brokerage for adolescents. The service includes an increase in the range of care options for children, and the introduction of brokerage funds providing flexibility to develop individualised care packages for those children, that is, for younger people, and families who are unsuited to the existing services. This is part of trying to develop other ways of providing care, to which I referred earlier.

There are deeds of agreement with new service agencies that expire at the end of June, and we have talked about the rolling over of those. We are working with them to try to refocus some of their services and achieve a better quality service, and they are very keen to progress this, because they have now had 2½ years of experience. It is very important that we take what we have learnt over the 2½ year period and try to build on it over the next two years. The deeds of agreement we have with Anglicare will be renegotiated. There will be an emphasis on performance and a commitment to solving some of the problems. Some of those problems have been highlighted today. They are the areas which we think need the greatest attention. That has answered most of the issues.

Mr MEIER: I am well aware that FAYS is called upon from time to time for financial assistance for people experiencing difficulties. That is certainly the case in my electorate. There have been cases where people's electricity is to be cut off because they have not paid their bill, and on other occasions the threat is made to cut off water. What is the policy of FAYS on giving out money? Is the minister aware to what extent such requests are abused; in other words, do people abuse the system of being able to tap into that free money? To what extent is there control of the way money is provided to people in desperate need of financial assistance?

The Hon. Dean Brown: I will add some more information to a previous answer, because the honourable member was looking also at child abuse and neglect in the alternative care area. The police in two areas—in the southern suburbs around Christies Beach and in the Port Adelaide area—have adopted different procedures in handling domestic violence and, as a result, where they visit a home twice on domestic violence issues and children are involved, they now automatically report to us that children are involved and that there may be a risk to those children. If you look at some of the figures in the budget documents, you will see an increase in the number of cases of potential child neglect being reported to the department.

We have decided to allocate an additional $1 million to deal with this increase in the number of cases being reported to us, specifically so that we can more effectively fight both child abuse and neglect. Instead of just dealing with the policing issue on a one off basis and trying to overcome the immediate problem, we are looking at the longer-term problems that may develop with some of the children in particular. The very fact that these children are reported as being in a vulnerable position does not automatically mean that there has been abuse, but it would contribute at least to the increase in the number of reports. There is also a greater awareness amongst those people who have an obligation to mandatorily report abuse or neglect cases, so more cases are being reported to us as well. It is important to adequately respond to them, thus we have made this a priority area and put in an extra $1 million.

Preliminary figures reveal that the number of child abuse notifications has increased by 12 per cent in the last financial year. We believe that the establishment of a child abuse report line, together with an increasing awareness of children's rights to be safe and free from harm, has resulted in an increase in the number of reports. Although the number of confirmed cases of abuse and neglect remains fairly stable, more suspected cases of child maltreatment are coming to the department's attention. Funding has been provided to enable the current system to be more flexible and to enable better response to the different and changing demands from one office to another. Sometimes we find that there is a demand in one FAYS office, and then that might come down for some reason, and there is a demand elsewhere.

It is impossible to predict the number of child abuse and neglect notifications that will be received on any given day in any of the 19 FAYS offices. Therefore, more flexibility is needed in liaising between offices. More resources will be dedicated to developing more culturally appropriate ways of responding to child abuse notifications, particularly with respect to the Aboriginal community.

Other priority areas include increased training for Family and Youth Services staff and more services to assist families in providing better care for their children. Parenting SA has published a parenting guide entitled *Parenting SA*, and something like eight million copies have been produced with 80 different leaflets. These are available from FAYS offices and, I believe, some members of parliament have copies. It is also available in various pharmacies throughout the state. I believe that parents have a growing awareness that they want to be better parents and, at times, they need specialist advice.

The parenting guide has been very successful, and now it can be accessed via the internet. The guide has been adopted by New South Wales, which has asked to purchase copies lock, stock and barrel and distribute them. New South Wales even had a supplement in the Sunday newspaper reproducing the advice sheets. Western Australia has requested copies of the advice sheets. We provide them with copies at a cost that covers our expenses. They use their own labelling so that it appears that they have produced it themselves. Requests have been received from overseas as well. This demonstrates how successful the publication has been. This $1 million—

Mr Meier interjecting:

The Hon. Dean Brown: I find that I need constant advice, and my children give me that advice at times. The $1 million in funding will ensure that we are able to deal with the increased number of child abuse notifications. Financial assistance is available for people caught in the poverty trap. Incentives are available in a range of areas such as rebates for water, electricity, council rates and public transport concessions. There is an ongoing demand for assistance through the anti-poverty program which offers financial counselling and support, financial assistance, funeral assistance, and concessions in the areas I have already mentioned, together with low income support programs.

The demand on financial counselling and support services has risen quite dramatically. There has been a 10 per cent increase each year for the past three years. In 1997-98, 22 000 counselling or support services were provided, and to the end of this year we expect it to be about 26 700, so that is a dramatic increase. There has been a 20 per cent increase in the number of financial assistance payments, from 21 200 in 1997-98 to 24 086 in 1998-99, and it is projected to become 25 600 by the end of this year. Community-based organisations in the private sector indicate that they are unable to service the demand and that there is a lack of access to training for financial counsellors and a lack of funding with which to employ them. There is increased demand on accommodation due to both homelessness and domestic violence. FAYS's assessment is that the number of people fleeing domestic violence is projected to increase by 15 per cent in comparison with the past year, despite the fact that there was a drop in the previous year. It has gone from 2 916 in 1997-98 to 3 400 for the year just finishing.

The current service agreements with low income support program providers require funds to be split 70 per cent for community education and 30 per cent for direct service delivery, including employment and financial counsellors. During the past three years, funding has increased from $700 000 to $735 000, and the current agreements expire at the end of June. In rolling these over, we want to make sure that in future there is a higher percentage of direct service delivery, so there will be a shift from the educational role across to direct service.

[Sitting suspended from 6.03 to 7.30 p.m.]

Membership:

Mr McEwen substituted for Mrs Maywald.
Mr Conlon substituted for Ms White.
Ms Thompson substituted for the Hon. M.D.Rann.

The ACTING CHAIRMAN: I am informed that, on the record, the member for Elizabeth has not exhausted a number of questions that she was entitled to ask.

Ms STEVENS: I have one question that I would like to ask regarding FAYS on the topic of the domestic violence crisis services. I have received a number of representations from women's shelter organisations in relation to the future of the Domestic Violence Crisis Service. They are saying to me that the service is threatened by losing its direct contact with clients in crisis. They say that a model has been proposed that will channel calls to a single centre and that this will, effectively, isolate the Domestic Violence Crisis Service from its client base.

The minister would know the background, so I will be brief. As a result of the three year collaborative systems review of the Women's Emergency Services Review, implemented in 1999, the Domestic Violence Crisis Service expanded its staff and operating hours and was placed as the primary source of information, advice and referral to women escaping domestic violence. Later, a six week agency review was conducted at the Adelaide Central Mission's Domestic Violence Helpline and, as a result of this, I understand that the minister has expressed a preference for a seamless service system, which is defined as a collaborative arrangement between the Domestic Violence Crisis Service and the Domestic Violence Helpline, resulting in a single system.

I have received a number of representations from people suggesting that that will be not a good way to go and that, in fact, the Domestic Violence Crisis Service has the confidence of the field and needs to stay as the primary source of information, advice and referral, as the review suggested. As funding runs out in nine days, what is the minister's intention in terms of the Domestic Violence Crisis Service and its referral system?

The Hon. Dean Brown: Three agencies are currently involved in this area. Officers from the Domestic Violence Crisis Service spoke to me at a function at Elizabeth when I opened the shopfront service. I was somewhat surprised when I talked to my own staff that they had been trying to get DVCS to talk to them and for months they had refused to even talk.

Ms Stevens interjecting:

The Hon. Dean Brown: I know that. It was almost as if they did not wish to talk to the government department that was providing the funds for the service. It was almost as if they thought that they were not accountable or if they were even willing to cooperate. All we had asked for was to have a discussion. This went on for month after month. I saw a letter—and I do not have the letter here, but I must say I was surprised that they had been asked repeatedly—in which the CEO basically said, 'Talks have been set up'; after about three months of trying DHS had finally put down times and dates, and the board had said they should proceed, but the letter implied that it may not take place—'We may not bother to go along to the talks'.

I find that to be a most unfortunate attitude. I might add that, after one of these discussions and after speaking to Rosie Gleeson, the next thing I heard—the next day I think it was—was that I was about to withdraw all the funding. I found this incredible. It did not relate to the discussion I had had with her at all. All I had said was, 'The department has asked you to sit down and work through the details', to see whether there was some way of producing a service that did not have three almost separate silos and, where there were clear problems, ensuring the provision of an appropriate service covering all the people involved.

We have agreed to continue to fund them at their present level, but I can tell the honourable member that I would be criticised—and should be criticised—by the Auditor-General and others if I do not continue to attempt to ensure that you have a service—because we are funding three services—that effectively covers everyone involved and that we do not have three competing services. That is all I want to achieve and we will continue to try to work with them to achieve it, but I can tell the honourable member that there has to be a degree of cooperation.

Ms Stevens interjecting:

The Hon. Dean Brown: I was astounded when I saw the responses being received. They did have a meeting yesterday, and I presume that talks are proceeding. That is helpful; after approximately three months, at least talks were held yesterday and I understand will continue, but I stress that running to the media to try to create a fear that I am about to cut off the service does not enhance the service in the eyes of the minister. All I am wanting to do is to achieve effective cooperation between the three services and I recognise the fact that the services have different areas of specialisation. When I have talked to the staff in the department, I must say that there is an air of frustration. I believe that they have been very tolerant, particularly considering how long this has been going on. Hopefully, it will now be sorted out.

The ACTING CHAIRMAN: The member for Gordon indicates that he has a supplementary question on this topic.

Mr McEWEN: I do appreciate that the shadow minister wishes to move on to housing, but SEACC (South-East Anglican Community Care) has expressed some anxiety about the lack of certainty over funding in a number of areas, including family support programs, low income support, and so on. First, they do not yet know what next year's funding will be. Although some verbal responses have been given, nothing has been received in writing. On a couple of fronts they are looking for what sort of per cent indexation they can expect. Can there be some more certainty about funding to assist them in planning, and is the minister considering triennial funding to take the uncertainty out of this sort of planning?

The Hon. Dean Brown: I will need to obtain that information. We do not have the details here. We have rolled them over into next year.

Mr McEWEN: Without any increase?

Ms Charles: The question of indexation is being sorted out across the department. We are still finalising the budget,

so it entirely depends on the source of funds and whether we get indexation, and that can be passed on.

The Hon. Dean Brown: In answer to the member for Elizabeth, I think that I referred to a letter. Actually, it was a detailed account from a telephone discussion someone in my office had with the DVCS, and where a senior member of my staff had written a full account of what had gone on in the telephone conversation. I am not sure that there was a letter; rather, it was an account of the response.

Membership:

Ms Rankine substituted for Ms Stevens.

Additional departmental advisers:

Mr J. Davidson, Executive Director, Strategic Planning and Policy.

Mr P. Jackson, Director, Asset Services.

Mr CONLON: I will preface my first question with a few brief comments, which will help the minister understand the concerns I have in the little time available. The Australian Housing and Urban Research Institute has confirmed what most of us who hold lower house seats know: there is a very significant shortfall between the availability of low income housing and the large number of low income households in South Australia. More concerning, the trend seems to be getting worse rather than better.

I want to ask a couple of questions arising from the budget, but it seems to me that the introduction of the GST coupled with the budget initiatives suggest that there will be no assistance in this regard. In fact, we can expect the trend to continue to be a troubling one. The minister may want to respond to that in his first answer, but it seems to me that we are heading into a lot of problems if we do not make more low income housing or reasonable quality low income housing available.

I understand that there is also a responsibility in the private sector for that, but it would be very concerning if we were to see the growth of a caravan park or trailer park culture for housing in Australia as we see in some places in the United States. Having said that, my first question relates to budget paper 2, the budget statement, and comments on the goods and services tax at page 4.5. I think we were all aware that, because input tax credits cannot be reclaimed for the provision of residential housing, this will cause a significant cost to the Housing Trust.

It says at page 4.5 that for residential housing the cost will be partly offset by additional funding provided through the commonwealth. I note the word 'partly' there. What is the increased cost likely to be and how much compensation for it have we had from the commonwealth?

The Hon. Dean Brown: This is an issue which I took up together with state and territory housing ministers. From the very beginning, I pushed strongly that, as part of the negotiations for the new Commonwealth-State Housing Agreement, we should argue for a special allocation of funds to cover the increased costs of the GST on the construction and maintenance of public housing. Together with the other ministers, I put forward a public case. We met in Tasmania, and we decided to take up the matter with heads of government as well. We took up the matter directly with Jocelyn Newman, the federal minister.

We estimated what the additional cost would be, and the federal government provided the extra money. I pay a tribute to the federal government. Its response was a bit of a surprise to us. We developed a good case; we pushed it over a six month period; we worked out what the individual estimated additional cost was for each of the states and we put in our bids. It varied from state to state depending on how many houses there were and the proportion of public houses within each state. Over a three year period, South Australia has ended up with a total of $28.5 million.

Mr Conlon interjecting:

The Hon. Dean Brown: To clarify the position, South Australia received $28.5 million out of, I think, $269 million for the whole of Australia. Normally, South Australia gets about 8.1 or 8.2 per cent of the national figure. We have ended up with 10 or 11 per cent, so we have done quite well. That was the first matter. I think it is fair to say that this is the only area of which I am aware where a group of ministers got together, put a case and actually got an increase in funding from the federal government. So, you can understand our pleasure and, therefore, our willingness to acknowledge the federal government for the way in which it responded. To be fair to the federal government, it basically gave us what we asked for. We had done a fair bit of modelling: we engaged an independent economist to do the modelling for us, so a consistent formula was developed across the states.

The second matter involved the fact that, when the federal government passed the GST, there was a 4 per cent increase in family payments. The Democrats had argued that there should be no increase in housing rent. Normally, we would take an extra 25 per cent of the 4 per cent, or an extra dollar a week. We agreed not to increase our rents. In fact, on 1 July there will be no change in Housing Trust rents, as there normally is.

As a result of losing that income, we put together a case and, again, wound up the premiers, chief ministers and treasurers and argued for compensation from the federal government, particularly as this had occurred subsequent to the previous allocation. As a result of that, one of the taxes which was to be abolished—I think it was stamp duty on unlisted shares—was not abolished. This then meant that additional revenue went back to the states over and above that for which they had budgeted. That money is held by Treasury, and we expect to put in a bid on the basis that Treasury has said to us that we will need to verify what we have missed out on and make a claim against that. Apparently agreement has been reached on that already, and it amounts to $14.4 million over a three year period.

To be fair, in the housing sector the commonwealth government has responded to both our requests and we are sticking by our part of the bargain, so there will be no change in the rent. Although in most cases the people will have received a 4 per cent increase in payments, we will not take our usual 25 per cent of that. I gave a commitment in a letter to Housing Trust tenants indicating that.

Mr CONLON: I understood that aspect of the 4 per cent from question time sometime ago. Supplementary to that question, there is considerable uncertainty in relation to the cost to housing and rentals with the introduction of the GST, with the revelation today that what was considered to be a 2.3 per cent increase in private rentals might be as much as 4.7 per cent. Is there any mechanism in the commonwealth agreement to adjust the compensation if it turns out that the cost over that three year period is significantly higher than the compensation offered?

The Hon. Dean Brown: No, there is not. Our modelling has been reasonably well done. We used the Econotech model and I think that I am right in saying that it was based on a

6.5 per cent increase in the cost of construction, and that is the basis on which we did the calculation to work out our claim for the $28.5 million. As I said, we got basically what we asked for. In fact, we felt that we had done very well. On the other side, this has been negotiated with our own Treasury and that pretty fairly reflects what we have asked for. If you put those two together, we are looking at $12.2 million extra this year for all the housing agencies, including SACHA and the Aboriginal Housing Authority.

Mr MEIER: Will the minister advise on vacancy rates of South Australian Housing Trust properties?

The Hon. Dean Brown: There has been a decline in housing vacancies in the South Australian Housing Trust and we need to use housing vacancies in a strategic way. We have applied a priority listing, as members know, so that those with the highest needs and those with complex needs, in particular, have a higher priority. The new priority system in the Housing Trust has worked very well and it means that the assistance we give goes to those with the greatest need. There has been a decline in vacancies. In 1996-97 there were 10 000 approximately; in 1999-2000 about 8 400; and in the coming year, it is projected to be about 8 117. I think it is best we leave it at that.

Mr McEWEN: I compliment the minister on the money that is put into stock redevelopment and urban regeneration. I note that the priority is some high stock concentrations, particularly double unit estates. I am wondering when East Gambier urban renewal will be considered as part of that strategy?

The Hon. Dean Brown: We are hoping to renovate about 1 000 homes this year, as well as build about 163 new homes. We do have a very extensive urban regeneration program. I use that phrase because it is not just about renovating homes: it is renewing the whole urban area. It is a partnership with local government, and there is a lot of public support and community support now. There was a bit of hesitation 2½ years ago, that I noticed, and a bit of uncertainty because residents were concerned they would be thrown out and would not have a home. A great deal of trust has been built up and it has gone well.

East Gambier is certainly a priority area. I am not able to give the honourable member any precise details tonight, but certainly we are wanting to get on with it as quickly as possible. I can indicate that apparently the initial work that we would normally do as part of any urban regeneration or renewal has already started. That involves consultation and working through the details. That is a planning phase and, while some people might criticise the length of the planning phase, it is very important because it reassures the local people and gets them to be part of it. That is a feature which is absolutely outstanding. I have been out to the conclusion of a number of these renewal programs and the one thing that comes through time after time is the extent to which it has been driven by a committee of local people who have consulted widely with every single resident. They know what is happening, they are very supportive of it, and they are very proud of it—and so they should be when it is finished.

Mr SCALZI: I refer to page 6.9 of the Portfolio Statements and the aim to ensure that South Australia's Housing Trust resources are effectively managed and targeted. Can the minister advise what is being done to regenerate the trust's communities? I know the minister has touched on that previously.

The Hon. Dean Brown: The main urban regeneration projects are Westwood (which is The Parks), Hawkesbury (which is Salisbury North), Windsor Gardens, Mitchell Park, Lincoln Gardens and Risdon. The member for Gordon might be interested to know we are doing preparations and feasibility studies on future projects at Kilburn South, Mount Barker, Peachey Belt (which is in the Salisbury area) and Mount Gambier. That is official: it is even in the briefing notes. It gives you some idea. As I said, we hope to renovate just under 1 000 homes this year; it will be 900 and something.

The important thing to realise is that it does have such a profound impact on the regions. I went to Salisbury North where it has occurred out there. It was a very run-down area with lot of social problems; where it has occurred is almost as if it is a new suburb and, I must say, I appreciate the very strong support from Salisbury council.

Mr CONLON: I am surprised at the minister's previous answer that everything is hunky-dory with the commonwealth and that the minister got everything he asked for—it surprised me. I had assumed that the minister must have been under some considerable budget pressure, either from the commonwealth or from his colleagues in cabinet, otherwise the $3 million pulled out of rent relief would not have occurred. I assume then that the minister has some explanation as to fairness in no new applications for state rent relief being granted. On the surface it seems to me that it is a cut to those who are right at the bottom end of income.

I find the notion that it is fair hard to accept. If it is because it is fair because of some allegation of double dipping, it is hard to see why other people remain on it. We want them all to remain on it. We would like to take new applications, too. If the minister is not under the budgetary pressure I thought he was under, just why has the minister taken the $3 million from what must be the lowest end of income earners?

The Hon. Dean Brown: First, there is a requirement on all agencies to identify some areas where savings can be made, even though we had got the additional money. We had to identify areas where a saving could be made and we put that submission forward. This is one of the last such remaining programs of any of the state governments; in fact, I think that it is the last. I do not think that it was as well targeted as it should have been. Certainly, the commonwealth rent assistance scheme was introduced after it was first established and had largely replaced the state scheme. I will ask Christine Charles to give the honourable member more detail because she knows this area particularly well.

Ms Charles: The rent relief program had been under review, in one form or another, for about the past decade. The amount of money that has been paid through this program has not increased for many years. It has been a reasonably static program with an income ceiling cut-off, which meant that it has tended to exclude larger families. I know that, during one review period when I was in housing in the late 1980s (and in the latest review), single parents with four children were no longer eligible for the rent relief program because they exceeded the available income ceiling. So, over time it became clear that we had a program that did not reflect what we considered to be the needs base.

About 6 per cent of recipients were families, about 33 per cent were single parents and 44 per cent were single people. Some of those people would qualify on a needs basis; but, certainly, it was more related to the income that one received rather than the income available for the dependants one might be looking after. For most of that time there has been a desire to retarget and focus the program. Certainly, the decision making was driven more immediately by some budget

savings; but this was a direction that had already been targeted in terms of housing policy—to try to move from a general top-up where some people were receiving very low amounts ($5 and $10), so a very high administrative cost was involved.

From 1989 to 1998, commonwealth rent assistance had increased by about 160 per cent; so commonwealth income maintenance had grown and, as a result of the last negotiations on the commonwealth-state housing agreement, there was a clear indication that the state emphasis would be on provision of housing assistance and housing forms and that the commonwealth would focus on income maintenance. In many ways the rent relief program has really been a residual program away from which all other state agencies have moved. However, we are going through a process of ensuring that we can provide more targeted financial assistance to those groups for whom we believe it is crucial.

In developing up the options around access for people with mental health issues, those people in the disability area, students and some other groups, we will be targeting subprograms on a needs basis rather than a broad program that tends to hit some but miss a lot who, we believe, probably need the assistance.

The Hon. Dean Brown: The member would appreciate that the total amount out of the program is more than the saving we had to achieve. The saving was a relatively small part of it and we are keeping the rest of the money and retargeting that, as Christine Charles has indicated. I will meet a group of people who have written to me about groups who they think could be disadvantaged—students is one of them. We said that we would look at those cases, but we want to make sure that it is appropriately targeted.

Ms Charles: The private rental assistance scheme has not been affected by these changes. So the rent in advance, the bond and other assistance is still available.

Mr CONLON: I can sympathise with the view that it was not a properly targeted focus, but that is not what you have done. You have not refocussed or retargeted; you have just simply cut it—

The ACTING CHAIRMAN: The member will direct his remarks through the chair.

Mr CONLON: There has not been a retargeting or refocussing—nothing has changed, except those who are on it stay on it and new applicants do not get it. I can see no program in the budget for it. On that basis, how long will it be before the people who receive a benefit from the scheme at the moment drop off it? How long do people stay on it; when will they drop off it; and when will there be a new retargeted scheme for them?

Ms Charles: The people currently on the program will remain on it for the length of their tenancy.

Mr CONLON: How long is that usually? What is the turnover?

The Hon. Dean Brown: Annual turnover is about 40 per cent. It is estimated that 4 600 recipients will leave the program in the first year.

Mr CONLON: That would be the same number or fewer each year. Do you expect that number to drop off each year?

The Hon. Dean Brown: It would be 40 per cent of a declining number.

Ms Charles: In terms of the other targeting, this work is already being done on particular housing options. With some of the work around certain mental health proposals in community housing, where accommodation is one of the key aspects for stability, we would be looking at targeted financial assistance in relation to those housing packages. We are also looking at housing packages in relation to young people in alternative care. It is clear that for adolescent young people we are having increasing trouble finding appropriate foster care arrangements, and moving to group homes and other forms of support is probably the way to go. That clearly will need some additional support in terms of income. With the changes to commonwealth rent assistance, we would like to match the state program so that we are picking up the gaps in the state program rather than topping up in an ad hoc way people who already have access to commonwealth assistance.

Mr CONLON: I do not understand the procedure regarding all the people to whom state rent relief has applied in the past. Will these changes mean that people who would have received state rent relief and who would not be eligible for commonwealth rent relief will get no rent relief? Has every low income earner the assurance that they will get some rent relief? Will there be people who will not receive rent relief who would have had it otherwise?

Ms Charles: Some people who have been income earners and not receiving full commonwealth rent assistance but a small amount of rent relief will no longer get it. The bulk of people qualifying for rent relief will qualify for commonwealth rent assistance. That is what the modelling shows. We want to pick up the groups that fall out. For instance, rural students from low income families who are studying in Adelaide and who have built in rent relief as a component of being able to survive are clearly a group we have said needs to be quarantined. Other young people, because they do not usually fare so well on the commonwealth rent assistance program, may need particular support as well as support for more expensive housing options in community housing.

We are looking at mental health at the moment, but we expect that there may be others. There has been a fairly good understanding of the profile of people on the program. As I said, while it will become fairly clear about picking up the gaps in the programs, we are not saying that there will be a general assistance. It is entirely consistent with changes in the Commonwealth-State Housing Agreement where there has been pressure on the income from there, too.

Mr CONLON: My concern is this: at a time when the GST is being introduced, when we already know there is a shortfall between low income housing availability and the high number of people seeking it, when we will see increases in market rents that might be 5 per cent, there could be people who would otherwise be eligible for rent relief but who will have none until such time as you work out something that stops them falling through the safety net. It does concern me.

Ms Charles: There will be a 7 per cent increase in commonwealth rent assistance in relation to the changes in the GST. As I said, we will try to monitor the impact.

Mr CONLON: I would have preferred that they continue to get assistance from the state. However, it is those who will not get assistance who are facing genuine hardship over the next 12 months.

The Hon. Dean Brown: In some ways, now that we have this money freed up, we can more effectively target it at the groups that may be disadvantaged out of the GST. There will be real money there that we can put into it.

Mr CONLON: At present, minister, I must take your word for it, because we cannot see any programs.

The Hon. Dean Brown: You have to understand that, in a climate where there will be dramatic change in a few days, we have to look at what groups are likely to be most disad-

vantaged and try to help them. Frankly, I think that having some flexibility in that regard is a good initiative.

Mr CONLON: I want to talk about another matter that has been touched on in recent days—the first home owners GST compensation scheme, which will give a $7 000 grant to those who sign contracts after 1 July. Of course, my concern—and it has been raised in recent days—is those who have signed contracts long before 1 July and who, because of a whole series of reasons, including the pre-GST building boom, will have the bulk of their work done after 1 July with increased GST costs. There seems to be nothing to compensate those people. Is there any plan or flexibility? I understand it is a commonwealth scheme that we administer and it is commonwealth funds. What can be done for those people?

The Hon. Dean Brown: The commonwealth government has been quite adamant that the $7 000 first home buyers scheme will apply from 1 July, and there is no way of modifying that. I worked with the housing industry here, and we put up a national request through the Housing Industry Association and the state governments, looking at some of the other ways of achieving it and trying to spread some of that money over a wider group of people. However, we could not get any assistance. The federal government would not change its policy.

Incidentally, I indicate that the first home buyers scheme is administered through the Stamp Duties Office of the Treasurer. There is some cooperation with HomeStart, and some publicity will be out shortly which will be available both through HomeStart facilities and lending institutions in terms of eligibility criteria, etc.

Mr CONLON: Does the minister agree that it is arbitrary and unfair that the $7 000 is available purely at the time the contract is signed, rather than on the costs incurred?

The Hon. Dean Brown: That policy is determined by the federal government—

Mr CONLON: It is not what the minister would do: he is a fair man.

The Hon. Dean Brown: It is not my money and my policy to determine. Of course, a certain number of people will be caught with houses partly finished and, therefore, will have to pay GST. In 1999-2000, approximately 8 800 houses will have been completed, which is a high level. One of the problems is the shortage of trades people in the industry because of the sudden lift in activity. I believe it will settle down within three to four months. In fact, I was talking to a builder yesterday and he believes that the industry will return to a fairly normal level about four months into the new financial year. We will need to monitor very closely what happens with Homestart. I am hearing some mixed messages: one builder indicated that he is still signing a considerable number of contracts, and other builders are experiencing a very quiet time.

Mr CONLON: The forecast for the effect of the GST on the private rental market is an estimated 4.7 per cent increase in costs, and I understand that cost may well be passed onto private rental tenants. Given the rental demand in South Australia I would have imagined that it is fairly likely that that will be passed on in full. Again I raise concerns about the availability of low-cost housing. I assume there will be an effect on the market rates and the market rents charged by the Housing Trust as a result of a change in the marketplace. You talked about the modelling that you have done; have you done modelling in that? What is the likely increase in market rentals? What do you foresee and what have you used in your modelling?

The Hon. Dean Brown: No, we have not done modelling and it is not our role to do the modelling. I think if you want to look at that modelling go off and talk to those who specialised in that on the GST—Econtech in particular. I saw only one news bulletin that talked about how the amount would vary in dollar terms between different states of Australia. That is really a matter for the federal government. It is not a responsibility of the state government.

Mr CONLON: To follow on from that, minister, I thought that, given that you were working out what the cost to the Housing Trust of the GST would be, you would have some forecast of what your income was likely to be from rentals and, in particular, from the market rentals. I would assume you would have some idea of what the market rentals over the next three years would be. That is when the modelling was done. If you do not have it, perhaps that information could be brought back to us.

The Hon. Dean Brown: The trouble is when you are looking at the Housing Trust you are looking at the fact that 86 per cent of the tenants at the Housing Trust receive subsidised rent so you cannot really model on that.

Mr CONLON: You must have a forecast about how much they are going to pay.

The Hon. Dean Brown: I think that we based our modelling on the impact on the new home at 6.5 per cent increase, and that was the figure we used to calculate what additional funds we should be asking for from the federal government.

Mr CONLON: Let me be perfectly blunt about what I am trying to find out. I have read these figures in the paper about what the marketplace thinks will be the effect on the rental market. It seems to me that you as a major renter, charging at least 14 per cent of your tenants market rents, have yourselves come up with an idea. What was your estimate of the effect of the GST on the private sector marketplace? You must have that somewhere in your modelling.

The Hon. Dean Brown: It does not; our full market rent is based on the Valuer-General's recommended market rent.

Mr CONLON: I am sorry to harp on the point, but—

Mr SCALZI: What line is it on?

Mr CONLON: Joe, one day if you are more important you can ask questions.

The ACTING CHAIRMAN: The member for Elder will address his questions to the chair. He will ignore interjections and when he wishes to make reference to other members of the committee he will use the name of the electorate they were elected to represent in this place.

Mr CONLON: I refer to page 4.5 of the budget statement, regarding the cost of the GST. We have heard an answer that significant modelling has been done on the cost of the GST to the Housing Trust and that compensation has been given. One aspect of the Housing Trust's financial affairs is its income from market rentals. The deal with the commonwealth has been struck over a three year period, so it seems to me obvious that whoever did the modelling would have forecast what the increase to market rental incomes would be in that period, and that would rely on a move in the marketplace. Having read the guesses in the newspapers about what the changes in the market rentals would be, I am trying to find out what the Housing Trust's economic modellers forecast the change in the marketplace to be.

The Hon. Dean Brown: I have a feeling that the honourable member is trying to get me out into a controversial

national debate which does not relate to the state government at all.

Members interjecting:

The ACTING CHAIRMAN: The chair cannot answer that rhetorical question. I ask the honourable member to contain himself.

The Hon. Dean Brown: I am making a statement that I suspect the honourable member is trying to get me involved in a national debate on this issue. It does not relate to the affairs of the state government. It is the Valuer-General who determines what the market rents will be for the Housing Trust, and that is a historical factor. Therefore, the Valuer-General does not come up with projected figures: he comes up with figures that reflect what has actually occurred out there historically. Therefore, I cannot help at all, because we are not sitting on any secret figure here, as the honourable member seems to believe we have.

Ms RANKINE: Page 6.10, point 3.1 mentions tenantable dwellings. To 30 June this year there are 53 300; on my calculations for the target for 2000-01, there are 950 fewer Housing Trust houses, yet you are making an announcement about 165 new dwellings, making it sound as if we are getting additional Housing Trust accommodation for people. Will you confirm that in fact we will be getting considerably fewer homes for people to occupy in the next 12 months?

The Hon. Dean Brown: That is correct; there will be a reduction of about 900 homes. This has been going on every year for quite a few years, and it is brought about by a number of factors. We build more homes, and the number of homes we have been building has been on the increase because we have now paid off the high interest rate debt that we inherited, which was over $300 million. We have paid off that high interest rate debt and, therefore, we are now able to direct that money into building more homes.

The reduction in housing occurs for a couple of reasons, one of which involves our urban renewal program. For example, in an area such as Windsor Gardens there are about 240 homes, and a number of the older homes are demolished; a number of the homes in reasonable condition are renovated, and you then have new homes—a lot of them private homes—built on blocks of land that are available. We sell those blocks of land. In some cases, some of the old homes might be sold; if they are in better condition people might do them up, or we might do them up and sell some of them. What we are trying to achieve is to turn those areas that were purely Housing Trust areas into a blend of Housing Trust and private accommodation but, in the whole process, the number of Housing Trust homes in that area diminishes. There are also a certain number of other sales but it is a very moderate program, because you are looking at 163 new homes as well.

What the member also needs to appreciate is that we are building new homes under the aegis of the South Australian Community Housing Association. I think we now have more than 3 000 such homes, and there also has been a transfer of homes across to the Aboriginal Housing Authority. So, again, that has an impact. If you are going to start looking at the number of homes available, you now have to look at all three agencies: the Aboriginal Housing Authority, the South Australian Community Housing Authority—both of which are increasing the number of homes significantly—and the Housing Trust, where the number of homes is on the decrease.

Ms RANKINE: At what point will the Housing Trust stock reduction cease?

The Hon. Dean Brown: I suggest that the honourable member look at the triennial review of the Housing Trust published about two years ago which set long-term forecasts for what was a sustainable level of assistance in terms of public housing. One has to appreciate that here in South Australia we miss out every year on our share of commonwealth rental assistance, because we have a lot more people in public housing. Because we have more people in public housing and they cannot access commonwealth rental assistance, we miss out on, I think, about $40 million a year equivalent. That is because we have made a bigger commitment to the Housing Trust. The long-term projections are for a reduction in the number of homes. However, I urge the member to look at the report (it is in the library), which gives the long-term projections over a 15-year period.

Mr CONLON: I have three questions that I think have been asked in many committees, and I address them to the minister in relation to all his departments and agencies, including those covered by any relevant junior ministers. I understand that the minister will take them on notice, as have other ministers.

An honourable member interjecting:

Mr CONLON: Yes, the omnibus questions as they are called. First, will the minister list all consultancies let during 1999-2000, indicating to whom the consultancy was awarded; were tenders or expressions of interests called for each consultancy and, if not, why not; and what was the reason for each consultancy and how much did each one cost? Secondly, which consultants submitted reports during 1999-2000; what was the date on which each report was received by the government; and was the report made public? Thirdly, will the minister detail all advertising and promotional activities and campaigns undertaken by all agencies within his portfolio for 1999-2000, what was the purpose of each one and what was the cost?

The Hon. Dean Brown: I will answer at least the first part of the question on consultancies, but I will have to take the detail on notice. In fact, the Department of Human Services has made a considered effort to ensure that we focus our consultancies and that we have consultancies only where there is a particular need. There is a need in some areas because we do a lot of joint state-federal programs, and the federal government invariably requires an independent assessment of those programs every three years (or something like that). Therefore, that requires us to engage a consultant as an independent person to carry out the review. So, we have a need.

I ask the honourable member to look at what has occurred with consultancies. In 1997-98, the Department of Human Services issued 251 consultancies at a total cost of $4.66 million. In 1998-99, we reduced that number to 146 at a total cost of $3.43 million, so we reduced it by about 25 per cent. In 1999-2000, the number of consultancies is 72—so we have reduced it to less than a third of what it was just two years ago—and the cost is $2.12 million, which is less than half the cost of what it was previously. I think that is a model for the rest of government.

This is an agency that accounts for just under 40 per cent of total government expenditure, yet in 1999-2000 it spent only $2.12 million on consultancies. I think that, on a pro rata basis, it is a very low level of consultancies. The fact that we have more than halved the cost of consultancies and reduced the number of consultancies to less than a third of what is was two years ago is a very significant achievement, and I compliment Christine Charles, the CEO, on the work that she

has put in and the systems we have in place to ensure that consultancies are conducted only when they are absolutely required. That equates to more money for services for the people who need them.

Membership:

Ms Stevens substituted for Ms Rankine.

Witness:

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

Additional Departmental Advisers:

Dr David Caudrey, Director of the Disability Services Office.

Ms Jane Mussared, Acting Director of the Office for the Ageing.

The ACTING CHAIRMAN: Do you have some remarks you wish to make to the committee about the matters within the purview of your responsibilities?

The Hon. R.D. Lawson: Yes, Mr Acting Chairman. There were significant achievements in the portfolio areas of ageing and disability services in the financial year just ended. I should begin by expressing thanks to the many dedicated officers and executives within the Department of Human Services who are personally involved in these areas.

I pay a tribute not only to those who are present here but also to the large number of committed people in the field. Whether they be options coordinators, workers at Strathmont Centre or policy people at head office, they all deserve credit. Many programs in this field, as members will know, are delivered by non-government organisations, and their boards, their management, their staff, supporters and volunteers are to be commended. That is particularly important in this field of disabilities and ageing.

Also of great importance is recognition of the families and carers of the frail elderly and people with disabilities. Collectively, they provide the bulk of care and support in our community, and they always will. Where possible, the maintenance of connections between people and their own families and friends should be one of the prime policy objectives in this field.

In all the focus on inputs and outputs, policy options, bottom lines, service matrixes, paradigm shifts and the rest, it is possible to lose sight of the individual people whose needs we seek to serve, and it is appropriate on an occasion such as this to record the paramount objectives that we have, and I am sure that this is a bipartisan view. Good budgeting and policies are only a means to an end, and the end is the quality of life for individuals and assisting them to live the life that they want to live.

Before addressing some of the issues that arise in the period covered by the estimates under review by this committee, I should mention a couple of the highlights from last year. In the field of ageing, 1999 was the International Year of Older Persons. In this state the year was celebrated very fully by the community. There was a large number of events and a large number of programs.

The theme of the year was ‘A society for all ages’, and I believe that, with the encouragement of the government and the support of the Council for the Ageing, Coalition 99 (a group established to manage the program), state and federal governments, together with departments and many other agencies, we had a very successful year. I believe that we succeeded in three of our primary objectives, the first being to reduce some of the stereotypes associated with particular age groups and creating a culture of positive ageing. It is, of course, a very long program to achieve that objective, but we are well on the way.

Encouraging full community participation was another message of the year, and I believe that we succeeded in getting that message out. Encouraging connections between different generations was another message, and a very important message, indeed the one that I think we perhaps succeeded least in. However, we certainly are making good moves in the field of intergenerational activities.

I would mention only two events from the International Year of Older Persons. A rural ageing conference, entitled ‘Harnessing the wisdom, harvesting the gains’, was held at Bungaree Station. It was hosted by the Ministerial Advisory Board on Ageing and by Dame Roma Mitchell. It was Dame Roma’s last official function as Chair of the Ministerial Board on Ageing, and I want to pay a tribute again to the great contribution that she made to ageing, as well as to many other aspects of our community life.

That conference was highly successful, well attended and I think produced a number of statistics and consultative mechanisms to ensure that the programs we devise in the metropolitan area will appropriately meet the needs of people outside Adelaide.

One other area which I mention in this particular field is projects to assist the Aboriginal community. The establishment of a Council of Aboriginal Elders is a positive initiative which I believe will provide us with the opportunity to use the wisdom of the elders in the Aboriginal community together with their knowledge, experience and the respect in which they are held to ensure that these programs, which all too often in the past have been well intentioned, are more likely to be effective as we move on. It is a sad fact that Aboriginal longevity in our community is substantially beneath that of the remainder of the population. We are committed to ensuring a distinct improvement in this area, and through programs such as Home and Community Care we will make a difference.

In the field of disabilities, there have been a number of significant achievements. I will not list them, but I believe that the additional funding that we have been able to find for disability services this year, which takes out the aggregate funding to record levels and which is a significant improvement, will go some way towards meeting the substantial needs in this field. Disability is largely a function of ageing, although not all people with disabilities are elderly. However, the majority of them are and, as is well known, we have the largest proportion of people aged 65, 70 and over in Australia.

The additional $6 million which has been devoted to disability services in the current budget, coupled with an additional $2 million which was allocated during the year on top of last year’s budget and the fact that we were able to add an extra $2 million to two separate programs for the purchase of equipment for people with disabilities—these are not walking sticks or walking frames but often highly expensive, complex and personalised wheelchairs, scooters, communication devices, computers and the like—the last $1 million of which having been allocated out of the capital works program only today, will make significant inroads into the demands of the community for additional equipment.

Coupled with the $6 million of additional money that is applied to this year’s budget, the commonwealth has allocated $4 million this year and $8 million next year for

respite for older carers. That will mean another $10 million this year and another $14 million next year. These are significant contributions to providing more extensive services.

The only other matter that I would mention on the subject of disability is the disability services framework. Too often in the past, it is fair to say that funding has been made on the basis of historic allocations rather than on the basis of precisely assessed needs and on a rational basis, and there are some distortions in our disability system that we have got to look at eliminating in future years. To that end, a disability services framework is being devised. It is being devised in very close consultation with all interest groups within the sector. It is presently out for consultation and I anticipate that, within the next month or so, the disability services framework will be signed off on, agreed by the sector and provide a blueprint for the development of future services.

Membership:

Mrs Geraghty substituted for Mr Conlon.

Ms STEVENS: I note that the government has committed a further $2.5 million under the Home and Community Care Program for services to support older people to remain in the community. Will the minister confirm that this is the minimum amount to match the expected commonwealth funds on offer for 2000-01?

The Hon. R.D. Lawson: It is the appropriate amount to match the commonwealth contribution. Since this government has been in office we have in each year matched the commonwealth contribution. That cannot be said of all states and territories. We made a commitment in the 10 year plan on ageing that we would continue to contribute to the program to ensure that we raised our levels of contribution to HACC to national averages, so that our level of support for the community would be at least at the national average. The figures which the commonwealth determined as the national average were based, I think, upon a 1993 analysis, but a more recent analysis, based on 1998 and still subject to review and examination, suggests that far from being substantially beneath national averages we are, in some cases, well ahead of them and, generally speaking, at about the national average at the moment.

Ms STEVENS: I understand that funding for the Home and Community Care Program remains below the national average for South Australia. In fact, comparing South Australia with Victoria, older home and community care clients here receive only 74 per cent of the hours of service received by older Victorians. In addition, South Australia has a higher proportion of the very old, that is people over 80, who are largely users of the service. Therefore, it could be absolutely argued that we should be receiving an even higher proportion of national funds on this basis. I understand that it is projected that the government will catch up to the benchmark of the national average by 2010-11. Is that the case; and when does the government intend to start increasing its commitment to reach the average?

The Hon. R.D. Lawson: I think I have to repeat what I was saying in answer to your earlier question, namely, that the most recent figures provided by the commonwealth formula, based upon 1998 averages and contributions, as well as the population and the potential client population, indicate that contrary to earlier beliefs we are not substantially below national averages. But I would also say in relation to, for example, the Productivity Commission's annual survey of Australian governments that, if you look at various service categories, there are certainly some where we are under and some where we are over. I think in 'respite' we are, as I recall, substantially over national averages and if you simply pluck out one particular element, as you did from Victoria and say, 'We are well below that,' I can point to others, I am sure, if I had the figures in front of me—and I would be happy to draw them to your attention—where we are ahead of Victoria and other places.

Ms STEVENS: I would like to talk about domiciliary care fees. I have your press release of Friday 26 May in front of me. I note that you are advising of fees that will apply from 1 July based on a combined fee per service of $5 for pensioners, which is capped at $20 per four weeks. You go onto to say, 'In cases of hardship no fees will be payable'; then 'special consideration will also be given to people who use multiple services'. How will that special consideration be worked out, particularly when people could be receiving services from a range of different agencies; and will it also take into account the just announced co-payments for dental care?

The Hon. R.D. Lawson: The decision to charge fees for domiciliary care services really stems from the decision announced by the commonwealth in its 1996 budget that, for the purposes of its funding of Home and Community Care programs, the commonwealth would assume that, after a lead-in period, the states would collect 20 per cent of the programs in the form of client fees. Some states adopted a government policy that all HACC-funded agencies would be required to levy fees and statewide fees are levied.

This state took a different course and said that each HACC service provider should make its own decision about whether fees would be appropriate because a provider would be aware of the needs of its particular client base, the sort of services that it offers and whether it was appropriate for those fees to be charged for areas, such as information services, for which a fee is not traditionally charged but which are supplied by some service providers. The Royal District Nursing Service, which is a very substantial HACC-funded agency and which provides services across the state, decided that it would introduce a fees regime.

The service undertook a very careful analysis of its client base. It surveyed the type of fee regime its client base would be prepared to meet and what would be appropriate. It hit upon a fee regime under which pensioners would pay $5 for a service, up to a maximum of $20 in each four-week period—basically the fee is $5 a week. The Royal District Nursing Service has prepared a list of rules and eligibility criteria, and the like, which is consistent with the HACC principles. Those RDNS mechanisms allow for a waiver of fees in circumstances where the person genuinely is unable to make a contribution.

The service allows for adjustment where, for example, the person is receiving more than one service from a HACC provider. Obviously, if one service provider is providing a service and another comes along, the person may be in a position where they cannot be expected to make another contribution. The service also provides appeals mechanisms, review processes, and the like. In developing the fees regime for domiciliary care services, which are largely funded in our system through HACC, the department will be embracing similar principles.

I have not yet seen the precise formula or rules but the principles to be applied are much the same as applied in the case of the RDNS. There will be flexibility for the domicili-

ary care services—to waive fees where appropriate. I would hope that the introduction of fees might lead to some rationalisation of services, because I believe that it is undesirable, for example, for the RDNS to be calling and providing one service, another service to then call on the same client, providing, say, personal care needs, and then Meals on Wheels to be calling. Four or five different service providers would be servicing the same client.

I think that we must look to the day when services will be more holistic and the single service provider will be able to provide all the home-care needs and support of the individual within the fee framework. That fee regime will replace the existing schedule of fees which applies, although I gather it is not widely levied. I think that approximately $250 000 a year was being collected in domiciliary care fees. That fee regime will come into operation, if I did not mention already, from 1 July 2000.

Ms STEVENS: As a supplementary question: I have discussed the issue of fees with people in that sector. I said, 'How do you work out who gets the fee first?' If someone goes to one agency first and begins to pay $20 a month and then they must go to another agency that second agency is disadvantaged because the person is already paying the fee to the first agency. They just said 'Yes', that it is first come first served. The big ones who have been in it for a while with the well known names are at an advantage because they have the clientele and people know them. There seems to be a need for overall coordination here, otherwise it will be the case that wherever a person goes first that agency will get the money and when they have to have multiple services with other agencies there could be a problem.

The Hon. R.D. Lawson: I accept that, and it is well understood that we will have to develop protocols and arrangements between service providers. One would hope that service providers will not say, 'We are here first, therefore we will take the fees.' They might, but these problems have not yet arisen in practice and many HACC agencies, especially in the country, have been charging fees for a number of years. We will have the mechanism centrally to require agencies to cooperate in an appropriate arrangement because, after all, HACC holds the purse strings. I still believe that it is better to allow individual agencies to develop their own policies rather than have some centrally imposed regime that requires them to adopt a particular fee structure.

Ms STEVENS: You will see if it works and, if it does not, you will have to do something else.

The Hon. R.D. Lawson: It is already working, and it has done so for many years. Those agencies have been providing multiple services to individuals, but if problems develop we will, as between particular agencies—and I am sure it occurs between the larger ones—be able to work out appropriate regimes. Let us take RDNS. If RDNS is seeing people post-discharge from some acute facility and it is the first service to that person, and subsequently other supports are provided by other agencies, for example, Domiciliary Care, we will have to make some arrangement between the agencies for appropriate adjustments.

As we hold the purse strings, at the end of the day, when we look at the analysis, if some agency says that it has been unable to collect fees because it finds that it is always tail-end Charlie, we will have to say that under those circumstances we will boost its funding and perhaps reduce the funding of other agencies that find themselves in an advantageous position for the purpose of collecting fees. We will have to exempt, for example, Meals on Wheels, which is an extensively HACC funded service. I imagine we will still require people to make a contribution to Meals on Wheels as they do now, notwithstanding the other HACC services that they receive.

Ms STEVENS: Has any thought been given to the cost of collecting the fees by the agencies, particularly when you have a situation of multiple fee collection and making adjustments between them?

The Hon. R.D. Lawson: Yes, consideration has been given to that. There was a proposal initially that we establish a separate fee collecting agency for the purpose of collecting HACC fees. That to me was not an attractive idea. We do not want to establish yet another bureaucracy. The responsibility for fee collection for metropolitan services for the domiciliary care system will be handled through a single agency, namely, Southern Domiciliary Care Service, which has the capacity and the desire to provide that service. Regional health centres will collect country fees for Domiciliary Care.

Mr McEWEN: It is my understanding that the commonwealth government is shifting the goal posts with regard to persons with an intellectual disability in supported employment. As a consequence of that, possibly up to 300 people will fall out the bottom of its scheme, and they will need to be picked up by the state. Given that many of our persons with intellectual disabilities seek a number of things—and one of them is security and disability—and that supported employment offers them a social network, certainty and security, is the minister looking at finding a way to support the people whom the commonwealth are no longer supporting within the framework in which they exist at present?

The Hon. R.D. Lawson: It is true that the commonwealth has changed its eligibility rules for supported employment or employment for people with disabilities—what we used to call a long time ago sheltered workshops. The commonwealth is now focussing primarily on the employment aspect rather than those social aspects which the honourable member mentioned such as social networks, activities and the like. The commonwealth takes the view that supported employment is employment related, that the employment services are required to turn a profit and that they are required to actually be engaged in activities of an employment type rather than simply providing day programs or activities for people with disabilities. This applies not only to people with intellectual disabilities but also to people with other disabilities.

We in South Australia have been often criticised by disability advocates because we have had, as they tell us, the highest proportion of people with disabilities in supported employment and the lowest proportion of people with disabilities in open employment. The point made by the disability advocates is that we have been too paternalistic in the way we have approached people with disabilities and we should have been encouraging more people into open employment. That is a worthy objective, and it is one that we would want to pursue, even though we do not fund employment services.

I am aware of the honourable member's interest in this matter. I understand that he has had discussions with the IDSC, which is most concerned about the fact that, for example, in Mount Gambier some people will no longer be eligible to work in one of the supported employment services there, and there are about three good employment services in Mount Gambier. Our day activity programs for supporting people are focussed largely upon the needs of post-school options and school-leavers but not exclusively. Many of the programs include older people.

We will have to find additional programs to meet those social network and other needs of people who are no longer eligible for commonwealth employment support. I do not believe that the commonwealth is prepared to change its mind. Certainly, we will be urging it to be a little more flexible in the policies it is adopting. A meeting of the commonwealth, state and territory disability ministers is scheduled for next month at which this very issue is to be raised on a national level. Notwithstanding my pessimism about what the Commonwealth might do, you can be assured that we will be pressing for additional commonwealth resources to make sure that those programs can work.

Mr McEWEN: I understand what the minister is saying in relation to the criteria being changed by the federal government. Why does that necessitate some of the people who are no longer eligible being moved out of the institution when, with some support from the state, they could stay there and many of their needs could be satisfied within that institutional framework? It gives them all the things for which they are still looking. Why would we simply want to move them out of there now and find another set of day options for them, when we could probably find an arrangement which would at least be as cheap—if money is the issue—within that framework and that network? That is what three families in Mount Gambier are requesting. They do not want the lives of these disabled people disrupted, keeping in mind that one of them is in his fifties. The families are begging for a way to maintain some continuity in the lives of the person with the disability. That should be our core focus—not an institution.

The Hon. R.D. Lawson: I am prepared to look again at this issue. I have received a report from IDSC in relation to the three clients and it does raise wider issues. If employment services are to be business focused, it usually means the introduction of more sophisticated and more dangerous equipment. It becomes a more work oriented business operation rather than the supportive activities previously conducted in sheltered workshops.

The organisations themselves need to be satisfied that these people will be able to continue, notwithstanding the changed focus of activities. For example, Orana has a supported employment service in Mount Gambier and it has changed markedly the sort of activities conducted there. What were once very simple and safe procedures are now quite complex.

I am prepared to continue to press the commonwealth and to investigate whether there is some way we can cooperatively work with those services to provide meaningful day programs. These days, we are not interested in providing activities just for the sake of activities: there must be some developmental component in our programs, and some sort of stimulation for people. It is quite a complex issue to ensure that we provide the necessary level of stimulation.

Mr McEWEN: Given that the new policy kicks in at the end of this month, is there some way—while we are finding another solution—that we can leave these people in their secure environment rather than totally disrupting their lives. I have been assured that no alternative options are in place as yet. Can we find some transition? The last thing we want is to cause a huge disruption in the lives of these individuals.

The Hon. R.D. Lawson: Certainly, as I mentioned, we are allocating additional funding to disabilities through the options coordination process. There will be additional moneys available to options coordination agencies, including the IDSC, to direct funds to those clients. There should be sufficient flexibility. I know, for example, that the IDSC will be establishing a supported accommodation service in Mount Gambier with some of the funds which have become available. Once again I think it is a matter through the options coordination process of allocating funds. I will ask Roxanne Ramsey to take your suggestions on board and I hope we can cooperate.

Mr SCALZI: Minister, it is reported on page 6.16 of the Portfolio Statements that the proportion of service providers for disability services with national service standards included in funding and service agreements is 100 per cent. Can the minister explain the advantages of the new system of funding and service agreements to non-government agencies supporting people with intellectual disabilities?

The Hon. R.D. Lawson: From July this year the funding arrangements through our government to the non-government organisations—and there are 34 major non-government organisations receiving funding—will be through the Disability Services Office rather than through the Intellectual Disability Services Council, as has been the case in the past.

The IDSC has previously allocated about $60 million of funds across the sector, much of which goes to its own services. We believe it would be more efficient and equitable and also overcome some of the criticism that has arisen as a result of suggestions that the IDSC has a conflict of interest if this process is dealt with centrally through the Disability Services Office. That would mean the DSO would negotiate the funding and service agreements, not only the funding but also what services are to be delivered, rather than the IDSC, which will continue to have an important role. It will have to concentrate on its core business of providing services to people with intellectual disability.

Ms STEVENS: I would like to ask a question about disability services and unmet need. At the outset I would like to say the $6 million you have committed is welcome. However, just to put it in context, we all know that the $300 million Australian Institute of Health and Welfare 1995 estimate was accepted as being realistic across Australia; and South Australia's share would be $26 million, and it is growing. On my calculations, what the commonwealth has agreed to pay and the state's contribution of the $6 million you have announced still leaves us with a shortfall of $12 million required to meet the unmet need in South Australia. What plans exist to address the remaining $12 million, which of course is growing all the time?

The Hon. R.D. Lawson: The honourable member's figures are correct regarding the $294 million nationally, estimated by the Australian Institute of Health and Welfare study. As is well known, the states and territories impressed upon the commonwealth to agree to contribute one-half that amount. In the event, the commonwealth was prepared to contribute only $150 million over two years, rather than over one year. The states made a lot of noise about the fact that the commonwealth had a better capacity than any states to make a substantial contribution to this demand but, notwithstanding that, the commonwealth was firm in its decision to contribute only the $150 million and to specifically target the $150 million to respite for ageing carers.

We were the first state to agree to match that commonwealth contribution, but we did it slightly differently. It has allocated $4 million this year and $8 million next year; that is, $12 million. We have agreed to put in $6 million each year, which means that we are a bit ahead of the commonwealth in our contribution. I think it is a significant contribution towards addressing unmet need, and it is acknowledged to be substantial. In the budgetary climate of this state, I was

delighted that I was able to secure the agreement of the government to make that contribution. There were many other bids for substantial amounts, and I was reasonably happy with the result in the disability sector. I will never be entirely happy, because we could use more money; and as much money as we get we will be able to spend.

In addition to the $6 million that we are putting in, I think you have to remember that we have put in another $2 million (admittedly, that is a one-off amount) in this financial year for the purchase of equipment. That was specifically addressed to the purchase of equipment—not to the improvement of facilities or the employment of additional staff but solely to the purchase of equipment to meet needs. So, $6 million has gone in, there is $4 million from the commonwealth, which makes $10 million, plus another $2 million for equipment. I believe that it is a substantial contribution to unmet need.

Ms STEVENS: I have a supplementary question. What is the shortfall? I was suggesting that I thought it was $12 million and growing. What is the minister's estimation of the shortfall? My question was: how does the minister intend to fix that?

The Hon. R.D. Lawson: We will fix it incrementally, as we have in the past. Studies such as the Australian Institute of Health and Welfare study are, of course, prestigious studies but they are really only statistical estimates of demand, and what we have is people in services with particular demands for particular services. I think that we have to focus our attention not on meeting some sort of financial target but on addressing the needs of the people who are coming through the door, and that is what we will be doing with the money we have allocated.

I mentioned in my opening remarks the disability services framework. I also mentioned that there had, I think, historically, been something of a misallocation of resources. That means that some people with disabilities have been rather better off than others in regard to the services they have received. Any distortions of that kind, if they can be eliminated, will mean that we can more effectively use the resources we have to meet the needs we have. So, I am not prepared to put a figure on what is required. We will simply go on pressing, and pressing hard, to get resources. I think that, if you look at the budgets of the other states, we in this state also have done very well, in comparative terms, in disability.

Ms STEVENS: In the minister's press release that accompanied the announcement of the money for the unmet need there were a number of things that I found surprising, bearing in mind that my understanding of the unmet need concern was in relation to fundamental support services such as accommodation, accommodation support and respite care. So, I was rather surprised to see in the things that the minister has funded out of that so-called money for unmet need—worthy as they may be—$200 000 to the Guardianship Board and Public Advocate; $1.02 million for therapy and early intervention services for children, which I would have thought was a health matter; and $50 000 for autism assessments, which I would have thought was also a health matter. I am sure that all of those are worthy causes but when we are looking at the level of unmet need in our community for people with a disability in relation to accommodation, accommodation support and respite care, I would have thought that that was where the priority ought to be for money that the minister said was related to unmet need.

The Hon. R.D. Lawson: The AIHW report identified unmet need in very general terms, and it included not only accommodation and respite but the whole range of needs of people with disabilities. It is true that when officials met for the purpose of refining the bid for that unmet need they identified a number of segments of greatest need, and two of those were accommodation services and respite. However, that is not to say that the unmet need is solely related to those two categories of service.

The honourable member mentions the Guardianship Board and the Office of the Public Advocate. They do provide an important service for people with disabilities; that is, people who are classified as having a disability under the disability services legislation. An effective guardianship board and public advocate is an important tool for people with disabilities. It is not only what one might term a raw service delivery but it assists and supports people with a disability in the provision of appropriate services for that office, which I can assure the honourable member is not over funded, and it certainly meets the needs of people with disabilities. The honourable member mentioned early intervention and autism. Early intervention is an important disability strategy: it is not a strategy that is simply related to disability because it also involves education—

Ms Stevens interjecting:

The Hon. R.D. Lawson: Yes, but there is a cross over, and we have had a number of examinations to see whether we can best support education with appropriate disability services. If we simply leave it to education, there will be gaps in the services, and it is well recognised in the reports that have been prepared that we need an integrated strategy and to do that we need funding. Autism also is a recognised and regrettably growing category of disability. It is true that the education system funds programs for autism, but, traditionally in this state at least, the Autism Association has performed the function of assessing whether or not a child is autistic. It is not simply a medical assessment: it is quite a complex range of diagnostic approaches, and through disability services we have funded the Autism Association to provide those assessments. It is an important part of our early intervention strategy.

Ms STEVENS: I must say that it seems to me that, until all the other department service providers—health, education and transport—take responsibility for all people in the community, we will continue to find that they do not take up their responsibilities because there is a disability bucket trying to top it up and that is how we get duplication, gaps and so on. I think the way to go is to force those agencies to accept their responsibilities under the disability discrimination legislation.

The Hon. R.D. Lawson: Certainly, I agree that the disability sector should not be used to prop up other sectors or to relieve them of the obligation to meet their demands, for example, in relation to transport, education or the like. However, a lot of work has gone into our whole of government early intervention strategy, and there are very close links between disability and education, certainly in relation to autism and also early intervention. Ms Roxanne Ramsey has been very closely associated with early intervention in chairing the committee. Ms Ramsey might like to add to my remarks.

Ms Ramsey: The early intervention committee looked at bringing together senior members from the education department, key health sectors, including regional health service, child and youth health and a variety of government agencies. The conversations and the agreements we reached in the plan that we put before the minister very much looked

at how we manage to pull together resources and work jointly to deliver services on the ground. The funding of early intervention coordinators was something that was strongly advocated within the sector, and it was through that process that we were able to jointly fund those programs.

The education department and child and youth health contribute to the funding of that, as well as the Disability Services Office. As well, there is an across-government strategy to make sure that all government services exercise their responsibilities with respect to providing services for people with a disability. That is being auspiced through the Senior Management Council, the committee of chief executives within government.

Ms STEVENS: I look forward to seeing one day that we do not have—

The ACTING CHAIRMAN: I assume that the honourable member will ask her third question.

Ms STEVENS: I will. I look forward to seeing in the future that we have health programs and education programs coming not out of disability funds but out of education and health budgets.

In relation to non-government organisations which, as the minister noted, provide a substantial role in the disability sector, I understand that the only increment they are getting on their funding is a 2.5 per cent increment—1.5 per cent for inflation and 1 per cent for occupational superannuation. This falls short of the expenses that they will need to cover. Inflation, for instance, is more than that, and they say that they are getting nothing to cover the national wage rise of $15 per week.

I noted, for instance, in the phase portfolio with the Gamblers' Rehabilitation Fund that the increment for this year is 4 per cent, which is more realistic in relation to the costs to be incurred. What is the increment that they will receive and, if they are not receiving up to the level of 3.9 or 4 per cent, what does this mean for them in terms of the provision of services?

The Hon. R.D. Lawson: I understand that the arrangements depend upon the funding source for the particular organisation and agency. The department is presently working on the budget for 2000-01 and, in that process, allocation will be made for indexation, superannuation adjustments and the like.

Ms Ramsey is more familiar with the process than I am, but I understand that as a matter of policy we will be passing onto agencies and organisations funds that we receive from the commonwealth for these purposes, and there will be a difference between agencies based upon the particular funding source, whether it be, for example, the Commonwealth-State Disability Agreement, the Home and Community Care Agreement, or the like. There will be different arrangements. Is there anything that you, Ms Ramsey, can add to that?

Ms Ramsey: No, other than to confirm that that is accurate: any indexation within the disability sector that is received through whatever source of funding will be passed through to the agencies.

Mr McEWEN: I have touched on some day options and, obviously, de facto, some respite options, but to my mind the biggest emerging difficulty is accommodation options. Many of our people with disabilities are living in families where the carers are now close to crisis themselves or are themselves inheriting disabilities, sometimes through old age, so the community is becoming quite alarmed. Where are we going in terms of supported accommodation options for many of our people with disabilities?

The Hon. R.D. Lawson: Additional supported accommodation has been a priority of this government over recent years. Wherever funds have been found, one of the first things to which we have been applying them is additional supported accommodation. We are opening additional services. For example, I mentioned that IDSC, which is the options coordination agency in Mount Gambier, is examining a new accommodation service for, I think, four men in Mount Gambier with high needs and other family circumstances which merit an accommodation service.

There is a list of people waiting to go into accommodation services. In many cases, it is difficult to find the appropriate compatibility to ensure that the disabilities of people are such that they can live together, that their personalities and other arrangements are congenial to other people, because these are normally four and five bed services. Geographical factors need to be taken into account. Some families want something with a christian base, and some organisations are based on churches. Others want to find accommodation close to a place of employment, or education, etc. It is difficult to develop these services to find appropriate compatibilities, notwithstanding the fact that we are opening them up.

At the same time, we have a program which enables people to leave the major institutions such as Julia Farr and the Strathmont Centre, which are two of the largest. Our surveys show that about 35 per cent of people in those institutions would like to go into a supported accommodation service in the community, if one could be provided. So, we have the dual desire not only of people who leave institutions and whom we are already supporting but also of people living in a family or a carer situation who are looking for additional accommodation. I do not believe that we will be able to accommodate in government funded places everyone with a disability who wants to live independently of the community. The demand is large, so that responsibility will fall back onto parents and carers.

The honourable member mentioned ageing carers. The commonwealth has recognised this issue and is addressing it not only through the unmet need funding but other commonwealth programs which, certainly under the current government, have focused on the needs of older people and the need to be relieved of the obligation of caring for a person with a disability. One of the tragedies is that so many people who have been living at home with parents and who have not had stimulation and training in independent living that we now provide to people find it difficult to live independently in the community.

Many people who previously would have lived in an institution now, with appropriate training and support, are able to live successfully by themselves in the community. For instance, some of the housing associations have been very active in giving independent living options to people with disabilities. That is the direction in which we are heading.

Mr McEWEN: The minister mentioned that there is a number of accommodation options. If Richard Bruggemann has not already briefed him on the studio concept which a number of parents in Mount Gambier have put forward, he will. Did I understand the minister to say that there are adults in the community with disabilities living in the family home who could never expect to be offered another accommodation option—that the resources are not available and that it is really more a matter of dealing with crises rather than options?

The Hon. R.D. Lawson: They will be supported. They have been in the past and we are allocating additional resources to meet these needs, and we will meet the needs into the future. People will not be thrown out onto the street because of a lack of resources. It is a great challenge. We have been able to meet it and I am sure that we will be able to meet it into the future.

The reason that I mentioned Housing Spectrum, which is one of the organisations that supports people with disabilities living independently in the community, is that we will be looking to other models of support and accommodation rather than setting up an institution for people who have been living at home for 60 years and who, when their parents pass on, have no-one to look after them. We have to find other, more innovative ways of supporting them. For example, they might be able to continue living in their own home, notwithstanding the fact that their parents thought that they would be unable to do that, provided we can give them some support.

Ms STEVENS: I raise with the minister an issue in relation to the Julia Farr Centre. I received a very concerning letter from an advocate of Disability Action Rights and Equity, and she is happy for me to mention her name, which is Ms Pat Garvey. I will read the letter because I ask the minister to look into the matters that she raises. She wrote saying that a meeting was organised on 29 May this year at Julia Farr Centre by a resident in the centre to hopefully receive help for the residents in the centre. The resident who called that meeting is paralysed and can communicate only by an alphabet board and by blinking. She was able to get this meeting organised. There were six people and the advocate present, representing three residents and members of their families. I will now quote from the letter, as follows:

> To summarise the complaints from both residents and their carers, I have listed some facts below.
>
> 1. Residents' needs are being neglected due to short staffing and nursing turnovers (i.e. agency nurses for residential nursing and patients/residents are being neglected). Only 10 per cent of care that is needed is carried out.

I asked her on the phone what she meant by that and she said that there are no hourly observations, that they are not often seen for many hours and that the carers feel that they have to do the work to look after their relative. The second point in the letter states:

> Residents are half washed, half dried and fear agency nurses feeding them.

I asked on the phone what she meant by 'fear agency nurses feeding them' and she said that the residents said that the agency nurses feed them but they do not wait for them to get their food down before putting more food in their mouth or that they are looking at the TV and not giving proper attention to the person whom they are proceeding to give more food to. The letter continues:

> 3. Residents have had injuries such as a black eye, cuts on a resident's leg, that could not be explained by the residents as they are unable to communicate their needs to nurses and are therefore depending on their families and carers to clean their noses, feet, fingernails, etc., as well as provide massage, as the residents are stiff in their muscles.
>
> 4. Patients/residents have been left on their own for anything up to six hours without seeing a nurse. Residents are put to bed at 4.30 until 7.30 when nurses may check on them.
>
> 5. Loved ones/carers have found their residential family member's shunt being blocked and was in severe pain. The wife had to threaten doctors before she could get any help. This resident is also blind and the complaint is that apart from no observation from nurses, the nurses would not explain to him what they were going to do when bathing and dressing him.
>
> 6. Medication is often inappropriately administered, that is, not given to residents regularly (consistent).
>
> 7. Carers have stayed in Julia Farr Centre for hours, sometimes up to 11 o'clock at night. They are fearful for their loved one's welfare.
>
> 8. Residents are fearful of their welfare/safety. They are also fearful of reprisals from staff for complaining. It's their word against the nurses.
>
> 9. Meals have been delayed, sometimes forgotten.
>
> 10. Residents and their carers are depressed, stressed and are at crisis point. Carers are burnt out and are depending on help.

I feel very concerned when I read these things. The Disability Action Advocate is quite prepared to talk about this further. She told me that the resident who had called this meeting had attempted to have this matter redressed through the management of Julia Farr Services but there has been no change. I would like the matter looked into and to be assured that these complaints will be investigated; that the people feel safe about having them investigated; that there will not be reprisals on them in relation to their care; and that we can be assured that, if these things are happening, they will stop.

The Hon. R.D. Lawson: I, too, am concerned by allegations of that kind. I must say that, although I have had complaints about Julia Farr Services, I have also had many compliments about the standard of service it provides. It is a service that, I think, gets state funding of about $28 million a year, which equates to over $141 000 per resident, so there are substantial resources devoted to Julia Farr Services. I would be most disappointed if the allegations of short staffing and staff turnover are sustainable.

I am certainly concerned by those allegations and I will have them looked into. I will get further details from the honourable member so that further investigations can be made. Serious as they are, I would not want to leave this committee with any suggestion that I accept the validity of the criticisms. I will certainly investigate them. I would not want my silence to undermine confidence in what is happening at Julia Farr Services because it is, and has been in the past, a very highly regarded service. It is a very important part of our service delivery mechanism and we want to make sure it is indeed a world-class service.

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

ADJOURNMENT

At 10 p.m. the committee adjourned until Thursday 22 June at 11 a.m.