HOUSE OF ASSEMBLY

Thursday 19 June 2003

ESTIMATES COMMITTEE B

Chairman:
Ms M.G. Thompson

Members:
The Hon. D.C. Brown
Mr P. Caica
Mrs R.K. Geraghty
Dr D. McFetridge
Mrs I.M. Redmond
Mr J.J. Snelling

The Committee met at 11 a.m.

Department of Human Services, $1 584 149 000
Administered Items for the Department of Human Services, $107 680 000

Witness:
The Hon. L. Stevens, Minister for Health, Minister Assisting the Premier in Social Inclusion.

Departmental Advisers:
Mr J. Birch, Chief Executive Officer, Department of Human Services.
Ms I. Haythorpe, Parliamentary and Legal Unit.
Dr T. Stubbs, Executive Director, Metropolitan Health.
Dr D. Filby, Executive Director, Strategic Planning and Population Health.
Ms R. Ramsey, Executive Director, Social Justice and Country.
Mr R. Michael, Executive Director, Corporate Services.
Ms S. Miller, Acting Executive Director, Aboriginal Services.
Mr G. Tattersall, Acting Director, Financial Services.
Mr P. Jackson, Director, Asset Services.
Ms M. Russell, Senior Project Officer, Parliamentary and Legal Unit.

The CHAIRMAN: As I think you all know, the estimates committees are a relatively informal procedure and, as such, there is no need to stand to ask or to answer questions. The committee will determine an approximate time for consideration of proposed payments to facilitate the changeover of departmental advisers. Will the minister and the lead speaker for the opposition indicate whether they have agreed on a timetable for today's proceedings?

The Hon. L. STEVENS: Yes, we have.

The Hon. DEAN BROWN: No, there has been no agreement on a timetable at all, and I made that very clear in a speech in the house. We have agreed on going through an order of divisions within the Department of Human Services, and I understand that we have health up until 4.15 this afternoon.

The Hon. L. STEVENS: That is my understanding. I thought that that is what you had agreed.

The Hon. DEAN BROWN: There has been no agreement with the opposition on timing overall.

The Hon. L. STEVENS: We will agree to that now, shall we?

The Hon. DEAN BROWN: We will see how it goes during the day. As the committee would be aware, the Speaker has written a letter saying that those who still wish to ask questions have a right to stay and ask questions. The Speaker has made that very clear under standing order 270.

The CHAIRMAN: However, we are expecting that the human services examination will continue until 4.15 p.m. and at 4.30 p.m. the Minister for Social Justice will be available; is that correct?

The Hon. DEAN BROWN: That is right.

The CHAIRMAN: Changes to committee membership will be notified as they occur. Members should ensure that the chair is provided with a completed request to be discharged form. If the minister undertakes to supply information at a later date, it must be submitted to the committee secretary by no later than Friday 25 July. I propose to allow both the minister and the lead speaker for the opposition to make opening statements of about 10 minutes each. There will be a flexible approach to giving the call for asking questions based on about three questions per member alternating each side. Supplementary questions will be the exception rather than the rule. A member who is not part of the committee may, at the discretion of the chair, ask a question.

Questions must be based on lines of expenditure in the budget papers and must be identifiable or referenced. Members unable to complete their questions during the proceedings may submit them as questions on notice for inclusion in the assembly *Notice Paper*. There is no formal facility for the tabling of documents before the committee. However, documents can be supplied to the chair for distribution to the committee. The incorporation of material in *Hansard* is permitted on the same basis as applies in the house, that is, that it is purely statistical and limited to one page in length. All questions are to be directed to the minister rather than the minister's advisers and through the chair. The minister may refer questions to advisers for a response. I declare the proposed payments open for examination and refer members to appendix D, page 2, in the Budget Statement, and part 7, Volume 2 of the Portfolio Statements. Does the minister wish to make a short opening statement?

The Hon. L. STEVENS: Yes, Madam Chair. On coming to government in March last year, we knew that we had to start repairing our health services and develop plans to build a better service system. This year's health budget provides $84.3 million in extra spending over the next four years. The extra money provided for 2003-04 is $21 million. This means that there will be more hospital beds (including intensive care beds), more nurses and better health services. New initiatives funded by the government include:

- $30 million extra for intensive care services over the next four years;
- $26.8 million extra for nursing over the next four years;
- an extra $16.3 million over three years to maintain and replace biomedical equipment in our hospitals, taking the total biomedical budget provision to $47.1 million;
- $9.6 million extra over four years for new and safer blood products and to comply with new national standards;
- $5.2 million extra over four years for kidney dialysis services to meet ongoing demand; and

- a boost of $4 million for mental health initiatives over four years to continue the implementation of the government's mental health reform strategies.

In addition to these new initiatives, there is additional ongoing funding from last year's budget. Members may recall that last year the government provided additional funding which included:

- $11.8 million to boost hospital capacity ($52 million over four years);
- $2.3 million for mental health reforms ($9.2 million over four years); and
- $2 million each year for improved dental care ($8 million over four years).

As with all departments, each year the Department of Human Services is required to consider where savings can be made to enable funds to be redirected to services.

This year, the Department of Human Services has identified $10 million of head office savings across the portfolios of health and social justice for 2003-04. These savings have been redirected to on the ground services and include $3.5 million on travel and accommodation expenses; $3.4 million on reducing the number of redeployees; $1.5 million on IT costs; and $1 million on the use of temporary administrative agency staff. The redevelopment of three of our major public hospitals continues with previously announced funding. Planning is also proceeding on the final stages for the redevelopment of these three hospitals, and the government has allocated an extra $222 million in the forward estimates for the capital works program to complete these redevelopments.

As shown in Budget Paper 5, the Queen Elizabeth Hospital has allocated $32 million for stage B; the Royal Adelaide Hospital has been allocated $130 million for stage 4; and the Lyell McEwin hospital has been allocated $32 million for its stage B. In addition to the capital projects I have just outlined, $10.9 million will be used to build the new Margaret Tobin mental health facility at the Flinders Medical Centre, and $9.8 million has been allocated for the construction of a 30-bed aged acute bed mental health unit at the Repatriation General Hospital. The sum of $4.6 million has been allocated to redevelop the Women's and Children's Hospital emergency department, with $1.6 million budgeted in 2003-04. This year, $1.5 million has been provided for the Murray Bridge Hospital redevelopment and $1.1 million for the upgrade of the Renmark Hospital.

These are major investments that deliver on this government's commitment to rebuild health infrastructure. Other initiatives funded in this budget are targeted to meet the immediate needs and longer term health outcomes of many South Australians by focussing on early intervention and prevention strategies that will reduce, over time, the burden of illness in this state. Investing in such programs is important. Each year, there are an increasing number of people diagnosed with end-stage renal disease. In people over 65 this condition means a person will need to undergo dialysis treatment for four hours, three times a week for the rest of their life. Therefore, it is important that dialysis centres are located across the metropolitan area and the state to reduce the impact and interruption that this illness has on people's lives. The budget provides $1.3 million every year for the next four years to expand satellite dialysis services.

This budget also provides new funding for some of South Australia's most disadvantaged groups. The government is determined to improve the health status of Aboriginal communities on the APY lands. These remote communities will benefit from $1.65 million allocated this year for health and wellbeing initiatives, including the establishment of rehabilitation and respite services for substance abuse. The budget has also set aside $30 million extra for intensive care services over the next four years. In 2003-04, this will provide 13 more intensive care beds, five each in the Royal Adelaide and Lyell McEwin Hospitals and three in the Flinders Medical Centre. An extra $16.3 million over three years has been allocated to maintain and replace biomedical equipment in our hospitals. This money will assist in the replacement of ageing assets, as for some years a backlog has accumulated.

Finally, and without distracting from the examination of this year's budget, I want to mention the Generational Health Review. In May 2002, we commissioned the Generational Health Review to develop a blueprint for reform over the next 20 years. Today, I have released the report of the review and the government's initial response. Review chair John Menadue and his team did an excellent job in identifying the pressures the health system is under and pointing the way forward. He issued a challenge to the government, and to the health system. The government accepts that challenge. The first steps forward in our health reform strategy will focus on three main things: building better governance, building better services and building better system support. These first steps will provide immediate action on two-thirds of the report's recommendations, and the government will give further consideration to the remaining recommendations as we implement these very first important changes.

A copy of all that material will be distributed to all members of the committee by the officers of the house. In conclusion, my officers and I—with their support—will do the very best we can to answer all the questions asked of us today as fully as we can. If in any way our answers fall short, we will be going through what we say very carefully and making sure that anything that needs to be corrected is corrected or added to within the time frames that you have specified. Thank you very much.

Membership:

Mr Snelling substituted for Mr O'Brien.

The CHAIRMAN: Member for Finniss, do you wish to make an opening statement?

The Hon. DEAN BROWN: Yes, I do. First, I start by saying that today we will look at the Department of Human Services' budget in a very broad area. It covers health, initially, but then we go on to community welfare, disability and the ageing. These are crucial social issues within our community, and it is absolutely essential that they be appropriately funded to maintain and increase services to keep up with demand within the community. The Department of Human Services' operating budget—the bulk of which goes to health—has been increased only by 2.4 per cent this year. The budget documents themselves say that we have an inflation rate of 3 per cent. The documents talk about the fact that there has been a 6 per cent increase in salaries in the last year. So, the government, by its own admission, on the figures in the budget, is saying that it will not even keep up with inflation, let alone wage increases. That means one thing only—a cut in services, invariably to those who are most disadvantaged within our community.

In the hospital sector we know that as of today, compared to 12 months ago, there are fewer hospital beds open. There has been less planned surgery in the hospitals in the last year,

the waiting lists for surgery have increased, as have the waiting times, and the pressures within the emergency departments have increased enormously. Today, we will look at broad areas in terms of care, and I will come shortly to the Generational Health Review. I want to touch, though, on the fact that today one of the issues that will come up is caring for frail aged people within the community, and that includes health care for these people in the community. We see that the government has failed even to match inflation when it comes to home and community care funding. It has failed to take up the offer from the federal government for a substantial increase and, by failing to take that up, we will lose $3.1 million of federal funds this year. Of course, the base this year becomes the new base for next year, so we lose $3.1 million next year and every other year past that. That means $5 million will not be available to care for and provide nursing and home care support to shower and feed older people who are struggling to remain in their own homes. It is $5 million this year. That is enough for services for literally tens of thousands of people.

This morning, I have been at the Cora Barclay Centre. The Cora Barclay Centre has not received a renewal of the $150 000 in funding it received from the government last year and in previous years. As a result of that, the Cora Barclay Centre is facing closure. Overnight, they received a letter from the government offering $40 000, but they need $150 000 just to keep the centre open. These deaf children are being taught to speak from the age of one. I met some of these children this morning. I cannot imagine a more heartless decision by a government. Deaf children are being taught to speak in a centre that has been in South Australia since the 1940s. It is an icon of this state and it is held in high esteem throughout the world, yet, as a result of the lack of $150 000 in funding, it is being forced to sell the premises, close the doors and sack the staff. That is what they were told by the President, Richard Pascoe.

To make matters worse, Richard Pascoe at the press conference revealed that this morning he received a telephone call from a staff member of the Premier's own office. That person made a threat that if they participated with the opposition at the press conference this morning, then the offer that had been made overnight would be withdrawn. This is intimidation of the worst type. Where is the freedom of speech within our community, when a person from the Premier's office rings to intimidate and threaten a member of an organisation that is trying to help deaf children? Frankly, this behaviour is indefensible and in breach of freedom of speech in our community—and the staff member should be sacked immediately.

The Hon. L. STEVENS: I have a point of order. The issue of the Cora Barclay Centre is not under my jurisdiction. I am wondering why the shadow minister continues.

The CHAIRMAN: I had noticed that the deputy leader was straying well away from the health portfolio and assumed that he was making an opening statement for the whole day. Is that the case, member for Finniss?

The Hon. DEAN BROWN: That is the case; I am making a statement for the whole day. In fact, this $40 000 of funding is proposed from the disability budget—

The CHAIRMAN: Order! I have not concluded my remarks. Minister, the whole line is open, so the deputy leader is entitled to make a statement covering all the portfolio areas. He has indicated that he does not wish to make a further statement later in the day, so I will accommodate that.

The Hon. DEAN BROWN: Thank you, Madam Chair. In fact, I point out that audiometry for deaf children is done at both the Women's and Children's Hospital and the Cora Barclay Centre. The Women's and Children's Hospital could not cope with its present facilities and staff to do the audiometry. An essential part of it is done at the Cora Barclay Centre. Therefore, extra staff and extra costs would have to be put back into the health system if the Cora Barclay Centre were forced to close. These children would be forced back into the state education system. Their present funding is only 25 per cent of what they would receive if they were in the public education system. It is a decision where the government is refusing to put in $150 000 and, in return, they are putting in a mere $40 000. They had enough yesterday for $800 000 for a three-day horse event, but they cannot find $150 000 to teach deaf children with cochlear implants how to speak. It is an absolutely appalling decision. I highlight that this threat that was made and talked about by the President of Cora Barclay Centre at the press conference this morning highlights how desperate the government has become when it makes a threat which intimidates the people to that extent. As I said, the staff member should be dismissed.

I turn now to the Generational Health Review. The review has not yet been tabled. As shadow minister, I have not been given an opportunity to read a copy. I asked for it to be tabled a week ago so that, when looking at the budget today, we could have the chance to consider the review as part of the budget. It is absolutely appropriate. If this is the most fundamental change in health for a number of years, then why not consider it as part of the broad approach we are taking to review the budget for the next 12 months? In fact, I have questions about the review, which I will raise shortly. I highlight the fact that John Menadue, as chair of this review, said that he wanted to see up to $170 million ripped out of the hospital system. That causes me concern. He said that more money needs to be put into community health care—and that is exactly how we would have used the $5 million that this government has failed to put into HACC.

I think our great disappointment is that the Generational Health Review was not out there a week ago, so we could have a broad examination and discussion about where it fits in with the budget for this year. It would appear that we have a Generational Health Review, plenty of words from the minister and some promises, but no substance. If the substance in terms of the money to carry out the review is not there, then it goes absolutely nowhere. Therefore, I think the minister is too afraid to put the review out there and for it to be examined as part of the detailed examination of the line today.

I am willing to cease my comments there and get on the with the questioning, which is the main part of today. My first question is about the Generational Health Review. How much money has been set aside for 2003-04 in the current budget to implement the recommendations of the Generational Health Review; and where in the budget papers is that money specifically provided for?

The Hon. L. STEVENS: I am happy to answer a question about the Generational Health Review, but I am surprised to be asked a question about it. Only last week, the member for Finniss was complaining that I was going to hijack the estimates committee by introducing the Generational Health Review, when in fact we should be examining the budget papers.

Mrs Geraghty interjecting:

The Hon. L. STEVENS: As the member for Torrens said, it was last week's story. We are becoming rather accustomed to things changing on a daily basis, in terms of the member for Finniss's position on a range of issues. I have been accused of being cynical, and it was suggested yesterday that I was locking out the media, so they could not get into the estimates committee—and I notice they all are here—to hear to what was going on while the member for Finniss questioned what was in the portfolio statements. I am happy to talk about the Generational Health Review. I was pleased to release that report today.

As members would know, the people of South Australia have been crying out for years for a plan and some action in a considered rational way to address the rebuilding of our health system. If we look back to the past and the time of the member for Finniss, I guess there was a plan of sorts in place to start with. That was the plan to privatise our health system. I remember that very clearly. I remember the minister at the time when the member for Finniss was Premier, and I remember the brave new world: Modbury Hospital first, the Queen Elizabeth Hospital next, and then the rest. We all know where that plan went. When that plan failed, that was about the end of any plans under the member for Finniss. During the member for Finniss's time as Minister for Health, his main approach was simply to manage the mess, to blame as many people as possible and to pass on the mess. Of course, that is what we have been faced with.

That is not what this government is about. We promised that we would rebuild South Australia's health services. That is our intention. What we need to do, obviously, with something as large and complex as this is to have a plan. We put in place the review headed by John Menadue. That review panel met over the past year and presented a report to me in April. That report has now been to cabinet and has had a lot of consideration. The government has endorsed that report and has come out with its First Steps Forward. The member for Finniss has asked in particular about the lines in the budget that apply to the report. First, if he has an opportunity, as I am sure he will, to read it in detail, he will see that John Menadue—

Mrs Redmond interjecting:

The Hon. L. STEVENS: The member for Heysen interrupts me but, as I say, up until today the Generational Health Review was a diversion from the budget: now we seem to have it as first question. When people read the report they will see that a number of measures mentioned in the generational review have already been covered in the budget, and in a moment I will ask the chief executive to detail those. I would also like to say that, if people read the details of the First Steps Forward, the government's initial response, people will note that the government is focusing on a number of areas. In coming months we will be doing detailed business cases in relation to those, one of which is the seven day a week, 24 hour a day call centre.

Those business cases will be done and they will come to cabinet for consideration, for funding and for timing of implementation. As I said before, this is a 20-year plan: this is not a flash in the pan. It deserves consideration: it is there for the long term. I will hand over now to Jim Birch to give some details about what is in this budget that applies.

Mr BIRCH: In answer to the shadow minister's question, there is not a specific line entitled 'Generational Health Review', but if he goes through the recommendations of the Generational Health Review he will see some initiatives that are actually funded very specifically in the budget. I will give some examples, but we would be happy to take the question on notice and provide the detail in due course. The first is recommendations regarding mental health reform. Two projects are funded this year that are part of the Generational Health Review recommendations. Whilst John Menadue did not recommend very specific initiatives in mental health reform but, rather, had some overarching recommendations, there are two within the budget.

First, the Flinders Medical Centre Mental Health Project, which is otherwise known as the Margaret Tobin Mental Health Centre. This delivers 40 beds of adult acute mental health facilities, incorporating 20 beds at Flinders Medical Centre and 20 acute beds from Glenside campus. The total amount in that project is $14 million, of which the government contribution is $12.3 million and the Flinders University contribution is $1.7 million, to be cash flowed throughout 2003-04 and 2004-05. The forecast expenditure in 2002-03 was $400 000. The second project that forms part of the mental health reform project is the Repatriation General Hospital Mental Health Project, which aims to deliver 30 acute aged care beds to that hospital to form part of the Southern Mental Health Services' role to people relocated from Glenside Hospital and Springbank House. In 2002-03, $450 000 was approved.

However, in the forward estimates there is $9.8 million for the project, and the forecast expenditure for 2002-03 was $186 000. There is also $1 million allocated very specifically to the Mental Health Unit for what is otherwise known as workload assessment, and also for work force improvement. This is largely to begin the process of training further staff in community-based mental health care, and we can talk about that in more depth later. The second initiative funded in the budget, which is also an initiative included within Minister Key's area, is the Early Childhood Development Project. That is a recommendation of the Generational Health Review, which is an early intervention project otherwise known as universal home visiting, for which in the budget $3 million is allocated under the child protection initiatives and a further $1 million, which is actually an ongoing amount, allocated for early childhood intervention initiatives from last financial year, which is a recurrent amount.

In addition, there is a reallocated effort from Child and Youth Health, which will be providing this service, equivalent to $3 million. It currently provides a universal home assessment process, which will now be extended to universal home visiting. The third is the one that the minister mentioned, the Anangu Pitjantjatjara Lands. The Generational Health Review makes a number of recommendations about Aboriginal health services, specifically around targets. There is an amount there, which the minister mentioned, regarding both the rehabilitation facility and the Health and Wellbeing Program for the Anangu Pitjantjatjara Lands.

Also held within CE's contingency is an amount which is yet to be finally determined but which will approximate $1 million for the transition funding that is needed until such time as business cases are written to further advance mental health, the call centre, as the minister mentioned, and other initiatives in the Generational Health Review. Other aspects are sprinkled within the budget, but, rather than go on, it might be better if we took that on notice and provide a more detailed response to the shadow minister in due course.

Membership:

Ms Bedford substituted for Mr Snelling.

The Hon. DEAN BROWN: I appreciate the information given but I think we need to put that into context. The Margaret Tobin Centre cannot be seen as an initiative of the Generational Health Review, and even to make out that it is a gross distortion of history, trying to rewrite history. Therefore, to say that $14 million has been put aside as part of the Generational Health Review for the Margaret Tobin Centre when that in fact was sitting in the forward estimates and has been for a couple of years is outrageous. In fact, I was at a function 12 months ago, before the Generational Health Review was set up, where it was specifically announced, and it had been put into the forward estimates by the previous government.

In talking about reform in mental health, the budget papers themselves show only $1 million extra for mental health this year. That is a very small increase and will not achieve any reform at all. It will not even keep up with demand. We talk about $3 million in the FAYS budget when the FAYS budget, as we will find out later today, has not even been increased to meet inflation, let alone to carry out new initiatives. In fact, the CEO of the department acknowledged on air that there would be no increase in funding in FAYS and no extra staff. So, I come back to the point that, clearly, there is no money for the Generational Health Review in this year's budget. I have given the minister the chance to tell us where, and she has not come up with anything.

I received a copy of the report in the past three or four minutes and I have counted 16 or 24 recommendations that require action either as soon as possible within three months or certainly within the first 12 months; in other words, in this budget cycle. As there are no extra funds in the budget for the Generational Health Review, where will the money be stripped from in other parts of the portfolio to make money available to implement the recommendations of this review? We cannot have all these recommendations that say they must be implemented immediately with not even enough money in the departmental budget now to keep up with inflation, let alone wage increases. And the minister cannot come up with any recommendations. John Menadue himself said on one occasion that he wanted to strip $170 million out of the hospitals.

On another occasion—I was at the forum in the town hall where he talked about this—he said that he expected to be able to strip $100 million or more out of hospital administration. All of that indicates that there will be a significant reduction in hospital services. You cannot wave a magic wand and produce the money. You cannot cut $100 million out of your public hospitals budgets and then say that you are going to maintain services. We have been running on that for the past 12 months—not very successfully when we see less surgery, longer waiting times and fewer beds.

Where will we find the money that has been stripped out of public hospitals to pay for these recommendations of the Generational Health Review, because clearly that is now what needs to be done. We saw last year how they hid the cuts to Julia Farr, the IDSC and the ILC. I want to know what is going to be cut in public hospitals this year. The budget for country hospitals has been increased by 1.7 per cent when there is 3 per cent inflation and a 5 to 6 per cent increase in wages. I would like to know specifically where the minister is going to make cuts to fund the so-called Generational Health Review recommendations.

The Hon. L. STEVENS: I was a little bit concerned that I was hearing another speech, because the shadow minister ranged over so many different topics in the lead-up to his question. There are no cuts to our hospitals. I can provide some details of the final allocations coming through from the department's work on our hospital budgets. However, I will comment generally on some of the 10 or more issues which I think the shadow minister raised.

If the shadow minister had taken a more positive approach to the Generational Health Review while it was taking place, he would have a better understanding of all the consultation and work that has been done and the arguments and discussions that have occurred over the last year but, as we all know, the shadow minister spent most of this time being negative and sniping from the side, scaring the country by saying that all their boards and acute services would go, starting fires all over the place, saying that the review was not needed and that it was inappropriate for him to make a constructive contribution.

The Hon. Dean Brown interjecting:

The Hon. L. STEVENS: That was another of your attempts to derail the review. The shadow minister said that the mental health reform could not be counted as part of the Generational Health Review. Perhaps the shadow minister might like to read the report, as I said before. John Menadue spent—

Members interjecting:

The Hon. L. STEVENS: Here they go again. I thought that today we were not going to be talking about the Generational Health Review but, of course, if you want to talk about it, we will. Regarding mental health, the shadow minister presided over the complete demise of the mental health system in South Australia. Peter Brennan, in his report in the year 2000, was damning of what had happened in the later years of the 1990s. John Menadue in his report focused on particular health inequities applying to certain populations of people. The government has accepted the need—

Members interjecting:

The CHAIRMAN: Order! There is too much scuttlebutt across the chair. Please let the minister be heard in silence.

The Hon. L. STEVENS: The government has accepted John Menadue's concerns that we need to address mental health urgently and that we need to address early intervention and primary health care, and we will do so in terms of a 20-year plan for this state. The shadow minister mentioned the Margaret Tobin Health Centre. I am keen to focus on this for a few moments, because the shadow minister claimed that this was in the forward estimates. It was sitting in the forward estimates, underfunded, not enough money in there to do it. I certainly remember as shadow minister that project being announced in, I think, three separate years as coming on-stream at the Flinders Medical Centre, but it never did.

When we got into government we looked at the capital works program and found that there was not enough money to do the mental health project that he had sitting in the forward estimates. This is not the first example of what we found, but it is very pertinent. So, we got that project going. We did a lot of work to shape up our capital works budget to be able to get it to actually operate. Perhaps some time today we might speak about some of the work that has had to be done to get the capital works budget into some semblance of order so that we could actually get these projects up and running.

So, the mental health project at Flinders has been funded, as has the project at the Repat, which was another one of this bunch of projects popped into the forward estimates without there being enough money there to fully and adequately build them. So, the government has started on the mental health

reform agenda, and we will continue that agenda. Last year was a very difficult year in mental health in South Australia. With the tragic death of Margaret Tobin we lost momentum. We are now pleased to say that we have appointed Dr Jonathan Phillips, an eminent practitioner and clinician—

Mrs Redmond: Good choice.

The Hon. L. STEVENS: I am pleased to hear the member for Heysen say, 'Good choice'. We believe that he is a good choice. He has been well received universally across the sector as a person who will be able to take over from where Margaret Tobin left off to build on the things that she started and address this very important issue.

The member for Finniss mocked the $3 million coming across into the early childhood initiative to fund the universal home visiting scheme. That will be a significant policy initiative for this government. We take early intervention very seriously indeed. We want to give every child in South Australia every chance of having the best possible future. We are making some immediate changes in terms of the way that we will organise this. We announced this morning that the Women's and Children's Hospital and Child Youth and Health will be joined together to form a new organisation, which will drive these early intervention initiatives right across the state.

The Hon. Dean Brown interjecting:

The Hon. L. STEVENS: If the member for Finniss could be quiet and let me finish. He raised about 15 different topics, and I am doing my best to answer them. A considerable amount of work has already been done in relation to the early intervention initiative, and we will continue that. Very good outcomes have been achieved in programs like this overseas and in other areas of Australia. We intend to make this a significant part of health reform over the next two or three years.

The member for Finniss ranged across issues in hospitals relating to elective surgery and waiting times in emergency departments. He made the point that there are fewer beds. Yes, there are fewer beds. Let us talk about why there are fewer beds. The committee will probably remember that in September or October last year I had to announce to the people of South Australia that we had to start taking beds off-line in our major public hospitals because we did not have the nurses in our work force to be able to keep these beds open. I might say again that I wonder why in South Australia we did not have a plan to address a crisis which had been looming for years and which other states had begun to address; they had set up systems, got their strategies in place and were actually working on major pushes in the recruitment and retention of nurses. We did not have that here in South Australia.

Within about a month of my coming into office, at the very first meeting of the ANF, I was told not only about the enterprise bargaining agreement that had not been properly accounted for or funded but also about the report on nursing issues that the minister at the time had sat on for over a year. The issues have been very difficult and they are not solved, but they were not helped by the mismanagement of the member for Finniss—chronic mismanagement, I have to say—in managing the mess and making it worse, mostly. I ask the Chief Executive to give some information to the committee in relation to hospital budgets for this year.

Mr BIRCH: Metropolitan public hospitals have had a difficult year with nursing and anaesthetic shortages, increased pressure with emergency admissions and increased demand for intensive care services. Other budget pressures have included the increased demand for mental health services, increased costs in new technology and additional costs associated with the greater use of private agency nursing staff, and that has been particularly in the Royal Adelaide Hospital and the Queen Elizabeth Hospital. In the 2002-03 outcomes, the government allocated an initial $5 million in February 2003 to assist with these cost pressures. Metropolitan public hospitals are anticipated to end the financial year with a deficit of about $2 million, although at this stage we cannot be absolutely certain, because the end of the year has not closed off; that is an estimate. In the 2003-04 targets we have factored in an increased hospital capacity of 13 ICU beds (five each at the Royal Adelaide and the Lyell McEwin Health Service and three at Flinders Medical Centre), 18 inpatient beds at Lyell McEwin Health Service and 26 flexible beds at the RAH for winter through additional funding of about $14 million to meet the increased demand.

We are aiming to address the ongoing nursing shortage through the implementation of a range of nursing recruitment and retention strategies. This is the extension of the retention strategy document that was released last year and will include the progressive commencement of these strategies again through July, August and September for overseas nurses who were recruited late in 2002-03. There is increased funding of about $8 million to the Lyell McEwin Health Service to enable additional ICU, ophthalmology and general medical services to be provided or expanded following the completion of the first stage of its redevelopment. The aim this year is to change the strategy in the winter period to increase the capacity of the Royal Adelaide Hospital to deal with that. You might recall that last year there was a winter bed strategy which made it very difficult to have diversions; that will not continue this year.

Other budget targets include reducing hospital length of stay, reducing emergency demand, improving patient discharge processes and increasing day-only admissions, largely through hospital avoidance strategies such as hospital in the home and step-down facilities. Once finalised, as indicated previously, the implementation of Generational Health Review strategies will be provided by business cases, obviously through the budget processes as we go forward.

The Hon. DEAN BROWN: My next question again concerns the Generational Health Review: specifically, how much extra surgical work will be carried out, how many extra procedures will be carried out in our hospitals and how many additional patients will be treated in our public hospitals as a result of the Generational Health Review?

The Hon. L. STEVENS: I will ask the Chief Executive to answer that question.

Mr BIRCH: It is quite difficult to answer that, because the general strategy of the Generational health Review—I cannot point to the specific pages, but I am aware of them—is to flatten the demand for hospital services into the future. The shadow minister indicated that Mr Menadue was indicating that a very significant shift of money needed to occur from hospitals. As the review progressed it became evident to the department that in fact what was required by 2011 were strategies to reduce the increasing demand through ageing and chronicity. We anticipate that if we do not implement the strategies of the Generational Health Review it will be necessary to open somewhat more than 400 beds by 2011, largely in metropolitan Adelaide, if we do not have strategies for primary care, step-down facilities, hospital avoidance strategies, etc.

So, we would not be anticipating a specific increase that I could point to in surgical or medical procedures, other than the normal growth of procedures up to 2011. I would stand corrected, but I think this represents the fact that, if we do not implement this, about 140 000 additional patients per annum would be admitted to hospital by 2011. I may stand corrected on that, and I can get that figure for you afterwards. The thrust of the department's response to the Generational Health Review is to implement strategies to reduce growth rather than reduce funding to the hospital system. I am prepared to take on notice the specific question that the shadow minister asked and look at what we would anticipate the impact of the Generational Health Review or the departmental strategies would be on surgical and non-surgical procedures in the next financial year and beyond, if that is the question.

Mr CAICA: Over the past decade the number and rate of South Australian people diagnosed each year with end stage renal disease has increased from 98 people in 1991 to approximately 170 people in 2002. What is the government's plan in line with budget statement 7.59 to deal with the increase in demand for services?

The Hon. L. STEVENS: I thank the member for Colton for his question because, as a member in the western suburbs of Adelaide, he would know only too well some of the issues in relation to renal disease in that area of Adelaide. Dialysis is a long-term treatment strategy for end stage renal disease. End stage renal disease develops when kidney function deteriorates, usually as a result of hypertension and, of course, diabetes. As these illnesses are common in people over 65 years of age, the rate of progression towards end stage renal disease will continue to increase in South Australia, consistent with the ageing of the population. Dialysis or transplantation is the only treatment for people with end stage renal disease. Without these, a person will usually die within a short period of time.

I might say that this just indicates how important early intervention and the issues in relation to tackling diabetes are when you think about what people are faced with when they end up with this condition in their later years—and sometimes not only in their later years. Transplantation is not the preferred treatment for people aged over 65 years. Some 44 per cent of people using dialysis are aged over 65 years; the rest, obviously, are younger. The government is committed to meeting community expectations regarding access to dialysis services. An additional $5 million new initiative funding has been allocated in this year's budget for expansion of renal dialysis services over the next four years. This year, 2003-04, this will provide $1.3 million for 40 additional people to receive dialysis services in satellite centres in metropolitan Adelaide.

Dialysis is a procedure that takes four hours, three times a week. It involves connecting the person by an intravenous catheter to a dialysis machine that filters the blood. It can be undertaken in a hospital, in a home or in a satellite setting depending upon the medical condition of the patient. At the moment, there are approximately 480 people using these services here in South Australia. We have three public hospital based renal units (at the Royal Adelaide, the Queen Elizabeth, and the Flinders Medical Centre) which provide dialysis services in the hospital as well as oversight of the regional satellite and home dialysis services. Metropolitan satellite units are located at Wayville, Noarlunga Health Service and the Lyell McEwin Health Service.

Dialysis is also provided at a number of rural locations including Port Augusta, Berri, Port Lincoln, Ceduna, Murray Bridge, Clare and Mount Gambier. The increased requirement for dialysis has been met over the years by improved efficiencies and expansion of dialysis capacity, but there is no capacity left within the metropolitan system to respond to further growth in demand for public dialysis services. The dialysis costing study in 2001-02 found that the average cost per satellite centre patient per annum was $33 143 or $130 000 per dialysis chair. These costs exclude major set-up costs of purchasing equipment—another reason for us to want to get in early in relation to cutting this off before it gets to such a serious stage.

A recent review proposed a comprehensive integrated plan for renal services. The Renal Reference Group is responsible for the implementation of the plan, for providing advice on priorities and for identifying strategies to achieve consistency of clinical standards, quality and monitoring. A clinical reference group involving representatives of hospital CEOs, renal clinicians, renal nurse managers and the Department of Human Services is responsible for determining the plan for the provision of satellite dialysis services. By September 2003, the clinical reference group will advise the government of the proposed location and model for the additional funded dialysis places.

This government is responding to the needs of people requiring dialysis—we are committed to meeting community expectations regarding access to those services. As I said, the additional $1.3 million allocated this year will open up capacity for 40 more people with end-stage renal disease requiring dialysis. As I also said, our new initiative funding provides $5.2 million in total over the next four years.

Mrs GERAGHTY: I refer to Budget Paper 4, Volume 2, page 7.66, referring to the delivery of health services. Minister, in your opening statement you referred to additional funding for intensive care. Could you please inform the committee how this additional funding will be used to address the increasing demands for intensive care?

The Hon. L. STEVENS: The budget includes an extra $30 million over four years to boost South Australia's intensive care services in three of our major metropolitan public hospitals, and we anticipate that that will enable us to treat an estimated 7 400 extra patients. The demand for intensive care services is at an all-time high, and when I finish I might get my chief executive to comment on this issue of the increase in the demand for intensive care services. The extra funding of $7.5 million per annum will enable 13 extra intensive care unit beds to open to treat an estimated 1 850 extra patients each year. The extra budget will include the Lyell McEwin Health Service receiving $1.4 million for five brand new ICU beds to treat an estimated 340 patients.

I might say that for a number of years clinicians from the Lyell McEwin Health Service have raised with me, and the member for Torrens, who is also a member in the northern suburbs, their concern at having to transfer very seriously ill patients from the Lyell McEwen to either the Queen Elizabeth or the Royal Adelaide because there have not been those services available in the northern suburbs. So that is a very welcome move and I am very pleased that we have been able to do that this year. The Royal Adelaide Hospital will receive $3.9 million for five extra beds in the ICU to treat 980 more patients, and Flinders will receive $2.2 million for three extra ICU beds to enable them to treat 530 more patients.

As to the issue in relation to the other hospital that has an ICU but which did not receive extra funding, the Queen Elizabeth Hospital, I would like to just assure the committee

that with the extra money at the Lyell McEwin Health Services this will take pressure off the Queen Elizabeth Hospital. As I have said before, because there was no unit at the Lyell McEwin Health Service we had to transfer those patients across to the Queen Elizabeth, and that will be taken care of with our new allocation for the Lyell McEwin, which will come on stream as soon as we can possibly get the new facilities opened, commissioned, the new equipment tested and ready to go, and then, of course, the staff in place. The latest Department of Human Services figures talk about the rise in intensive care beds and I am going to hand over to Jim Birch to give some more detail on that.

Mr BIRCH: Thank you, minister. Before doing so, I refer to the question that the shadow minister asked about the workload increases. I was not absolutely certain at the time about the specific number of indications that would be increased by 2011 if the changes were not made. I can refer to page 13 of the Generational Health Review where the total admissions would increase by 10 per cent, which is largely population driven, and I believe that represents 40 000 not 140 000 patients per annum. The total beds, same day and overnight, required would increase by 16 per cent, which is 472 beds, and the total cost per annum would increase by 9 per cent, which would be $87.9 million per annum at 2001 prices.

In relation to intensive care activity, I will be brief. Yes, it is true that the intensive care activity across metropolitan Adelaide has increased. It has not increased across all of the metropolitan area to the same extent, but it has in certain specific regions, in particular the south. The Flinders Medical Centre in particular has experienced dramatic growth. The growth curve has been, as the shadow minister would know, trending up for some years but in the last two years in particular it has spiked. We are undertaking an assessment at the moment of intensive care unit admission practice to determine whether in fact the criteria for admitting into intensive care is common across the metropolitan area. That will be undertaken in the coming year. However, we are experiencing what we believe to be a national trend in intensive care activity. Clearly, this is as a result of ageing but also increased technological capacity to treat people in intensive care. I do not intend to go over what the minister has already gone over with the specifics about the number of beds, but we do need to understand this in more detail because it is a cost that actually is very expensive and is driving the cost of hospitals, particularly in the metropolitan area, very high.

Mrs GERAGHTY: Minister, I refer to Budget Paper 4, Volume 2, page 7.66, which refers to health services. In your opening address you mentioned additional funding in the budget for nursing. Could you provide the committee with details of this initiative?

The Hon. L. STEVENS: I would be very pleased to put this on the record in a little bit more detail than the previous answer, because I want to make it quite clear to people that there have been increases to the budgets of our major metropolitan hospitals. I want to make sure that people understand and know this because there has been considerable misinformation around in relation to this very matter.

As we said in answer to the last question, the budget provides $30 million extra for intensive care services and $26.8 million for extra nursing over the next four years to address pressures resulting from increasing demand on the public hospital system and, of course, the shortage of trained nurses. The budgets that will be going to all our metropolitan hospitals, and I should add all our country regions, have been increased. The Royal Adelaide Hospital budget increases by $16.2 million from $375.5 million to $391.7 million, an increase of 4.3 per cent. The Repatriation General Hospital budget increases by $6.6 million from $84.1 million to $90.7 million, an increase of 7.8 per cent. The Queen Elizabeth Hospital budget increases by $8.1 million from $188.9 million to $197 million, an increase of 4.3 per cent. The Lyell McEwin budget increases by $6.6 million from $97.4 million to $104 million, an increase of 6.8 per cent. The Flinders Medical Centre budget increases by $9.8 million from $217.7 million to $227.5 million, an increase of 4.5 per cent. The Women's and Children's budget increases by $6.2 million from $156.4 million to $162.6 million, an increase of 3.9 per cent. The Modbury Hospital budget increases by $1.7 million from $58.7 million to $60.4 million, an increase of 2.9 per cent. The Noarlunga Health Service budget has increased by $1.6 million from $36.7 million to $38.3 million, an increase of 4.4 per cent.

As I mentioned previously, the final allocations to the hospitals will reflect the outcomes of negotiations for the Australian health care agreement and also the 2002-03 budget outcomes and the negotiation of the 2003-04 service agreements with health units. I will now talk about the additional funding in detail in relation to the budget for nursing. As mentioned in my opening remarks, nursing services will receive a $26.8 million funding boost over the next four years. An amount of $6.7 million will be spent in each of the next four years to fund the recruitment and employment of extra nurses. Within that allocation, we are devoting $4.7 million a year to employing up to 85 extra nurses as we recruit them and to continue improving nurse staffing ratios. This extra money is not only being used to get more nurses into the system but to keep them in the system.

As the member for Florey knows, nurses underpin our entire health system and we certainly cannot function without them. While our retention and recruitment strategy is starting to show results, in this budget we are also spending an extra $2 million a year to cover the additional costs of the short-term use of agency nurses. However, our commitment to nursing and the early success of our recruitment and retention strategy means that we are now able to start bringing some additional beds on line, and we are very pleased that we have been able to do that.

The Hon. DEAN BROWN: In September last year, the minister made a few public statements about the nurse rostering system to replace Excelcare. In fact, on 2 September last year, the minister said that money had been set aside, the tendering process was well under way and the system should be in place within months. In fact, last year during an interview the minister said 'by the end of the year', and in several other interviews she indicated within six months, which would have been 1 March this year. How much has the minister allocated for the replacement system this coming year, that is, the Excelcare nurse rostering replacement system? Where is it in the budget? How much has the minister spent approximately—and a broad figure will do—in the past year? When does the minister expect the system to be fully operational?

The Hon. L. STEVENS: This is a complex issue and we are in a situation where we are not able to say very much at the moment because of probity issues. I will ask the chief executive to provide what information he can to the committee. However, I must say that it was a very big shock to the government on its coming to office to find that there had been

an enterprise bargaining agreement that encompassed a nursing system replacement program.

The Hon. Dean Brown interjecting:

The Hon. L. STEVENS: On coming to government, we found out that we were about to be in breach of the enterprise bargaining agreement and that we could do nothing at all to stop the fact that we would be in breach of it because, essentially, the process was not under way and sufficient funds had not been put aside to pay for it. It was only because of the good graces of the Australian Nursing Federation that we did not find ourselves in very big trouble in terms of breaching an EBA. As I say, that was one of the very first shocks I had when I took up my ministerial portfolio. I will hand over to Jim Birch to make what comments he can.

Mr BIRCH: The specific amount allocated in the budget paper in the capital budget and forward estimates is $2.5 million. It is under the heading 'Clinical management and nursing administration'.

The Hon. DEAN BROWN: Sorry, which page of the budget documents?

Mr BIRCH: I will get that information in a second. I have a photocopied example which does not have the page number on it. The specific amount which I will read out has been reclassified this year from the capital program into the operating program, and therefore I assume that that is why you were not able to find it in the budget papers. I will give you the specific amounts that are allocated in the operating program: $2.5 million for 2003-04; and we have in the forward projections half a million dollars for 2004-05, half a million dollars for 2005-06 and half a million dollars for 2006-07. As the shadow minister would know, given that it is operating, that may change on a year by year basis, but that is our planned expenditure.

The minister is correct in saying that, at present, we are finalising the tender process. That has been finalised and we are considering the recommendation. I would anticipate that within the next few weeks we will have a public answer to that process. Obviously, we have to advise the vendors who have tendered for that process first, but we would anticipate doing that very soon.

The Hon. DEAN BROWN: One part of the question has not been answered. When will it be operating in the hospitals?

Mr BIRCH: The issue is subject to the actual evaluation process. I am not trying to avoid the question, but there are two or three different possible options. One is to maintain the existing system and migrate progressively to a new system. The other is to completely build a new system, which would take much longer. I am really conscious of not breaching probity regarding that, but again within two or three weeks I will be able to give you a specific answer.

The Hon. DEAN BROWN: Can you give a broad ballpark period? Will it be by the end of this year? At the end of last year we were told that it would be operating by March.

Mr BIRCH: It depends on the outcome. By telling you, I would be telling the vendors which one was successful.

The Hon. DEAN BROWN: I accept that. I would like to talk about the doctor/medical specialist situation at Mount Gambier. Yesterday, the *Border Watch*, the local paper in Mount Gambier, said that general surgical services would be maintained and that locum services would be brought in. I would like to know how the minister can guarantee that, because we are only about 10 days away from that situation. There are basically two locum services in Australia, one is called On Call Locums, and I know it got a rather desperate fax from the Mount Gambier Hospital on Friday of last week. As of Tuesday this week, I know it still did not have a job description. It had still not put down what any locum would be paid. However, it indicated that it would be $1 000 plus for a general surgeon per day, plus the state would pick up the cost of medical indemnity, of all meals, of all travel—that is, airfare in and out, from wherever in Australia—all accommodation, all telephone and other office expenses, and all car expenses.

If you look at that, you see the cost is approximately twice that which the existing resident medical specialists at Mount Gambier are being paid per day. However, clearly, the amount of work being done will be substantially less, because apparently the locum would deal largely with emergency work. Of course, if there were any consultations done as outpatients, that would be done in the hospital. I understand two very small rooms at the Mount Gambier hospital have been set aside—and they are very small, indeed. That then means the cost for that comes out of the hospital budget, whereas the cost previously where patients saw the medical specialists in their own clinics would come out of the federal government's MBS scheme.

Clearly, there is enormous concern in the South-East, particularly by the GPs. As the minister knows, 41 GPs have signed letters to the Premier, with a vote of no confidence in the performance of the health minister on this issue. They are concerned for the safety of their patients. Let me read what Dr Senior said:

> I am now very concerned and frightened for them—

that is, his patients—

> for I believe that your Health Minister and her Department have taken recent, carefully calculated actions that are at best sadly misguided and at worst could be considered quite evil. These actions will put the lives of my patients at risk, and will now cost the South Australian taxpayer much more than s/he needed to pay. We are about to get a poorer quality health service in the South-East, that will cost much more than it has before, will serve less people and will cause more extended public hospital waiting lists for people in Adelaide.

There is another letter signed by six doctors at the Ferrers Medical Clinic. I will quote part of that, as follows:

> It is with great concern that the doctors at the Ferrers Medical Clinic believe that the situation in the South East with respect to the local surgeons has reached a point where all three have now announced their intention to leave the area on 30 June. As a consequence of this, and other recent events that have affected the medical care of the residents of the South-East, we feel we have no alternative but to express a motion of complete no confidence in the current Health Minister. In fact no confidence in the complete Labour Ministry including yourself—

and this is a letter to the Premier—

> The manner in which this crisis has been managed is appalling and I would hope that you would feel the full displeasure of the local population at the next election.

How will the minister guarantee locum services at the Mount Gambier hospital in about 10 days' time, from 10 July, and will she confirm the cost is likely to be about twice that which the resident specialists are currently being paid for a substantial reduction in the amount of work actually done?

The Hon. L. STEVENS: I am very pleased to answer this question. At the outset, let me assure the committee that the government is absolutely committed to providing the services that are required in the South-East. I remind members that there have been ongoing issues concerning the delivery of services in the South-East, dating well back to when the member for Finniss was the minister. These issues started on

his watch. In the year 2000, GPs raised concerns regarding their inability to participate in the on-call roster for accident and emergency at the Mount Gambier hospital. As a result of the inability to negotiate a resolution, a decision was taken by the Mount Gambier District Health Service to introduce salaried medical officers. By the end of the 1999-2000 financial year—when the member for Finniss was minister—the South-East Regional Health Service had an accumulated deficit of $2.6 million.

In 2000-01, an additional resident general surgeon was recruited to the South-East. This was intended as a transitional arrangement, given the understanding that another surgeon was planning to retire. However, this did not happen in the time frame, nor was there any successful negotiation regarding the redistribution of surgical activity between the three residential surgeons. This necessitated additional activity funding of approximately $100 000, resulting in oncosts to the hospital of some $400 000. In 2001-02, this situation remained unchanged, and again additional funding was required, all under the watch of the previous minister.

In 2001, the Mount Gambier District Hospital Board and the South-East Regional Health Service Board sought the assistance of the Department of Human Services. Mr Tom Neilsen was seconded from the Mid North Regional Health Service for an initial period of three months, commencing on 8 October 2001, to undertake a review of the situation. A key recommendation from the Neilsen report was the establishment and implementation of a specialty services plan to ensure that the Mount Gambier District Health Service could operate within its allocation and manage its debt while maintaining service outcomes.

The Neilsen report also recommended that negotiations regarding contractual obligations with resident specialists be completed prior to 30 June 2002. Mr Neilsen's contract negotiations with the resident specialists began in August 2002, and from time to time these negotiations have strayed into the public arena—often, I understand, with the help of the member for Finniss. A major issue in negotiations has been the belief of surgeons that historical unfunded activity should be the benchmark used, not budgeted activity. In November 2002, the chair of the South-East Regional Health Service Board, Mr Bill DeGaris, with the agreement of the resident specialists, contracted the services of a mediator and facilitator, Mr Bob Gaussen, to assist with the contract negotiations.

Mediation meetings began in December 2002. Throughout the negotiation process, there has been continual debate in the public arena. Members should realise that these are negotiations for people's contractual obligations to work and provide services. There has been continual debate in the public arena. Due to confidentiality agreements, as part of the facilitation process, the region was unable to share confidential information. However, the Chief Executive of DHS did say at a public meeting held in February 2003 and chaired by my colleague, the Hon. Rory McEwen, that the department would continue to negotiate with resident specialists in an attempt to retain their services. Negotiations with all resident specialists have continued throughout this period.

The Mount Gambier District Hospital Services Board and the South-East Regional Health Service Board determined that negotiations should be concluded by 30 May 2003 to ensure that any contingency plans required could be orchestrated to take effect on 1 July should negotiations fail. After all this time and all these negotiations, they finally realised that a line had to be drawn so, in case it still did not work out, the hospital could provide services. An advertisement for general surgeons was placed in the *Weekend Australian* of 14 June 2003—last weekend.

Without being at liberty to provide specific details, the contract offers, I can assure members, are very generous and offer higher incomes than received by the Premier, and, indeed, the Prime Minister of Australia. However, if people choose to move away from the region, that is their choice—and we respect that choice. If necessary, Professor Guy Madden from the Queen Elizabeth Hospital has given an undertaking to provide locum services from 1 July 2003. These services will cover acute work and outpatients for elective work. The Mount Gambier District Hospital and Health Service is arranging to have outpatient clinical facilities for one surgeon available, Monday to Friday, for three months from 1 July.

These interim arrangements are put in place so that—if it comes to this—we can recruit new people to be there permanently. I am advised that, from 1 July 2003, it is expected that there will be three resident anaesthetists, one specialist and two general practitioners. Professor Guy Ludbrook from the Royal Adelaide Hospital continues to work with Dr Kevin Johnston, Director of Anaesthetic Services at Mount Gambier, and arrangements have been made to provide cover of a fourth anaesthetist from the metropolitan area for the next six months while recruitment occurs.

Before I hand over to Ms Ramsey, Executive Director, Country Services, I must say that these contractual negotiations have been protracted and very frustrating for all concerned. Members of the board of the South-East Regional Health Service, the Mount Gambier board, the chairs, the regional general manager and the hospital CEOs have bent over backwards—as has the Department of Human Services—to get a satisfactory outcome that will mean that we have a sustainable health service in Mount Gambier and the South-East region. Country members are not present in the committee at this time—

The Hon. Dean Brown interjecting:

The Hon. L. STEVENS: Well, the member for Finniss is, so perhaps he might think about this, too. Every time the Mount Gambier District Health Service overruns its budget to the tune of what it has been, where does the money come from? It comes from the budgets of the other country health services. What I say as minister is that everyone has to do the right thing by their budget and the way in which they manage their budget and their services. It is not fair and it is not right for that to continue. I will hand over to Ms Ramsey to give greater detail on the other issues the shadow minister raised.

Ms RAMSEY: This information is current as at 18 June. I want to stress that, because of the way in which the contract negotiations have been occurring, they change and they are very fluid, so I can only say they were accurate yesterday. In terms of orthopaedic surgeons, discussions are occurring with both surgeons, with draft contracts being offered or discussed. In relation to anaesthetists, one anaesthetist has signed an agreement for 18 months; one has indicated he wishes to sign, but the construct of the contract is awaiting Crown Law advice; one other has rejected the contract offer—however, that process has not been finalised; and one doctor's contract has ceased. In relation to ophthalmology, discussions on the offer draft contract continue. In relation to specialist obstetrician-gynaecologists, negotiations continue. The outstanding matter to be decided is whether it is a

regional contract or two separate contracts, one for Millicent and one for Mount Gambier.

In terms of GP obstetricians, a draft contract has been offered with the outstanding issue being medical indemnity. The department is awaiting final advice from the commonwealth regarding commonwealth reforms on this matter. In the interim, the Chief Executive of the department has written to country doctors to inform them of the work occurring between the department and the Medical Defence Association of South Australia and to inform them of the current grants being offered by DHS and the insurance options for 2003-04. It is hoped that this letter will clarify the concerns for this group. A further letter is expected to go out on this topic tomorrow.

In relation to general surgeons, while formal advice has not been received, it would certainly appear that one surgeon will not be re-signing his contract; one will be retiring in the imminent future; and negotiations appear to be reopening with another. The FIFA service budget for general surgeons, the actual gross paid in 2001-02, was $846 000. The actual gross being offered in the new contracts this year is $935 901, which is 10.6 per cent on the 2001-02 figure. I think the minister has talked about the interim arrangements.

The Hon. L. STEVENS: The government has a strong commitment to provide services in the South-East region, just as it has a strong commitment to provide services across all country South Australia and across the metropolitan area, as well. We have tried always to be reasonable in our approach. I am hopeful that these negotiations will reach an end shortly, because we will reach 1 July. What we can say to the people of Mount Gambier is that services will continue and we will put in place interim arrangements until we can replace the permanent positions.

The Hon. DEAN BROWN: Before I ask my next question, I must comment on some of that. It is just unbelievable that this debacle has been going on for eight months. I was down with the doctors—

Members interjecting:

The Hon. DEAN BROWN: Just be quiet if you would, please.

Members interjecting:

The Hon. DEAN BROWN: Madam Chair, I ask for your protection.

The CHAIRMAN: You seek protection—I am happy to afford it. Members on my right will maintain silence.

The Hon. DEAN BROWN: For the last eight months this debacle has been going on. I was down in Mount Gambier in December and spoke to many of the specialist medical practitioners. They wanted to stay in Mount Gambier. They were willing to stay. The anaesthetists have been out of contract effectively since 1 January this year, now almost six months. I understand that one of them has signed an interim agreement for 18 months, but that specialist anaesthetist—and he is the only specialist anaesthetist there—is fuming at the poor way the negotiations have been handled.

I have talked to the doctors. They would sit down and reach agreement with the mediator who had been brought in from Sydney—and I would like the minister to give details of the cost of that mediator, as I understand the mediator has flown in from Sydney on five or six occasions to have discussions—would reach an agreement in principle, go off into the operating theatre and come back five or six hours later to find that what they had agreed to had been completely changed in their absence, even though they had expected to come out and be able to sit down and sign contracts. When you have general surgeons who have been in the town for 23 years, like Dr Mark Landy, who is a highly respected person in the Mount Gambier community, who packs up and leaves in absolute disgust; when you have 41 doctors from the South-East expressing no confidence in the minister; when you have contracts still unsigned eight months and more after negotiations have been commenced, there is something fundamentally wrong with the way the negotiations have been run by the minister.

I made the suggestion to the minister back in December that she get on a plane, fly down to Mount Gambier and sit down and talk to the specialists. She declined to do that. A perfectly reasonable step, I would have thought. The Premier in fact spoke to one of the specialists when he was down there a couple of weeks ago but, clearly, the minister is just not willing to get in and resolve what could be resolved with some appropriate steps by the minister. As a result of that, the people in Mount Gambier are now ending up with the demolition of their specialist medical services. Three specialists have left. We had the reply that one of them may retire shortly. That specialist has rung me from Broome, absolutely hostile at the way he has been handled, and said that he does not intend to go back working and is fuming at the manner in which the negotiations have been handled.

One of the other two specialists, on the day that he was considering his options, was told 'Sorry, all further negotiations have come to an end.' Therefore, he had no option that day but to elect to go to Albury Wodonga. I understand that the third one is expecting to finish and has given notice of finishing as at 30 June, in about 10 days' time. For the minister to come back and give the answer that she has just given belies the facts of what has occurred. You do not have an entire community down there in absolute uproar unless there is something fundamentally wrong with the way the negotiations have been run and with what has been achieved.

If the minister wanted to get rid of medical specialists out of Mount Gambier and bring in a hospital based system, why did she not say so eight months ago? Because that is exactly what all the actions of both the minister and the department have been about: trying to get rid of the specialists. There is a series of articles today, I see, with about four pages in the *Stock Journal* on it. We have the headline 'Government walks away from rural SA', from John Lush, the President of the South Australian Farmers Federation. You have the entire community down there fuming at the way they have been dealt with by the government and at the breakdown in their medical services. My question to the minister is: why did the minister not get on a plane, fly down to Mount Gambier six months ago and resolve this issue, rather than see what is clearly going to be a less than satisfactory service at approximately twice the cost of what it is currently costing to provide those services in Mount Gambier?

The Hon. L. STEVENS: I would like to pose a question of the shadow minister. Why did he not fix it when he was minister?

The Hon. DEAN BROWN: I am happy to answer that, Madam Chair. I have been asked a question: I am happy to answer that.

The CHAIRMAN: The minister can ask a rhetorical question but the deputy leader is not in the position to answer the question. Would the minister like to continue with her remarks?

The Hon. L. STEVENS: He can comment later. I know that the deputy leader has been involved in this all along. It

is really disappointing when he is someone who knows only too well about the issues in Mount Gambier; who knows them back to front because he in fact was the minister and knew of a range of issues that have been ongoing in Mount Gambier in relation to the provision of services, in relation to medical specialists and in relation to the coverage of those services. I was down in Mount Gambier myself as part of a select committee when the member for Finniss was minister, and the same issues were occurring then. We had a number of conversations, which of course I will not talk about, in relation to those matters, and the member for Finniss was well aware of the issues.

The issues were presented to me when I became minister and, when I went down to Mount Gambier the very first time as minister, I was confronted by the regional board, the members of which actually pleaded with me to do it differently from the previous minister: to back up the process; to stand firm with the board in negotiating reasonable and fair contracts, and fair negotiations and fair processes across the region; not to cave in and undermine the board and its process, which appears to have happened on not a few occasions on the watch of the previous minister. I agreed with the board at that time to do it differently, to take it through the fair and reasonable process that we have been doing all over the rest of the state.

Unfortunately, the member for Finniss was not prepared to behave in a responsible and constructive way in relation to these negotiations. I remember the December fly in, fly out of the member for Finniss. I think he was fresh from being done over on the ABC about legionnaire's disease. I remember that very clearly because he jumped on the plane, went down, stirred things up, got back on the plane and came back again. I would have thought that, as a former minister who knew only too well what was going on, he might have been constructive and helped, as other people have tried to do, to resolve this issue. So, again I say to the member for Finniss that the department will continue to work. As minister, I do not get involved with face to face negotiations with people about their contracts.

This is the role of boards, the employers of the persons concerned. These sorts of negotiations occur right across the system. Of course I am concerned about what has happened. I have been kept informed and have said all the time, 'Do everything you can to be reasonable.' And many people have spent hour upon hour doing this. It has not been helped by being in the media with one side of a confidential arrangement displayed across the pages of a paper, aided and abetted by politicians from the city, including the member for Finniss, just stirring things up.

I say again that, obviously, we are committed to continuing the services at Mount Gambier. If people choose to go from their contracts, to leave the district, so be it; new people will be put in their place. In the meantime, interim arrangements are being set up now with the help of people from Adelaide, and we will make sure that they are in place to cover those gaps while we get new people in.

The Hon. DEAN BROWN: The minister asked me a question. Can I answer it?

The CHAIRMAN: No. Ministers answer questions here.

Mr HANNA: I have a question about the Royal Adelaide Hospital. The budget line is Budget Paper 4, Volume 2 (page 7.72). I have heard recently that there are five radiotherapy machines at the Royal Adelaide Hospital but that crews are provided for only four of them so that the full demand is not met as quickly as it should be. Why is this so, and will additional funding this year resolve this issue?

The Hon. L. STEVENS: I will ask my CEO to answer the detail of that question for the member for Mitchell.

Mr BIRCH: If this does not specifically answer your question, please indicate. The RAH replacement linear accelerator program is part of the medical equipment purchases program. In the coming years, $8 million is provided for the RAH linear accelerator replacement program with expenditure planned in 2003-04 of $3.6 million and, in 2004-05, $4.4 million. Approval of an increased three-year program of biomedical equipment capital expenditure will enable this to happen. I think you asked whether there were four or three machines.

Mr HANNA: The question is about adequate crews for the five machines.

Mr BIRCH: I will have to take that on notice. I believe it relates to the inability to recruit and retain radiological staff. There is a national program currently under way in relation to staffing. I will take your question on notice, and we may be able to give you an answer before the end of the estimates period. I understand what you are talking about, but I do not have a briefing on it at the moment. So, I will take that question on notice.

Mr HANNA: My next question relates to Aboriginal health. I refer to Budget Paper 4, Volume 2 (page 7.17) which specifically refers in program K1 to the Anangu Pitjantjatjara lands. I am surprised that there is no specific reference to the critical problem of drug abuse and, in particular, petrol sniffing. Are there any specific new programs to address this issue and, at the same time, can the minister advise why petrol sniffing is still dealt with as more of a policing and crime issue on the AP lands than a health issue?

The Hon. L. STEVENS: I am happy to answer this question. I say at the outset that the whole issue of petrol sniffing in particular and the general health and well-being of people in the APY lands has been the subject of a multilateral bid from the government. So, it is not only a policing and crime issue; it is, in fact, a health, justice and social justice issue. I will provide some information and Jim Birch will provide some more details.

Responding to the needs of petrol sniffers in the APY lands is a priority for the government. It was a major recommendation, as I am sure the member for Mitchell would know, of the Coroner's report into three petrol sniffing deaths in the lands, and it was one of the priorities for action outlined in the statement of intent agreed to by the state government and the AP Executive.

In 2002-03 a number of things were achieved. First, the Aboriginal Services Division is now in the process of appointing Anangu youth workers in six designated APY lands communities. FAYS is developing an outreach early intervention secondary intervention program for petrol sniffers with the Pukatja community. South Australia also proposes to contribute (with the Northern Territory, Western Australia and the commonwealth) to a feasibility study to establish a detoxification and rehabilitation assessment facility to service the central Australian and tri-state area.

The Department of Human Services has also negotiated with the commonwealth for $150 000 to be provided to the Nganampa Health Council to operate assessment and treatment services for police drug diversion programs on the AP lands. In 2003-04, a four-year commitment of $1.16 million is allocated in the budget for respite and rehabilitation services for petrol sniffers on the APY lands, with $650 000

of this allocated in this year's budget to develop local responses to address the immediate needs of young people and adults who have been affected by substance misuse and to support their carers.

Rehabilitation and respite initiatives will not be limited to buildings. The department is exploring local level responses with individual communities and the APY Council to ensure that local communities develop their own programs to support petrol sniffers and their families in sustainable ways rather than just provide facilities. So, we understand that this issue involves much more. DHS discussions concerning how the money will be utilised are preliminary as any plans are tentative being subject to full consultation with the APY Lands Council and their communities.

Another initiative to happen over this year is the appointment of six Anangu youth workers. The annual funding for this totals $396 000 and includes a coordinator's position. Funding levels are also being negotiated for the following programs: establishing an outreach program at Pukatja, and establishing a supported/respite accommodation facility for Anangu with acquired brain injury at Amata, which will accommodate approximately four to five clients and provide 24-hour care and respite services.

The next community meeting of the cabinet will be in the Pit lands in about three or four weeks' time. I am keen to go up there and look at precisely what we will be doing with the health money. I concur with the member for Mitchell that petrol sniffing is most definitely a health issue and needs to be tackled as such, but the other parts of the multilateral bids with justice have also been necessary to support the security of the community.

Mr BIRCH: I will attempt to be brief. Last week I was in the Anangu Pitjantjatjara lands with the chief executives of education, justice and what is known as DAARE, previously DOSAA. This very question was the one that we were not totally but primarily focusing on. We met at some length with the Anangu Pitjantjatjara Land Council and other people, particularly from Pukatja, which is otherwise known as Ernabella, and Fregon. The key issues that we essentially have agreed with the Anangu Pitjantjatjara Land Council are that, first, we need to pursue much more actively the employment of Aboriginal people on the lands, in other words, increase self determination and the ability to divert people from white employment into Aboriginal employment. It may not be commonly known, but the vast majority of people employed on the lands are in fact white people, and there is some concern that the moneys that are being used are not necessarily being used for the direct benefit of Aboriginal people. So, notwithstanding the additional moneys that are available, we have committed within our existing programs to enhancing that capacity and increasing employment.

Another key issue is the diversionary or rehabilitation facility; I think it is certainly agreed between justice and ourselves that policing is not the answer to the problem of petrol sniffing. I am advised that about 116 petrol sniffers have been identified on the lands. We are now looking at a feasibility study as to where we should site a rehabilitation facility. There are two schools of thought among the Aboriginal people on the lands. One is that it should actually be centrally on the lands themselves and the other is that it should be off the lands or at least adjacent to them in order to be able to give people sufficient respite away from petrol sniffing. That is a particularly controversial problem, because of the different schools of thought among the people themselves.

Another issue I also want to raise is that we have also met with the commonwealth which, as members may know, has identified the Anangu Pitjantjatjara lands as a COAG projet, and it wishes to put in substantial funds to health and well-being primary care programs. The Anangu Pitjantjatjara Land Council believes that significant input of additional resources is needed in two other areas to help young people, that is, higher education and secondary education. Those issues are being taken up by Greg Black from DFEEST and also Stephen Marshall from education. We hope that we would have six youth workers to roll out on the lands from DHS funds in the next three to four months. I believe that a group from the Aboriginal Services division of the department is working with the land council and others to get that happening now. So, the approach is development of youth, education and diversion into employment on the lands—this is particularly applicable to certificate level 3 nursing and care worker type employment—and also a diversionary and rehabilitation facility either within the lands or adjacent to them.

The Anangu Pitjantjatjara Land Council was very explicit that it did not believe that petrol sniffing would be solved by the traditional approach of simply providing western health care services on the lands and that in fact enhancing the capacity of young people to understand their culture and gain renewed respect for their elders and their community were the bases upon which it would ultimately resolve the petrol sniffing problem. Finally, it is interesting to note that the lands are not a generic community; there are significant differences between the problems that exist from community to community, and the distinction is very clear.

Communities that have maintained their community fabric, their culture and their capacity to avoid the dysfunction of a breakdown of the elders structure seem to be viable communities; others, like Fregon, unfortunately, appear to be quite the opposite. I hope that gives you some indication of the approach we are taking from the Department of Human Services. I can say that the other CEOs concur in that and would be happy to provide you with ongoing information about how that rolls out.

Mr HANNA: I have a supplementary question about the budget papers and the way they are presented. Given the minister's and chief executive's answer indicating the priority given to this problem, when the budget papers under Program K1 refer to initiatives on the AP lands and primary health programs based in AP communities, why would such an important issue not be specifically mentioned?

Mr BIRCH: I think you have raised a very good point about the presentation of the budget papers, because invariably the budget papers tend to focus on the moneys that will be specifically allocated as new initiatives and projections. Historically we do not go into large explanations about funds that are built into the existing DHS budget—in other words, 95 per cent of the money. So, I guess that is a matter that the Treasurer and Treasury will have to take up, but I am happy to take up that issue as to whether our explanations should be fuller in the future.

[Sitting suspended from 1.07 to 2 p.m.]

Mrs GERAGHTY: I refer to page 7.48, which refers to the renegotiation of the Australian health care agreement. Minister, would you advise the committee of the current state of these negotiations and the problems which would arise if the current offer were to be accepted?

The Hon. L. STEVENS: Madam Chair, before I answer that question, we have an answer to one of the questions raised by the member for Mitchell in relation to the linear accelerators at the Royal Adelaide Hospital. Would it be appropriate for that to be put on the record now, before I answer the question from the member for Torrens?

The CHAIRMAN: That would be fine; please proceed.

The Hon. L. STEVENS: I will, therefore, ask Dr Tom Stubbs to give the answer to the committee.

Dr STUBBS: The member for Mitchell asked a question about crews for radiotherapy and whether they were not able to fully staff the available equipment. The answer is that there is a nationwide shortage of radiotherapists, but the Royal Adelaide is managing the process by having different shift arrangements. So all the work is getting done. It is clearly a work force issue and not a funding issue. The waiting list in South Australia is about three to four weeks, which we understand is far less than anything nationally. The problem is expected to last about one year, and is associated with a change in the undergraduate program from a three- to a four-year program. We are expecting that problem will be solved. I think it is important to note that it is a nationwide work force issue; the work is getting done; the staff are doing the shifts; and it is not a question of inadequate funding to the hospital.

The Hon. L. STEVENS: In response to the member for Torrens in relation to the Australian health care agreement, as members would know from other statements that I have made in the house and in the media, the current Australian health care agreements expire on 30 June 2003. On 23 April 2003, the Prime Minister wrote to state premiers and territory chief ministers outlining the commonwealth's offer for the next agreements. The offer is unacceptable to states and territories. Over the five years of the next agreements, the offer is $14 billion less than the amount sought by states and territories in their February 2003 submission to the commonwealth. It represents a $1 billion reduction in funding compared with a roll-over of existing funding arrangements. It is quite clear that money that was previously earmarked for public hospitals is now being redirected to fund the commonwealth's Medicare reforms.

The offer fails to reinstate shortfalls in commonwealth funding over the life of the current agreements and also includes no capital funding. It also excludes funding for GP-type services provided in public hospital emergency departments. Although these services are clearly a commonwealth responsibility, a state and territory claim for compensation has been ignored by the commonwealth. States and territories have also sought compensation for the cost to public hospitals of caring for elderly Australians waiting in hospital beds for residential aged care places to become available.

This claim has also been ignored. An extensive process, involving eminent clinicians and other industry experts and agreed to by all health ministers, including the federal health minister, to develop a health reform agenda commenced in April 2002. Despite the considerable time and effort that has gone into this process, the commonwealth's offer provides no commitment or additional funding for health reform. Having been part of that very long and detailed process, I find that incredibly disappointing.

Despite this, work is continuing on the development of a health reform agenda. However, lack of reform funding in the commonwealth's offer, and its insistence that the reform agenda must be implemented without additional commonwealth resources, demonstrates a very disappointing lack of commitment to the process. At a time when the need for health reform has never been more pressing, the commonwealth's refusal to consider any proposals that may involve additional funding puts the whole reform agenda process in jeopardy and works against the impetus being generated here in South Australia by our own Generational Health Review.

On Friday 13 June, health ministers met in Sydney to progress the health care agreement negotiations once again. Unfortunately, for the second time in recent months, the commonwealth minister, Senator Paterson, chose not to attend. In light of the federal minister's consistent failure to enter into multi-lateral discussion on the future of health care in Australia, ministers agreed at that meeting that negotiations for the next Australian health care agreement should be elevated to the Council of Australian Governments.

The state and territory ministers reaffirmed their commitment to Medicare and the principles of universal health care including the following: free quality public hospital care based on need; subsidised GP visits and bulk billing; and subsidised pharmaceuticals. Ministers agreed not to accept the commonwealth's existing 2003-08 Australian health care agreements offer for the following reasons: the absence of any means to progress the fundamental reforms required of the health system in order for it to meet changing demand; the proposed funding fails to keep pace with growth and demand for health services; the general practitioner rebate is insufficient and the funding for it should not be drawn from the public hospital system; and, finally, the reporting requirements are inadequate. I would now like to ask Dr David Filby to outline in more detail the difference between the states' and the territories' claim and the commonwealth's offer.

Dr FILBY: At a national level, the major differences between the amount identified by state and territory health ministers as being required over the next five years and the amounts offered by the commonwealth include, in terms of the overall amount state and territory ministers identified, about $56 billion whereas the commonwealth offer over four years is $42 billion. That represents from state and territory eyes a nominal annual increase of about 8 per cent, whereas the offer is 5.6 per cent. In terms of indexation provisions within the grant arrangements, the commonwealth has offered us 2.25 per cent applied not to the complete grant, whereas state and territory ministers sought 3.25 per cent.

In respect of population growth and ageing, ministers had sought to have increased funding associated with growth and ageing of the population applied to the whole grant whereas the commonwealth has offered it with the money it provides for pathways home, and equality money has been excluded. The funds that ministers sought in relation to technology improvement, and the additional costs associated with that, was 2.6 per cent whereas the commonwealth offer is 1.7 per cent applied only to 75 per cent of the grant.

As the minister identified, there are significant differences in the funding provided for further reform within the health care system. State and territory ministers had sought, in addition to the base grant as they intended, $566 million for support for GP-type services provided in public hospital emergency departments. There is no provision for anything in the commonwealth offer. In relation to $1.7 billion for residential aged care services provided in public hospitals—these are for people who are assessed as eligible to go into nursing homes but for whom nursing home places cannot be found—there is no provision within the commonwealth offer. A small provision of $253 million for pathways home or

rehabilitation services in fact replaces the commonwealth's earlier provision for reform in IMIT.

The state and territory ministers had sought a little over $2 billion in recognition of the subsidy that state governments pay for privately insured people who use the public hospital system. There was no provision for that within the commonwealth arrangements. As a result, in the first year of the new agreement (which starts on 1 July), the amount identified as required in South Australia, using the state and territory ministers' methodology, is about $800 million compared with the commonwealth offer of $638 million. Over the five years of the agreement, we estimate that this difference would be something in the order of $1.1 billion.

The Hon. DEAN BROWN: My question concerns the newly developed portion of the Lyell McEwin Hospital. Can the minister explain whether the eight new cardiac bed unit at the Lyell McEwin Hospital will remain idle for at least a year? Can the minister confirm that the offices built for the cardiologists in that new portion will be occupied instead by clerical staff because a cardiologist will not be available to occupy these offices? Just before the budget, the minister allocated $1.4 million this year for five new ICU beds. They already had five ICU beds, so that took it up to 10 intensive care unit beds. However, there are 15 new intensive care beds in the new facility, which means that five of them will remain vacant. In fact, the media took that up with the CEO of the hospital. He acknowledged that by Christmas time they would only be using 10 and that that was all they were funded for this year.

However, no mention was made of the eight cardiac beds in the new cardiac unit, and certainly no funding has been provided for the new cardiac beds. There were also 20 purpose-built step-down beds specifically to take people out of both the intensive care unit and the cardiac unit. However, these 20 purpose-built step-down beds will now be used as a general hospital ward, and I think that advertisements appeared in the *Advertiser* about a week before the minister's announcement specifically trying to engage nurses so that that ward could be opened. My concern is that there is this eight-bed cardiac unit, which, from all the announcements made in the budget, would appear to be totally unfunded. I know staff at the hospital are very concerned that this eight-bed unit will remain closed. Will the minister also confirm that the offices that were built for the cardiologists next to the eight-bed cardiac unit are about to be occupied in the next month or so by clerical staff of the hospital?

The Hon. L. STEVENS: I will make a few remarks and then I will ask Dr Tom Stubbs to fill in the detail of the answer. First, I would like to say how pleased I am with the progress of the Lyell McEwin Health Centre redevelopment. The government has fully funded that project now in its entirety, which was not the case when we came to office, just as the Queen Elizabeth Hospital was only partially funded by the previous government. However, both hospitals are now fully funded. As the Lyell McEwin Health Service is in my own electorate, I am very well aware of the issues and the need for that facility. I am also well aware of the announcements and reannouncements made over many years—probably three, four or five—about the Lyell McEwin Health Service and nothing happening. However, we now have an outstanding facility and stage A is nearing completion.

In relation to the intensive care unit, currently there are no intensive care unit beds: there are five high-dependency unit beds, not intensive care unit beds. As I mentioned earlier when speaking about the new intensive care unit beds that we are funding across the system, I have been spoken to on a number of occasions, including when I was shadow minister, about the danger of transporting very seriously ill people who require intensive care treatment by ambulance to either the Queen Elizabeth or the Royal Adelaide. I am very pleased as minister to be able to add five intensive care unit beds to the five HDU beds at the Lyell McEwin Health Service to make a more comprehensive service available.

It is quite correct that, in the end, the facility will take 15 beds. However, I make the point that the redevelopment at the Lyell McEwin Hospital is for the short to medium term and we envisage that those services will come on stream as required in future years. I might add, because the shadow minister mentioned that this issue had been taken up in the media, that when the chief executive of the Lyell McEwin Health Service was asked about that very point—that is, whether the facility we were providing was falling short of what was required—he said that the 10 that are now in place were all that they needed at this point in time. I would also like to put on the record that it was pretty concerning at the time the announcement was made that the shadow minister immediately appeared in the media complaining that we were delaying the whole project when, in fact, we were not doing that at all. Of course, that misinformation was corrected by the chief executive of the hospital.

Things are on track. As soon as the announcement was made in the budget, the hospital began recruiting staff. However, as I mentioned earlier, the unit is not ready to be opened right now. In fact, when the Premier and I had our press conference at the site, we were wearing hard hats and things were hanging out of the ceiling: it was certainly nowhere near the point of being ready. I invite Dr Tom Stubbs to answer the rest of the question.

Dr STUBBS: The one area raised by the member for Finniss on which I cannot comment without checking is the use of clinical areas by office staff, so I will have to check that one. There are a couple of contextual issues to the Lyell McEwin which need to be fully understood. One is the specific area of intensive care and high dependency units, which was referred to earlier today. We are commissioning an eminent physician from interstate to do a review of intensive care activity admission and discharge criteria and where the optimal location in the metropolitan area for intensive care facilities and beds would be. The ramping up of the intensive care unit at the Lyell McEwin is as planned and as the minister said, but the future may well involve the movement of activity between the metropolitan hospitals because, at the moment, our focus is on trying to get the hospitals to work more as a system, and hopefully some of the reforms announced in the Generational Health Review today will facilitate that.

We have had a lot of trouble getting clinicians and activity moved from, say, the Royal Adelaide Hospital to the Lyell McEwin, and that is critical if we are going to provide a safe and efficient service across the system. In relation to the cardiac unit, when I spoke to the chief executive of the Lyell McEwin Health Service just a week ago, he was quite confident that that would be opened on time. In relation to the issue of the step-down facility and how it will be used, at the moment members would not be surprised to know that we are investigating a range of strategies to deal with the winter demand which is expected to be even more severe this year than last year. In fact, three days ago we had the first outbreak of influenza as detected by the emergency department in the hospital.

Each hospital is having to undertake (as agreed on a system wide basis) a range of activities which may not be the way in which they would normally choose to operate. One of the things that the Lyell McEwin has agreed to do, and endorsed by other chief executives around the system, is to try to use some of that area to relieve winter pressure. What we are finding we are having to do throughout the system is to balance the elective and emergency load during winter. Last year we had a strategy of cancelling 25 per cent of elective surgery across the system, but one of the focus areas for us is to still try to maintain elective surgery rates and not have escalating waiting lists.

We will be balancing those hospitals that have to deal with emergencies at a great rate—for example, Flinders, which is almost exclusively an emergency hospital these days—and those with capacity do elective surgery. Whereas in the past there might have been a more inflexible approach to what particular wards and beds were for in particular hospitals, we are trying to get greater flexibility.

The other issues in the background with some of the delays in the Lyell McEwin are the delays in commissioning the new redevelopment, and that is due to things in the building industry, and the work force shortages which continue to make it difficult to manage hospitals, particularly in the areas of anaesthetists and nurses. Even when nurses are available, to get them from nursing agencies there is a premium of 30 per cent or so. I did speak to Paul Gardner again just yesterday in terms of the anaesthetists situation, and he believes that is surprisingly good now at Lyell McEwin, and that has happened quite quickly. So, the basic answer is that most of these things will come online as scheduled, but with that flexibility that I talked about in terms of the step down unit being used to relieve pressure across the emergency demand in the hospital system as a whole.

The Hon. L. STEVENS: I will make a few additional remarks in relation to the hospitals collaborating together as a system. This is certainly what we are working towards. Of course, with the establishment of the two regions—the Southern and the Central North—we will be expecting a much greater collaboration between the hospitals within those regions to move and to meet the demand, and to carry through that principle of trying to put the services where the people are, and to balance emergency versus elective, particularly in winter when the emergency demand is quite severe.

The Hon. DEAN BROWN: In relation to medical indemnity for country GPs, just under a year ago the minister set up a working party, and that working party had two clear objectives: one was to come up with a new offer for this coming year and do so as early as possible—and certainly well before the end of the current year—and the second was to fix the ongoing period for liability, especially for obstetrics work, which can be as high as 15 to 20 years.

Clearly, on the first count you failed, because the country GPs are waiting for an offer, and I understand an offer may go out today or tomorrow. They have 10 days left in the financial year. There is enormous uncertainty, so they are very anxious. I have seen some of the stuff on the media, particularly in country media—and that was about a month ago—saying that they were waiting for an offer, and now that offer is about to go out to them.

The second part, though, is that I understand the offer that is going out to them maintains the tail for obstetric work. Therefore, although the adverse incident may occur this year, the claim may not be made for 15, 20 or 25 years, and the doctors must maintain medical indemnity, because under the new federal requirements now there is a requirement that you must have both coverage at the time of the incident and coverage at the time of the claim. I understand that this tail, after perhaps five or 10 years, could be as great as $40 000. So, when the doctor retires, in present day costs, they would have to put aside $40 000 to pay for the ongoing medical and indemnity insurance for that period, even though they will have retired and not be working, just to cover that tail.

I know that last year a number of GPs dropped out of obstetrics work because of the difficulties last year, and we talked about that in estimates committees. Towns such as Maitland no longer have births at their local hospital. I understand—and I have had a number of phone calls on this matter—that the problem this year will be considerably worse. At least three GPs in the South-East are expected to drop out of doing obstetrics work. GPs at Murray Bridge are likely to drop out; GPs at Booleroo Centre have already indicated that they will no longer do it. They are just three examples. I am told that there will be examples right around the state. Minister, you have had 12 months, and they still have not even finalised their offer for this year. They have not seen their offer for this coming year, despite how close they are to the end of the financial year, and they are anxious over that. When are you going to get your act together and fix the problems, particularly of ongoing medical liability for that longer period of treatment after they have retired?

The other issue is that, this year, when the doctors pay their medical indemnity, they are required to pay an 11 per cent stamp duty for the first time on their medical indemnity. I will not go into all the details because it is a complex thing, but in the past it has been a mutual society, where most of them have insured at the South Australian Medical Defence Association, and there have not, therefore, been formal contracts. Now there is a formal contract, and they have to pay stamp duty on that contract. The federal government has specifically asked the state and territory governments to forgo stamp duty on that. The Treasurer has that power.

Did the minister attempt to get the Treasurer not to impose that 11 per cent stamp duty on medical indemnity insurance? Did she just clearly fail? I was interested to hear the Treasurer's response when it was put to him on radio this week about the lack of pull of the minister in arguing a case in cabinet and that the Treasurer overrides her. He said, 'So, what's the point?' What efforts did the minister make to stop that 11 per cent being imposed, because it is the people who go to see doctors who will have to pay for that, and it is quite a significant amount, particularly for obstetricians?

The Hon. L. STEVENS: I will just make a few remarks. We can rise above that behaviour; we are used to it. The issue of medical indemnity is very serious, and we know that it is something that we need to work through, and we have been working through it. It has been quite a complex process. I must say that last year we spent considerable time working with a range of doctors' groups. As a result of the process we went through last year which resulted in the scheme we put in place for a year, we had some very positive feedback from doctors, who said that they were never consulted by the previous minister to the degree that we were doing. I was pleased to see that, because that is certainly the way I like to operate and the way the department is now operating with doctor groups, in a very proactive way to solve complex problems.

I will just give a very brief overview here. In a nutshell, a lot of work was done by departmental officers with the Rural Doctor Work Force Agency, in particular, to work on

a new scheme that could give some certainty for medical indemnity into the future for our rural doctors. It is a very important issue. We know that we need those doctors in the country. We also know that this is a major issue for them. So a lot of intensive work was put in by the department and the Rural Doctor Work Force Agency in developing quite an exceptional scheme.

We received approval from the Treasurer in relation to the scheme in order to continue that work and to negotiate with doctor groups. At that time the federal government announced its new arrangements in medical indemnity, and, essentially, threw a lot of new things into the equation, some of which were not clear and some of which created uncertainty. It became clear that the scheme, on which we worked very hard, was not going to be up and ready with every t crossed and i dotted, and that issues resolved with all doctors across the state would not be ready in time for 1 July. We have had to revert to last year's arrangements. I have been advised that doctors will be notified about that within the next day or so. It was unfortunate that we could not follow through completely with the new scheme, but continuing work will be done with the agency, the department, the Rural Doctors Association and the AMA. They are working with us to work through the issues in relation to the longer term scheme. Hopefully, in the coming months until December, the commonwealth arrangements will become clear, as well, so we can get it organised.

Ms RAMSEY: The minister has covered most of the information. It has been a quite long, drawn-out process and very difficult, in terms of being able to get the detail we needed from the commonwealth to look at how what we were offering and what the commonwealth was offering could be worked together. We still do not believe that we have full details from the commonwealth. I think it needs to work through its scheme as time goes on. We are not yet clear, although it becomes clearer each week, about what the commonwealth is offering.

The tail cover has been a difficult issue for the doctors. This year we will continue to offer what we offered last year, and those letters are due to go out. The department puts considerable subsidy into assisting doctors through the rural health enhancement package. As members would know from previous years, quite a lot of money goes into that. Obstetrics in country locations is a major issue. It is not just to do with insurance that obstetrics is slowly being consolidated now in regional centres. There are all the safety and quality issues that sit around the delivery of babies in small locations. We are finding that, increasingly, doctors and communities are needing to make difficult decisions to ensure that quality and safety issues are addressed through the provision of obstetrics.

The Hon. L. STEVENS: On the other matter of the stamp duty, the Treasurer has taken a decision in relation to that matter. He will not be paying for the stamp duty. I will not reveal the contents of private conversations I have had with the Treasurer on this, or any other matter.

Mrs REDMOND: I want to follow up on the issue of the professional indemnity insurance. I notice that sub-program K9.2, page 7.37, in the performance commentary, states:

> Legislative change proposed by the government in response to the review of the law of negligence report (Ipp Report) is expected to have a positive impact on the professional indemnity (medical malpractice) program.

Given that the significant amendments made to the law of negligence in parliament last year and the capping of claims, which commenced operation last year, have had no positive effect, why is there an assumption that the Ipp recommendations will have any impact? Given that insurance will be required to be in place by 30 June this year for coverage for the 2003-04 year, where and when will this positive impact occur? Is it not the case that any potential positive impact in the foreseeable future will be in settlement of claims which have come about post the Ipp report recommendations, if and when those recommendations ever become legislation?

The Hon. L. STEVENS: In relation to the Ipp recommendations, there is legislation before the House of Assembly.

Mrs REDMOND: No, the report is before the House of Assembly, not any recommended legislation.

The Hon. L. STEVENS: I will check that; I thought there was.

Mrs REDMOND: A report, which is the Ipp report, has been issued. That is before the house. There is no recommended legislation before the house at this stage. It has not been introduced.

The Hon. L. STEVENS: I will ask Jim Birch to answer the question.

Mr BIRCH: It is difficult to answer the question, other than to say that we do believe that the changes reflected in the recommendations of the Ipp report will make a quantifiable difference. However, it is not quantifiable at this time. One of the reasons why that may be the case—and I can speak only for our own program, which is through the State Government Self Insurance Program (SAICORP)—is that it does involve reinsurance on the international markets. That reinsurance in the international markets has a lead time before there is some impact on the following year's premiums. We will be in a position to better answer that, hopefully, this time next year, rather than at the moment. There has not been sufficient time to analyse whether there will be a change in the period about which we are talking. It is definite but it is not quantifiable at this stage.

The Hon. L. STEVENS: In relation to medical indemnity and the strategies required to deal with that issue, one of the very important parts of this is to try to reduce the costs incurred in relation to lawyers and legal costs in fighting medical indemnity cases. Certainly, during the all-day meeting in Canberra that was called by Senator Patterson in May last year, one of the important strategies was to ensure that transparent complaints procedures were in place in all states that emphasised mediation and conciliation. I note that the government has such a bill before the house and I would very much like the opposition's support in getting it through.

Ms BEDFORD: My question relates to Budget Paper 4, page 7.66, dealing with funding for major public hospitals. How do the latest percentages of people requiring urgent surgery being treated within recommended times compare with percentages for previous years?

The Hon. L. STEVENS: I am very pleased to get this question in light of recent comments from the shadow minister on the same subject. As the committee would know, there are national guidelines for waiting times for elective surgery. Category 1 is classed as urgent, that is, within 30 days; category 2, semi urgent, within 90 days; and category 3, non-urgent. The shadow minister recently said, and quite vociferously in the media, that patients have to wait longer. Compared with March 2002, it is true that there has been a small change in the percentage of people who are waiting longer than the recommended period of 30 days for urgent surgery.

The government has taken steps to increase funding for surgery to meet this demand. In fact, we did that very thing earlier this year in March. The figure went from 11.4 per cent to 15.2 per cent, as our hospitals tried to managed increased workloads and greater levels of acuity at emergency departments, with more people requiring admission and, most of all, a shortage of nurses, requiring us to take beds off line. What the shadow minister did not say was that people are not waiting as long as they did when he was minister. The shadow minister also tried to blame the nurse shortage on the new government. He said, and this is the most remarkable thing about his reported comments in the daily press:

> The new government did not get out early enough to deal with the nursing crisis.

I do not think we could have got out any earlier than we did—unless of course the previous government had not dilly-dallied so long and had let us take over several weeks earlier than we did, on 5 March last year.

Ms BEDFORD: They could even have had a plan themselves.

The Hon. L. STEVENS: That is true: they could even have had a plan themselves. As I noted before, this is the former minister who sat for a year on a report that warned him of the nursing crisis and failed to act on the warning. I have had my office look back over the years to see how many patients have been treated within the recommended time frames under the former minister, and I want to talk about the urgent category that I noted earlier. In March 2003, 84.8 per cent of people were treated on time and 15.2 per cent waited longer. In March 2002, 88.6 per cent were on time and 11.4 per cent waited longer. In March 2001, in the time of the former minister, 84.3 per cent were treated on time, coming down from us, and 15.7 per cent waited longer. In March 2000, 84.6 per cent were on time and 15.4 per cent waited longer.

In March 1999 only 70.6 per cent were treated on time and 29.4 per cent waited longer. The year before, it was slightly better than that. In March 1998, 82.2 per cent were on time and 17.8 per cent waited longer. I must just explain to the committee that all the figures that I have just quoted for March 2001, 2000, 1999 and 1998 are worse than what the shadow minister was complaining about a week or so ago. We looked through media statements of the former minister, and in a media statement dated 6 December 1997 the Hon. Dean Brown said that the number of urgent, overdue patients had fallen from 47.6 per cent to 20.2 per cent. Compare this with the figure of 15.2 per cent that he now criticises and the figure in 1999, when it peaked at nearly 30 per cent.

In that media release put out on 6 December 1997 Mr Brown was commenting on the release of the September figures for surgical waiting lists, and he stated that in September 1994 there were 333 overdue patients (47.6 per cent of urgent patients); in September 1996 there were 130 overdue urgent patients (27.4 per cent); and in September 1997 there were only 70 urgent patients on the list, which was 20.2 per cent. He actually makes a virtue of figures that are even worse than those he is now criticising. I guess the comment is: how interesting that is. How things change, and how short some people's memories are as time goes by. But I want to make one final comment. Of course we want our hospitals to do better. We are committed absolutely to achieving that goal and we are working on a daily basis to make that a reality.

Mr CAICA: The minister briefly touched on nursing but, given the additional $2.7 million allocated for recruitment and retention of nurses in the 2003-04 budget, what strategies are in place to address the critical shortage of nurses? I refer specifically to Budget Paper 4, Volume 2, page 7.66.

The Hon. L. STEVENS: The nursing shortage, of all the serious challenges that are facing us today in the provision of health care, is one of the most significant. As I have been saying in the answers to previous questions, it is absolutely relevant, given the current difficulties that we are facing in being able to provide a sustainable level of staffing within both our hospital and our community settings in order to meet the increasing health needs of the community. As members know, the shortage of nurses has meant that hospital beds have had to be taken off line, putting pressure on hospitals to meet increasing demands for services. The supply and retention of nurses depends on many factors, including educational opportunities, clinical training, support for new graduates, improved workplace practices, meaningful careers and continuing education.

I am acutely aware of the significant issue that is facing us as a government to ensure that we are able to provide sustainable nursing and midwifery services in the state. The government is working with all the key stakeholders, which include the Australian Nursing Federation, the universities and the public, private and non-government sectors, in order to produce a sustainable, effective and valued nursing work force for the state. On becoming Minister for Health last year I initiated a range of strategies with the department in order to provide a platform for us to move to a more solid future for the recruitment and retention of nurses and midwives in this state. The major component of this platform was the establishment of a task force to develop a nursing and midwifery recruitment and retention strategic plan for the state, a plan that was completely missing from the government's armoury.

The high level of collaboration between nurses and midwives from the public, private and education sectors, the Department of Human Services, the ANF, industry partners and peak professional nursing and midwifery bodies, has ensured that the task force's strategic plan reflects recommendations to address the recruitment and retention of nurses and midwives in South Australia. The involvement of the education sector guaranteed that the links between the preparation of students undertaking nursing programs and clinical practice needs were maintained.

I launched the South Australian Nursing and Midwifery Recruitment and Retention Strategic Directions Plan 2002-05 on 3 October 2002. The recommendations in this plan reflect a broad range of strategies and provide a blueprint for decision making about recruiting future nurses and midwives to the professions and making sure they stay, whilst ensuring effective risk management for the future. The government has provided funding to support a range of nursing and midwifery recruitment and retention strategies, and these include:

- refresher and re-entry programs for registered and enrolled nurses;
- funding for postgraduate nursing scholarships for rural and remote, metropolitan and Aboriginal and Torres Strait Islander nurses;
- recruitment of overseas nurses, with which we have had some success;
- the continuation of the enrolled nursing cadetship and VET in Schools program in regional areas, and the Nursing and Midwifery Schools Speaking and Job Shadowing programs for metropolitan areas;

- the establishment of a program for Aboriginal students to prepare to become enrolled nurses;
- a clinical leadership program for nurses; and
- ongoing funding support for additional undergraduate places at Flinders University and the University of South Australia.

It will be a long haul to get on top of this issue. We estimate that it could take 10 years because, whilst we have established our strategy and begun our work and are continuing to fund this strategy, these issues are the same across Australia. There are also dramatic shortages in the United States, Canada and the UK, so essentially we are all fighting for the same work force.

I was extremely disappointed with the number of extra places that the federal government announced as part of its budget. I think it was just over 200 new places for nursing across Australia. If it was on a population basis, we would get less than 20 when we know that we need 400 new nurses every year. It is just a joke. The state government has already funded from its strategy 100 places in our universities. The federal government's core business is the funding of university places, so this is just a joke. We have to continue to put pressure on the federal government to make it see what a serious situation this is. This is a good indication that this federal government does not have a hands-on approach to the delivery of care. It will have to face and deal with the reality of what is happening in our hospitals, because 200 places across Australia is ridiculous.

We will be calling the universities together in the near future. Last year, I met with the vice-chancellors of the three universities to talk about nursing issues, and we made some plans for how we would cooperate in this. I had the opportunity of talking with Professor David Wilkinson of the University of South Australia earlier this week. We will establish a further meeting with the vice-chancellors to progress this issue in South Australia. Following on from the Generational Health Review's recommendations about the need for system support through workplace strategies across the board in health professions, we will be looking to work with the universities in South Australia and, more broadly, we will need to work with the federal government in relation to work force issues, certainly in respect of nurses but also in respect of doctors and dentists (particularly dentists in country areas) and allied health professionals. In fact, the whole issue of the health work force, what it will be and how we will manage it in the future will be a major challenge.

Mrs GERAGHTY: My question relates to Budget Paper 4, Volume 2 (page 7.66). Will the minister tell the committee whether there is increased interest in nursing as a career—I know that she has already commented on this to some extent—has the vacancy rate at public hospitals fallen; and are our training programs linking with the need for staff with intensive care qualifications?

The Hon. L. STEVENS: I am happy to go into more detail, because the answer that I just gave related in a general way to the broader question regarding the nursing shortage. Data provided by the South Australian Tertiary Admissions Centre on students applying for the bachelor of nursing pre-registration and the bachelor of midwifery pre-registration indicates that, over the past 12 months, first preferences for nursing programs have risen by 413 applications, whilst overall preferences for undergraduate nursing programs have risen by 1 315 applications.

Those figures are very gratifying in one sense, because I think the publicity around the nursing shortage that occurred when we were forced to take drastic action in September/October last year and our pleas to the public about the need for more nurses gave rise to this increased interest. The downside, of course, is that a lot of those people had to be turned away because the places are not there. That is the other issue to which I have referred.

The vacancy rate of nurses and midwives at our public hospitals has reduced by 100 full-time equivalents between July last year and January this year. The nursing work force is to be boosted further by the recruitment of 85 overseas nurses who will work at the Royal Adelaide Hospital and the Queen Elizabeth Hospital. Some of those are already on board and others are coming in now. Funding support for the graduate nurse programs at our public hospitals continues through the department's case-mix nurse teaching grant allocation.

The recruitment of 334 graduate nurses and midwives in the metropolitan area and 73 in rural and remote health units commenced in January for the 2003 graduate nurse and midwife programs. The department continues to work on a range of strategies aimed at addressing the critical shortage of nurses. To address this shortage in specialist clinical areas such as intensive care, clinical postgraduate scholarships have been offered. Funding support has also been given to the neonatal intensive care nurse practitioner program. This is a joint program between Flinders University, the Flinders Medical Centre and the Women's and Children's Hospital. Neonatal nurse practitioners will provide high-quality clinical care to neonates utilising a blend of nursing and medical skills consistent with that of a skilled neonatal nurse and an advanced paediatric neonatal trainee.

The Hon. DEAN BROWN: On a point of order, Madam Chairman, I think one of the questions asked by the member for Torrens was: what is the current vacancy rate? I do not think a specific answer was given to that question.

The CHAIRMAN: The member for Finniss would be aware that the minister may choose how to answer the question, but I will give her an opportunity to add further information if she wishes.

The Hon. L. STEVENS: From memory, the question was whether there has been increased interest in nursing and whether the vacancy rate has fallen. I answered that in relation to—

The Hon. DEAN BROWN: I would like to know what the vacancy rate is now.

The Hon. L. STEVENS: Perhaps the member for Finniss can ask that question when it is his turn.

Dr McFETRIDGE: My question relates to Aboriginal health. The main highlight is: implementation of the recommendations of the Generational Health Review. In the Generational Health Review under category 1 recommendations (page 46) there is reference to implementing new ways of improving Aboriginal health. We would all agree with that. Included in First Steps Forward, referred to in the flyers which the minister gave out this morning, are the following: adopting a metropolitan Aboriginal Health Advisory Committee, supporting and building culturally appropriate approaches to services for Aboriginal people; and launching culturally sensitive material in early childhood health strategies.

I hope all that is going to happen. My concern is that under Program K1 (page 7.17) there is a $1 million increase, but under Program S4 (page 7.46) there is a decrease in funding from $8.199 million to $8.024 million. On page 7.82, with reference to Aboriginal health, there is a very marginal 3.7 per cent (hardly inflation) increase in funding.

Having attended the Fourth National Aboriginal and Torres Strait Islander Health Workers Conference at the Convention Centre for one of the short plenary sessions the other week, I know that we cannot underestimate the urgency of Aboriginal health improvement. We heard some talk about increasing expenditure by $7 million over four years on the Anangu Pitjantjatjara lands and $.89 million for Mount Gambier, Port Pirie and Murray Bridge, but what we did not hear (and perhaps Mr Birch or one of the others might be able to help there as he did with petrol-sniffing programs) is what is happening with diabetes, family and domestic violence and sexual assault programs and mental health programs. What are we doing about training Aboriginal health workers? Are there any plans to register Aboriginal health workers as has occurred in the Northern Territory?

The Hon. L. STEVENS: That is a huge but very important question from the member for Morphett. Absolutely undoubtedly, the health status of Aboriginal people is really a national shame. It is something that we must address and, certainly, the Generational Health Review has indicated that that must happen. The very small first steps in the Generational Health Review were essentially more in the nature of the governance issues and the involvement of Aboriginal people in the planning and advice on health services, but we need to do much more. I might add that, in the early intervention program that we will begin later this year, one of the areas that we will specifically start to roll out is one where there will be high numbers of Aboriginal people. Certainly, issues in relation to the general health status of Aboriginal people plus those in relation to those specific areas that you mentioned are very significant. I will ask Jim Birch whether he might answer this, because he also chairs the national AHMAC committee on Aboriginal health nationally, so he has considerable knowledge and expertise in that area.

Mr BIRCH: First, I would like to look at the questions in *Hansard* and give you some specific responses on each one out of session because, frankly, I cannot remember all the questions. However, I can make a number of specific responses. I will not go over the Anangu Pitjantjatjara lands response again, because I think that is very clear, unless you want to ask a supplementary question. The moneys in there are the $1 million for health and wellbeing and the $650 000 for the rehabilitation facility. A substantial amount of funding is already in the core budget of the Department of Human Services, largely administered by the Aboriginal Services division and granted out to the various agencies such as the Aboriginal Health Council, many councils around this state, the Pika Wiya Health Service, etc. We could detail all those funds and indicate what they are used for.

You asked a couple of specific questions and one in particular regarding Aboriginal health workers. We have the only Aboriginal health worker association, which has been established with the assistance of the commonwealth and some state funding. We hope that it will become an Australia-wide trend to establish a support association for Aboriginal health workers. The aim is ultimately to move towards some form of accreditation or registration of Aboriginal health workers and, given that you were at the conference, I assume you would be aware of that. That is not in place at this stage, but that would certainly be the aim.

I should have mentioned that an additional $1 million in each of 2003-04 and 2004-05, and $1.5 million in 2005-06, is provided in the capital program to assist with maintenance, refurbishment and upgrading of Aboriginal health service facilities. We have not had that before. We felt there was a need to put money into that area, because the facilities that are providing services in rural and remote areas usually need upgrading. I want to make a specific point about mental health services for Aboriginal people. In particular, in 2002-03 we have appointed a principal consultant for Aboriginal mental health to the Mental Health Services and Programs Unit of DHS, and the women's exiting prison project carried out a pilot to identify the key elements of the social and emotional wellbeing and supported accommodation needs for indigenous women with mental illness who are exiting prison.

Three community mentoring and leadership projects were developed and run under the Aspire, Achieve, Affect program, which is part of the beyondblue initiative, and they commenced in Murray Bridge, Yorke Peninsula and Port Adelaide. Visiting psychiatry services also commenced to indigenous communities in the Anangu Pitjantjatjara lands, Oodnadatta, Yalata and the Pika Wiya Health Service in partnership with commonwealth medical specialists outreach assistance programs. Mental health liaison services were also established by Port Lincoln Aboriginal Health Service. A regional mental health worker position was established by the Hills Mallee southern region. A mental health Aboriginal arts program targeting young people commenced in Oodnadatta. For 2003-04 we want to do further work partnering with Western Australia in order to assess culturally appropriate methods for dealing with mental health problems. We are also investigating the possibility of undertaking an analysis as part of the Western Australian child health survey for Aboriginal children, which Professor Fiona Stanley has conducted over many years, and extending that study into South Australia.

There will also be ongoing development of the supported accommodation project for indigenous women exiting prison, and country initiatives will include establishing Aboriginal mental health liaison services in Ceduna, Whyalla, Yorke Peninsula, the South-East, Murray Bridge and the Riverland and to improve the delivery of culturally appropriate in-patient and community mental health services in those regions. That is an initial answer on mental health in particular, but I would be happy to take each of those other points on notice. I should have mentioned that through a program known as PCAP the commonwealth has established a Medicare cashing out type program for Aboriginal primary clinic services in metropolitan Adelaide through Nunkuwarrin Yunti, I believe. That is to be extended, and the work is under way to extend that to three country regions. I am not absolutely sure what those country regions are, off the top of my head, but we can provide that information to you as well. If I have missed something specifically, I am happy to answer that.

The Hon. L. STEVENS: There are some very significant and innovative programs occurring in various regions in the metropolitan area in relation to Aboriginal health. I am certainly aware of one in my own electorate in Elizabeth in the northern area, running out of Muna Paendi, which is very much a primary health care approach with a very strong team of Aboriginal health workers. Having the Aboriginal health workers delivering the services is a significant issue. I am sure that if the member is interested we could provide a full briefing for him on the extent of all those things. Is there anything else?

Dr McFETRIDGE: As a supplementary question: is the mental health funding going into family and domestic

violence? We just saw a murder in the Anangu Pitjantjatjara lands last week.

The CHAIRMAN: Is that in relation to Aboriginal funding?

Dr McFETRIDGE: Yes, in relation to the mental health program I asked about.

Mr BIRCH: Particularly in relation to the Anangu Pitjantjatjara lands and problems with deaths and suicide on the Anangu Pitjantjatjara lands, the $1 million that has been allocated to health and wellbeing specifically for those purposes has yet to be allocated for a particular purpose. We are negotiating that with the Anangu Pitjantjatjara Lands Council, and we think we will be putting some of that money into family violence measures, but we hope to allocate it to the six communities fairly equally. It would work out that $150 000 per community would be used for home-maker programs and programs related to domestic violence and children. An element associated with the commonwealth COAG money will also assist with that.

Dr McFETRIDGE: I refer to Budget Paper 4, Volume 2, page 7.79—SA Dental Service funding. It says in Performance Commentary that the reduction in the net cost of this program in 2003-04 is due to the completion of the $4 million two-year private dental initiative. It is a reduction of $2.357 million. My concern is that we need extra funding in the dental services, because my information is that patients at Strathmont who need general anaesthetics for dental treatment are not getting any treatment because the Strathmont Centre does not have the money to employ anaesthetists. Also, while waiting times in the budget papers are expected to stay at about 35 weeks, my information is that because of the reduction in funding they will be back out to 40-plus weeks. As a consequence of the reduced funding, the dental hospital will have to significantly reduce its support for the Adelaide University dental faculty. Could the minister say what she is going to do to resurrect the situation?

The Hon. L. STEVENS: Madam Chair, I would like to clarify a small point before I answer the member's question. For the information of the member for Heysen, I refer her to the *Notice Paper* of Wednesday 25 June for the House of Assembly. Number 15 on the *Notice Paper* is the Law Reform (Ipp Recommendations) Bill (No. 128), brought into the parliament by the Deputy Premier, and the adjournment of the debate on the second reading was secured by the Hon. D.C. Brown on 2 April. Unfortunately, he must have forgotten because he did not volunteer that information at the time. But there is a bill in relation to that matter.

I want to thank the honourable member for the question on the SA Dental Service, because it is a very important issue. We have had major problems in the availability of our public dental care since the abolition of the commonwealth dental program by the commonwealth government in 1996. I want to be really clear: the fact is that there is a shortfall in funding of $2 million from this year to next year and it has come about because last year there was an overlap of extra funding, and I will explain why that occurred.

The previous government under the previous minister, after some years of not doing anything to increase the state's effort to try to make up for the commonwealth's axing of the program, provided an additional amount of, I think, $7 million over three years: $2 million, followed by $1 million, followed by a further $2 million, which was in last year. When we came to government, one of our election campaign promises was that we would put in $8 million over four years—an extra $2 million per year. Our first $2 million came in last year, and carries through. That means we had one of the previous government's $2 million amounts and ours last year, and that gave us the overlap of extra that occurred that year and that overlap is not there this year.

I am in some ways disappointed that we were unable to continue that commitment. Unfortunately, we had more pressing priorities elsewhere in the budget and we were not able to put additional money on top of the $8 million that we had already put into the budget. What I would say is that the SA Dental Service has done very well in terms of managing waiting lists and dealing with the demand for dental services.

I certainly remember in those days, in the early years following the cancellation of the commonwealth program, that numbers blew out to up to 100 000 at one time. People were on waiting lists for four years, which is totally unacceptable. I understand that, particularly in the past year, the additional funds that have occurred along with strategies developed by the South Australian Dental Service to manage the growth in emergency demand has reduced waiting lists from 49 months in June 2002 to 30 months in April 2003. There is no doubt that, because we no longer have the overlap of extras, there will be an impact on waiting times and waiting lists. We will be monitoring that very closely. As I have said, SADS has employed a number of strategies to do its work better and to target its work better. We will be watching very carefully, and if there is cause for significant alarm on this we will be looking at that when it occurs throughout the year. Dr Stubbs will add more detail.

Dr STUBBS: There is not much I can add to what the minister has said. An important point to note is that emergency dental care does happen virtually immediately so the waiting lists, although bad, do not affect people with emergency situations. The other thing is that the Generational Health Review, in terms of the focus on primary care, may offer us an opportunity to look at alternative ways of funding some of the initiatives that the Dental Service was going to put forward.

One of the interesting areas of the estimates process is that the budgets are always under review and are constantly being refined. This is one area, in fact, where the figure that is in the budget papers you have has changed significantly, so I would be happy to make the more recent figures available. It does not affect the issue of the $2 million/$4 million but it would give you some more accurate figures and it is actually now something like $2 million higher than what appears in the budget papers.

Dr McFETRIDGE: I have a supplementary question to clarify that the Strathmont Centre cannot afford to employ an anaesthetist and, as a result, its clients are not having dental treatment. Is that a fact?

Dr STUBBS: There have been problems getting an anaesthetist to go there and there have also been problems in getting dental services to aged care facilities. Those things are being looked at, and I can quite happily give you an update on the progress in that area after the hearing, if you like.

The CHAIRMAN: Does that conclude the answer, minister?

The Hon. L. STEVENS: Yes.

Mrs REDMOND: First, I apologise to the minister for misleading her on the Ipp report and I stand corrected. I am happy to be corrected. Now that I think about it, I recall that the bill is before the house. In fact, I have a copy of it. My question is about the target which I think the member for Morphett already mentioned, the implementation of recommendations from the Generational Health Review. During

this morning's session, Mr Birch referred to one of the overall targets of the Generational Health Review as being to flatten the demand for hospital services. Is it not the case that what is happening now is that those health services are still at an all-time high and, in the meantime, we are not providing the additional services which are needed to cope with that in the hope that eventually we will have a flattening of demand?

The Hon. L. STEVENS: I will let Jim Birch talk at length, if he chooses, on that particular question, but I would like to make it really clear to members of the committee that, although the member for Heysen read a recommendation from the review in relation to keeping services at current levels, the government has made no decision whatsoever to curtail in any way the funding of acute care services at this time. However, we will need to address how we achieve that balance and eventually how we try to flatten that demand in the long term. I will hand over to Jim Birch to talk about that in more detail.

Mr BIRCH: I think the question really relates to whether there are strategies or activities under way in advance of the Generational Health Review, or will these strategies which occur now have to be funded by taking money out of hospitals in order to create activities that will ultimately suppress demand? I guess the contextual issue is that I cannot comment on whether or not budgets are adequate for health services because there is always a case for arguing for more money for health services. The reality is that there are no specific strategies in place now in the context of the Generational Health Review which are to be funded out of the hospitals. The specific process upon which we now have to embark in the department is to take maybe the four or five really critical recommendations from the generational review relating to reducing emergency services demand, hospital avoidance, mental health reform and call centre—which we know from international and national research do suppress hospital demand or reduce length of stay and therefore the need for services—and develop business cases.

It is certainly not the department's intent to recommend to the minister that we strip money out of hospitals in order to fund those business cases, because I think what Mr Menadue is saying is that you need to sustain that system while you are putting strategies in place to do it, unlike the original mental health reform deinstitutionalisation when deinstitutionalisation occurred without adequate funding in the community. It is certainly our intent to develop business cases for future budget consideration that would build up capacity in the community primary care sector before we are in a position to reduce hospital demand. In any case, if you look at the relevant part in the Generational Health Review, even the suppression of that demand will see our having more hospital activity by 2011 than what we have currently. I hope that answers the question in terms of the strategy.

Ms BEDFORD: How will the additional $2.7 million allocated for recruitment and retention of nurses in the 2003-04 budget provide for advances in culturally appropriate nursing in rural and remote indigenous communities? I believe that is dealt with in Budget Paper 4, Volume 2, page 7.66.

The Hon. L. STEVENS: This is another one of those more detailed questions which focuses on nursing and perhaps also links into the question from the member for Morphett (which I answered earlier) about Aboriginal health. We know how important it is for Aboriginal health programs and services to be delivered by Aboriginal people, Aboriginal professionals. Therefore, a very important strategy is to be able to increase the percentage of indigenous nurses. At the current time, we recognise that the percentage of indigenous nurses in South Australia is considerably less than what we would want it to be. The Unique Centre of Learning based at the Pika Wiya Aboriginal Health Centre in Port Augusta—and if members have not had an opportunity to visit that centre, I would recommend that they do so because it is quite an outstanding project—provides a learning facility for Aboriginal people training in health related courses.

The emphasis is on providing culturally appropriate academic, personal, peer, social and administrative support for students studying TAFE courses. In support of this initiative, funding has been provided for a tutor and 16 Aboriginal students to undertake the certificate 4 health indigenous enrolled nursing pilot program. Two indigenous nurses have been employed under the nursing cadetship program at the Coober Pedy Hospital. An indigenous recruitment and retention nursing video called 'Caring for Our Future' will be launched on 27 June 2003. Indigenous students have also been supported to attend the Annual Congress of Aboriginal and Torres Strait Islander Nurses. This is just one of a range of strategies which is being undertaken and which demonstrates the commitment of the government, the department and industry leaders in ensuring that the future foundation of our nursing and midwifery work force will be sustainable.

Ms BEDFORD: As a supplementary question, is there a gender balance in the recruitment of nurses?

The Hon. L. STEVENS: To the greatest degree that we can possibly have it. We really need to recruit and train as many Aboriginal people as we can of either gender to work in our health professions, and in particular nursing.

Ms Bedford interjecting:

The CHAIRMAN: Order!

The Hon. L. STEVENS: I do not know whether we know what the gender balance is. We will provide that detail later.

Mr CAICA: I refer to Budget Paper 4, Volume 2, page 7.66. Minister, you have an ambitious program for reform of the mental health system for which I, for one, believe you should be congratulated. Will the minister tell the committee of the capital program required to develop mental health facilities within mainstream health units?

The Hon. L. STEVENS: I would say that the reform of mental health services is our number one priority in terms of the things that we need to do in South Australia, and there is much to be done. Mental health service reform has been on the agenda for some 10 years, since the development of the national mental health strategy in 1992. However, I have to report that South Australia has fallen well behind national and international trends in the provision of mental health care. Members would remember—and I think I mentioned it earlier today—that the Brennan report, which was released during the time of the previous government, I think in the year 2000, gave a damning assessment of South Australia's performance in recent years in mental health reform.

This means that we are at the back of the pack. This government recognises this very serious issue and has embarked upon mental health service reform as a major government initiative. These reforms build upon and significantly enhance the program commenced previously, and particularly under the leadership of the late Margaret Tobin. In order to understand the significance of this issue for the state, it is important to understand the impact that mental illness has on our community. One in five South Australians will experience a mental health problem at some stage in their life, with almost half of these people affected long-term.

Mental health disorders accounted for nearly 30 per cent of the non-fatal disease burden in 1996. We also know that mental health issues contribute to 20 per cent of the total disease burden in Australia.

It is so common that every one of us will know someone from within our family, friends or our networks who will have a mental illness of some sort. We know that people with mental disorders are more likely to experience drug and alcohol issues and other health complaints such as cardiac problems, diabetes and stroke than any other group in the community. What is also concerning is that 68 per cent of people with mental health disorders do not access any health services for assistance. That is quite an astounding statistic—68 per cent of people with a mental health disorder do not access any health services for assistance.

The government has commenced a comprehensive reform package to improve the provision of Mental Health Services in South Australia to meet national and international standards and, more importantly, to achieve best practice mental health care for all South Australians. The major objectives of the reform agenda are to transfer the existing acute Mental Health Services operating at Glenside and Oakden to the major metropolitan hospitals. That really links into the general principle of moving the services out to where the people are, so that they are spread throughout the community into our major metropolitan hospitals.

Another objective of the reform agenda is to reduce hospital admission rates and inpatient length of stay through changes in clinical practice, and the provision of expanded community services such as community cottages and community packages of care. A further objective is to establish psychiatric disability support services, such as supported accommodation, delivered primarily through community based non-government agencies. We have had some outstanding success in some of the programs currently running. I certainly know of marked success achieved through programs run by the Port Adelaide Central Mission in relation to supported programs for people with a mental illness that have had significant positive outcomes in terms of less return to acute care by those people, more stable housing and certainly a much better prognosis for their ongoing life chances through the support of the program.

Another objective is to improve the capacity within the primary care sector to better meet the primary health care needs of the community, and this particularly involves general practitioners throughout the community. The final objective is to significantly improve and enhance community-based specialist mental health services to ensure assertive case management is implemented. The mental health reform agenda is planned to have a progressive implementation process over the next seven or so years. Capital investment in asset development is the most significant tangible requirement to ensure the success of mental health reform and also to ensure the success of its objectives. Without capital investment, decentralisation of clinical services will not be possible, and recurrent funds will not be released to invest into community services.

The capital program required to achieve these reforms will result in the development of the capacity of all mainstream health units in the metropolitan area to meet the mental health needs of their local populations. In addition, we are developing the capacity for some country facilities to manage less complex cases, allowing people to remain in their local communities rather than having to be transported to Adelaide where they require inpatient care and, as a result, becoming socially and geographically dislocated. As I briefly mentioned before, the first of these developments is occurring at the Flinders Medical Centre. I know the Public Works Committee has approved the construction of a 40 bed adult acute facility, with intensive care unit capability, to be known as the Margaret Tobin Mental Health Centre, at a total cost of $14 million.

That will operate as a single 40 bed unit and will be one part of a fully integrated community health service in the southern metropolitan region of Adelaide. My information is that the design of the facility is well advanced and has involved significant consultation with local consumers and carers, as well as staff. This facility will set the benchmark for future developments of this nature and will provide the infrastructure to allow the development of a seamless service. Consumers will no longer need to be transferred to Glenside if they require intensive care, because it will be there in the facility itself.

The flexible design of the facility allows control of the environment to match individual client need to ensure safe management of all clients within the least restrictive environment. That centre is scheduled to open in mid 2005. Documentation is also currently being prepared for cabinet consideration in relation to the aged care facility at the repat general hospital. This 30 bed facility will serve the southern region of Adelaide as one component of a fully integrated community mental health service for older people. Pending cabinet approval, we hope that construction of this facility will be completed by mid to late 2005. Progressively these developments and others will allow the transfer of acute inpatient services currently operated at Glenside in very old and clinically obsolete buildings to new purpose built facilities within each community.

Mrs GERAGHTY: How will the $1 million allocated in Budget Paper 4, Volume 2 (page 7.66), support the ongoing reform of Mental Health Services in South Australia?

The Hon. L. STEVENS: I am pleased to continue on the topic of Mental Health Services, moving from the capital investment to the $1 million allocated in the budget. Mental health reform requires a very highly coordinated approach, with many strategies running parallel. Examples of two strategies that are required for the reform to succeed in South Australia include a work force development strategy, because we really need to train, retrain, develop and support our work force to work in a different way in relation to mental health service provision.

Of course, the other strategy is legislative reform. In this year's budget, as the member has mentioned, the government has allocated $1 million recurrent for the development of a work force development strategy, and the legislative reform. The work force strategy will see the department working with health units and other key stakeholders to identify the current human resource profile of specialist mental health services in South Australia, and a profile for future mental health service in the state. The need for the work in this area is not new. Again, I mention the report of May 2000 by Dr Peter Brennan, in which he outlined a big picture framework for mental health in South Australia as part of that review.

Brennan's review identified education, training and professional development of the current and future work force as one of a number of key areas for action. The funding provided in this budget provides the impetus for immediate action, and it is absolutely an investment in the future. The work force development strategy will focus on developing three key frameworks to support mental health reform, human

resource planning, education and training, and industrial relations. The review identified that the majority of staff employed within South Australian Mental Health Services were trained within a hospital-based program. New models of care based within the community will be developed as part of the mental health reform process. The new staff development programs, together with ongoing support, will be implemented to ensure that staff have the skills they need to work in new models of care and non-institutional settings.

Previous reform attempts of Mental Health Services in South Australia really have not focused sufficiently on the education and development needs of staff, and it is a key area. This $1 million is a key strategic decision by this government. It recognises that education and training of the mental health work force is essential to the success of the reform of Mental Health Services in South Australia. Mainstreaming of mental health means that mental health must be seen, and will be seen, as core business of all health services. It means that mental health consumers will have access to mental health services wherever they live in South Australia, rather than their being dislocated from their families and supports in the community at a time of greatest need. For both mental health specialist staff and mainstream health staff, there needs to be a statewide coordinated approach to supporting skills and competencies.

The $1 million provided in this budget will support development of a coordinated approach to professional development, education and training for staff. The funds are intended not only to support the education, training and development needs of the work force but also to support the development of a human resources plan and industrial relations framework to support the reform process. Development of an industrial relations framework is critical for the success of the reform of mental health services in South Australia. We have got a positive record of consultation with industrial associations and we will be building on this to move forward in the mental health reform process.

We also recognise that improved quality of services to mental health consumers relies on the mental health work force. The work force needs to be supported through the reform process and we intend to provide that support. Recruitment and retention is a significant program in all sectors of the health system—and mental health is no exception to this. Recruitment and retention of specialist mental health staff is also an acknowledged issue in other states. In addition to the funds allocated for mental health in this budget, the government has also allocated funds to assist in nurse recruitment and retention in this area.

The Hon. DEAN BROWN: My question concerns events surrounding the opening of the new emergency department at the Royal Adelaide Hospital several weeks ago. At that occasion, the minister made an announcement concerning the employment of extra staff. It was a pre-budget leak for an extra 85 nurses. In fact, her staff told the media that it was 85 extra nurses a year for four years. That then had to be corrected because clearly funding was not there for that: it was 85 nurses paid for four years. I know the media at the time questioned the minister or her staff about the actual number of nurse vacancies. They were told there were currently 100 nurse vacancies within public hospitals. Will the minister confirm whether the figure is 100?

The Hon. L. STEVENS: Do you want clarification that the number of nurse vacancies, as at today, in metropolitan public hospitals is 100?

The Hon. DEAN BROWN: Yes.

The Hon. L. STEVENS: I will hand over to the Chief Executive.

Mr BIRCH: This question relates somewhat to the earlier question about the number of nurse vacancies and the change in the vacancy rate. While I cannot give the vacancies for the metropolitan area—but we can get the metropolitan vacancies—the vacancy rate across metropolitan and country South Australia at present—

The Hon. DEAN BROWN: The country is okay, too.

Mr BIRCH: The January to January rate was 350. It was 450 in the previous January. So there are 350 vacancies across metropolitan and country. I do not know the metropolitan split at this stage, but we can get that information.

The Hon. DEAN BROWN: In late May the minister's staff told journalists that there were 100 vacancies for nurses; I think it applied to public hospitals in the metropolitan area.

Mr BIRCH: I can most definitely say there were more than 100 vacancies at that point, and there would be many more vacancies now. My estimate is in the order of 250 or 300 vacancies at any given time.

The Hon. DEAN BROWN: I will go back to the journalists, but that is what they were told. I wonder from where the minister's staff got that figure?

The Hon. L. STEVENS: I am not sure. Are you saying it was at the opening of the Royal Adelaide Hospital emergency department?

The Hon. DEAN BROWN: It was on that day and it was to do with the fact that you announced there would be an extra 85 nurses. During the election campaign, the minister made an election promise to employ an extra 50 cleaning staff for metropolitan hospitals. How many of the extra 50 cleaners have been employed?

The Hon. L. STEVENS: In relation to that whole area, at present there have been no extra cleaners directly out of that initiative.

Mrs Redmond interjecting:

The Hon. L. STEVENS: Before you jump to that conclusion, perhaps you might like to hear me out. The government has taken this issue very seriously. The issue was raised with us constantly when we were in opposition. It was also something which was raised with us when we were in opposition in relation to issues of safety and infection control in our hospitals. I will tell the committee what has been done in relation to the matter. We decided that the best way in which to proceed on the whole initiative was to institute a comprehensive cleaning audit of contracted and in-house cleaning services across our hospitals.

The audit included visual inspection and was undertaken across all major metropolitan hospitals and the South Australian Dental Service. That audit was completed in February 2003 and a report was released a couple of months ago to the hospitals for comment. The Hon. J. Weatherill, my ministerial colleague, provided advice on whole of government directions for cleaning contracts. As members would know, as a result of the outsourcing of a range of these contracts under the previous government, we have a situation where some hospitals have in-house cleaning and there are different arrangements in different hospitals.

Mrs Redmond interjecting:

The Hon. L. STEVENS: I am not saying we are not going to fix it. I am saying we are going through a proper process to work out how to fix it.

Mrs Redmond interjecting:

The CHAIRMAN: Order!

The Hon. L. STEVENS: The recommendations from the audit indicated that the existing level of cleanliness in hospitals was appropriate, but that the scope of work and the contract definitions which applied in different locations should specify uniform cleaning standards across all hospitals. That is what the audit report showed. In order to improve quality and safety in care delivered in hospitals, the audit recommended investment in infection control procedures and monitoring across hospitals. The audit has been done. We have received feedback from each hospital and the union, of course, in relation to the audit that was done. Cabinet is now considering those recommendations. The money that has been set aside will be used for the purpose that the government promised, namely, to improve cleaning standards, to deal with issues to improve the general level of cleaning standards and to ensure that the contracts that exist in the hospitals in relation to cleaning are properly monitored and properly adhered to.

The Hon. DEAN BROWN: My next question relates to the aged care facility at Port Pirie Hospital, which is called Hamill House. Will the minister confirm that the cost of doing a major renovation of Hamill House has blown out from about $2 million to now more than $4 million and, I understand, perhaps as high as $4.5 million.

The Hon. L. STEVENS: I will ask Roxanne Ramsey to provide some more information on this, but soon after we came to government, when I visited Port Pirie and undertook discussions with a range of community representatives in relation to the future of Hamill House (which, for those people who do not know, is an adjunct to Port Pirie Hospital and is used as an aged care facility), they explained to me that the previous government had preferred to outsource that whole arrangement away from the hospital. It was the community's strong desire that Hamill House be retained and that the funds available be put towards upgrading that facility. The government accepted the views of the community and agreed that the $2 million that had been set aside in the capital works program would be used to upgrade Hamill House.

Ms RAMSEY: I can confirm that the cost of the upgrade, as it is currently planned, is of the order of $4 million, not $2 million. I would say, however, that we are in the process of auditing Hamill House as it currently stands against the proposed commonwealth standards, the 2008 standards, and within that there is certainly some capacity to look at upgrading within the $2 million to reach the standards. At the beginning of this process, the Port Pirie Health Service board, the hospital board, had had some work done by a local architect, I believe it was, who had established that the full upgrade could be done within $2 million.

When we followed that through with a more substantial assessment of the need, it came in as I said around $4 million for the proposals as they currently stand. So, we need to work with the mid-north region and with the Port Pirie Hospital board, to look at how the upgrade can fit within the $2 million or what other options there may be.

The Hon. DEAN BROWN: This may be the appropriate time for me to read out the omnibus questions, and we could then come back and continue the questioning. I have the following omnibus questions, which I expect answers to at a later date, obviously, and not now.

1. For all departments and agencies reporting to the minister, are there any examples since March 2002 where federal funds have not been received in South Australia or will not be received during the forward estimates period because the state government has not been prepared to provide state funds for a federal/state agreement? If there are examples, what issues and what level of federal funding has been or will be lost as a result?

2. Did all the departments and agencies reporting to the minister meet all required budget saving targets for 2002-03 set for them in last year's budget? If not, what specific proposed project and program cuts were not implemented?

3. For each department or agency reporting to the minister, how many surplus employees are there and, for each surplus employee, what is the title or classification of the employee and the TEC of the employee?

4. In financial year 2001-02, for all departments and agencies reporting to the minister what underspending on projects and programs was not approved by cabinet for carryover expenditure in 2002-03?

5. For all departments and agencies reporting to the minister, what is the estimated level of under-expenditure for 2002-03, and has cabinet approved any carryover of expenditure into 2003-04?

Dr McFETRIDGE: I refer to the Generational Health Review, referred to in the highlights here. The front page of the *Advertiser* today referred to 'dial a doctor'. I see some merit in the recommendation that the call centre be set up and, according to the Generational Health Review, overseas reports and studies have been done on that. I note that the Generational Health Review, at page 70, says that South Australia currently has more than 160 state government-supported health-related help lines. Can we get some details on those? While I am in support of this new initiative, and I believe that the former minister was looking at it, can I get some information as to what has been revealed by the research?

Will A&E admissions actually drop as a result of this and will the number of calls that can be received for general advice be monitored in some way, because I would imagine that most of them will not be A&E related, it will just be a general medical helpline. The only other concern is that from the front page of the *Advertiser* I thought it was being set up but the sheets we were given this morning stated that the government was investigating the setting up of the establishment of a 24 hour, seven day a week statewide call centre.

The Hon. L. STEVENS: It was a recommendation of the Generational Health Review. In fact, if we look closely at John Menadue's recommendation he recommended an after-hours call centre. We are actually interested in extending that and investigating a full 24 hour, seven day a week call centre. That is one of the recommendations of John Menadue that cabinet is very interested in and wants further work done on. The department will start that work immediately. I am aware that there is a call centre established in Western Australia that has been running for three or four years now, and call centres are also established in other countries. I visited a call centre in the west of London and one in San Francisco that was run by Kaiser Permanente as part of its service to its members.

They are quite exciting concepts, and Jim Birch will give more detail, I guess particularly about the Western Australian one but also in general. In both of those that I saw operating I was able to hear an interaction with a caller. I remember the one in San Francisco was a young mother with a child who was giving her a lot of grief at a particular time, and the nurse—and again it was a nurse on that line—counselled that woman through the issues and pointed her in the right direction. We will need to look very carefully at the models that currently exist, what would suit us here in South

Australia, how much it costs and, therefore, what we put to cabinet for consideration for possible implementation.

Mr BIRCH: The 160 different lines that are funded through one form or another by the Department of Human Services vary from crisis care lines to after hours home support lines and child and youth health lines, which are for child and maternal support, usually for young parents who have had babies and who in the first three to six weeks are having difficulties. A number of those lines will still need to exist. We do not anticipate collapsing all of those 160 lines, because a number of them do not relate specifically to health services (some do, some do not), but there are only so many functions that a 24-hour/seven day a week call centre can take. The specific task that we want a 24-hour/seven-day a week call centre to undertake relates to emergency calls, although indications from Western Australia and overseas are that you get enormous numbers of general calls as well.

I am more familiar with two overseas call centres than I am with Western Australia. One is obviously Kaiser Permanente in Southern California, and the other is the NHS Direct call centre in the UK. Call centres by themselves are not a solution; they usually have to be put into place in conjunction with other strategies. The other strategies that places such as Kaiser Permanente in Southern California has put in are similar to some of the strategies that have been suggested elsewhere in the Generational Health Review. These relate to the provision of after hours primary care services, GPS services, and the ability to be able to obtain health promotion information and educational information for families. Therefore, there are a number of strategies that need to be put into place that provide better health information and better after hours support for people.

Of course, a call centre needs to be able to divert people to appropriate alternatives other than emergency care. So, the strategy in the Generational Health Review around having integrated primary care centres involving GPs and therefore the need to negotiate with the commonwealth about the relationship between GPs and those centres is quite critical to a call centre strategy. Generally the annual growth in emergency department visits—I am happy to confirm these figures afterwards, but I believe they are fairly accurate—is about 5 per cent per annum in most states, although I believe that in Western Australia in the past year it was 2 per cent. I think they are still doing their evaluation, but it is generally felt that that lower level of growth is primarily due to the call centre that they have put in place.

They did not experience an immediate reduction in the first two years of the call centre's operations. The other issue with any call centre is that people need to have confidence that it will provide an alternative, and it has taken Western Australia at least the first two years before that happened. So we are quite well advanced with the business case in relation to the 24-hour, seven-day a week call centre. We hope that we can provide that for consideration in the budget process some time in the next few months. Again, I am happy to provide further information; that is just a general overview.

Mrs REDMOND: Will the minister guarantee that this call centre will remain in South Australia? I have a fear of call centres ending up offshore or interstate.

Mr BIRCH: The department's recommendation will most definitely be that it be a South Australian based call centre. You need to have nursing staff and medical staff back-up. With reference to protocols and screen algorithms, you would be familiar from the South Australian Ambulance Service call centre that screen algorithms need to be fairly localised and that there needs to be a good understanding of where people can be referred. That is not as easy to do with an interstate or national call centre. It can be done, but it is not as easy to do.

Ms BEDFORD: I refer to Budget Paper 4, Volume 2 (page 7.66)—the provision of health care services. How will the new safety and quality web site established by the South Australian Hospitals Safety and Quality Council enable the public to find out what is being done in South Australia about safety and quality health care in our public hospitals?

The Hon. L. STEVENS: I recently had the pleasure of launching a new safety and quality web site established by the South Australian Hospitals Safety and Quality Council. This site will provide on-line access to information about safety and quality initiatives being undertaken within South Australian health services. The section dedicated to advisories and alerts will allow the prompt and broad dissemination of information regarding high risk events and provide a forum in which organisations that have experienced an event can share their information. So, it is about sharing information and improving from that information being shared and analysed.

This information will be able to be accessed to inform further clinical practice reviews and may provide the impetus for change. Importantly, the web site will provide recognition for best practice in safety improvement. Consumers, health professionals and other users will be able to view and download documents, project reports, discussion papers and reviews. Individuals can subscribe to the web site and be prompted to visit the site each time an advisory alert is issued. I must say that patient safety is a priority for the government, and the development of this web site is another step towards extending the promotion of safety and quality in health care.

This is a very interesting concept. When I launched the web site I was impressed by the methodology and the philosophy of being up front about issues that occur and using issues to learn how to change practices and then to share that information with others and therefore raise the standard of quality of patient care throughout the system. It is worth having a look at this very interesting web site, so I will give members the address, which is: *www.safetyandquality.sa.gov.au*.

Mr CAICA: My question refers to Budget Paper 5 (page 23). Will the minister provide details to the committee about the proposed redevelopment of the emergency department of the Women's and Children's Hospital? The Public Works Committee visited this site on Tuesday and dealt with the matter yesterday. It is a terrific project.

The Hon. L. STEVENS: The emergency department of the Women's and Children's Hospital will undergo, as soon as we have gone through the proper processes, an extensive $8.2 million redevelopment. The member for Colton would have noted on his visit to the site that this part of the hospital was constructed in 1978, and it looks like it was. Some parts of this hospital which have been upgraded look stunning, but the emergency department really needs an upgrade. Since its construction in 1978, it has not had any major refurbishment apart from minor painting and floor repairs, so it is well needed.

The proposed development of the emergency department aims to provide modern, efficient and functional areas for the effective care of women and children requiring acute medical assessment and treatment. The project will overcome current inadequacies in the department, allowing for improved observation from the central staff base, optimised placement

of triage with dedicated assessment rooms, increased waiting area capability ensuring—

Members interjecting:

The Hon. L. STEVENS: —we hope not, particularly if we move ahead with the call centre; perhaps for mums and dads with kids in the middle of the night perhaps that will be helpful—ensuring privacy of treatment and assessment and providing additional treatment and assessment rooms, enhanced patient observation, collocation of paediatric, emergency and the women's assessment service and providing confidential interview facilities. I mention those particular characteristics, because those are the sorts of characteristics that accompany emergency department upgrades generally these days, and it is good to see each of them, because obviously they each have a specific purpose.

With government support, the Women's and Children's Hospital undertook a fundraising campaign on a dollar for dollar basis to raise funds for the emergency department development, and we were very pleased. The dollar for dollar fundraising campaign began during the time of the previous minister, but no money had been set aside from the state government in the forward estimates, and we were very pleased to be able to ensure that the funds were there. However, it was and is a fantastic fundraising effort through Savings and Loans, and we are delighted that, with our capital works program pulled into an ordered form, we are now able to commit our share of that.

The Women's and Children's Hospital entered into an arrangement with the Savings and Loans Credit Union, introducing the special Savings and Loans Women's and Children's Hospital Visa Card, which gave a contribution towards the emergency services redevelopment. It is a really exemplary and excellent campaign, and it won the Prime Minister's award for excellence in community business partnerships in the large business category, reaching the initial $1 million target earlier than they had anticipated. What they have done really is a 'credit' to them.

The Premier publicly endorsed this innovative fund raising on 7 November last year and committed the government to funding on a one to one shared funding basis and acknowledged the role of the Savings and Loans Credit Union in progressing fund raising to that initial $1 million level. The government contribution to the project will be $4.1 million, a figure that will be matched by the Women's and Children's Hospital, and we expect that $1.6 million will be and has been set aside to be spent in 2003-04. Cabinet approved the project on 2 June this year and it is currently obviously before the Public Works Committee, as the member for Colton, who visited just a few days ago, mentioned. We are hoping that, if all goes well and the project passes through all the assessments that it needs to, the work will commence in December this year and be completed in June 2006.

The CHAIRMAN: Just before we break, I indicate that I have already been able to find the Human Services safety and quality web site, and can see that it is an excellent, beautifully structured site, with great room for development, and I see that the Flinders Medical Centre is featuring well in a number of the initiatives being taken.

The Hon. L. STEVENS: Very good. The Department of Human Services has an outstanding web site in terms of the information that it provides to the world, not only from the quality and safety web site but also other aspects. We were looking at the hits on the web site and saw that there had been 700 000 hits on the Generational Health Review's web site, so I would say that anyone who says that people are not interested in health reform should look at those figures; it is quite a stunning result.

The CHAIRMAN: I thank the minister and her advisers for their patience and forbearance during a very long sitting.

Witness:

The Hon. S.W. Key, Minister for Social Justice, Minister for Housing, Minister for Youth, Minister for the Status of Women.

Additional Departmental Advisers:

Ms N. Saunders, Director, Family and Youth Services.
Dr D. Caudrey, Director, Disability Services.
Mr C. Overland, Director, Ageing and Community Care.
Mr P. Fagan-Schmidt, Director, Human Services Reform.
Ms L. Durrington, Director, Community Services.
Ms G. Cooper, Policy Officer, Parliamentary and Legal Services.
Ms S. Barr, Ministerial Liaison Officer.
Mr J. Rundle, Ministerial Liaison Officer.
Ms K. Jefford, Parliamentary Officer.
Mr A. Story, Chief of Staff.
Ms S. MacDonald, ministerial Adviser.
Mr A. Fairley, ministerial Adviser.

The CHAIRMAN: Have the minister and the lead speaker for the opposition agreed on a timetable?

The Hon. DEAN BROWN: I again make the point that there was no agreement on time. There was agreement on the order of departments but there was no agreement generally between the government and the opposition for times for any of the committees.

The Hon. S.W. KEY: There is a message here to say that you agree with the allocation of time but would like to change the order to Community Services, Disability and Ageing, which I agreed to.

The Hon. DEAN BROWN: That was not the message that I sent back, but I do not believe that it is a big issue.

The CHAIRMAN: The member for Finniss has been making a point, I think, about the overall program and whether or not that was agreed.

The Hon. DEAN BROWN: Madam Chair, neither you nor this committee can override the standing orders. The standing orders allow this committee to go beyond 9 p.m. if there are members here who wish to ask questions, and the Speaker has sent out a letter to that effect.

The CHAIRMAN: I am well aware of the standing orders. We will deal with that if and when it is necessary. This morning the member for Finniss made an opening statement which he indicated covered all areas of the portfolio. I now invite the minister to make an opening statement.

The Hon. S.W. KEY: I would like to take this opportunity to make some introductory remarks about the social justice portfolio and budget. The budget carries a small accrual deficit of $20 million in 2003-04 but promises a growing accrual surplus from 2004-05. This was a tight budget and there have been some difficult decisions made on the priority areas of government funding.

I am pleased that, despite the constraints, many of the new initiatives the government has announced will be implemented through the Social Justice portfolio, for which I have responsibility. In the next four years this government will spend over $71 million on new initiatives in the portfolio areas for which I am responsible. This new money will go to

alternative care, early intervention, disability services, deinstitutionalisation, new youth detention facilities and indexation for non-government organisations. There are a number of other initiatives but these certainly stand out.

In addition, as part of the shared portfolio responsibilities with the health minister, over $20 million will go into new initiatives for the Anangu Pitjantjatjara Lands and measures aimed at tackling homelessness.

Last year, during estimates, I referred to some of the challenges facing the government, in particular the issues of poverty and disadvantage in our community, which result in the need to tackle homelessness, support young people at risk, provide assistance to those with disabilities, reform our child protection system and deal with the consequences of gambling and other addictions. This budget has tackled those issues, however some good work has already been started and some of these initiatives have been in the current financial year.

One example of that is supported accommodation. There are over 44 supported accommodation assistant program services totalling $18.13 million in metropolitan Adelaide. These have been funded and directed at homeless and vulnerable people. There is the development of the St Vincent de Paul night shelter in Whitmore Square, the Vincenzi Centre, costing $3 million. This is a capital asset program initiative and will increase the amenity, quality and capacity to manage client needs. Anyone that was at that opening will, I think, support the fact that this has been a very important initiative.

There has also been the implementation of a 45-bed hostel for frail aged homeless at Bowden. That is progressing and it is expected to be completed in December this year. Anglicare has received capital asset program funding totalling $2.7 million and a $700 000 interest-free loan for this project. Funding of $90 000 has been provided for early intervention pilot projects in Elizabeth, Port Pirie and the Riverland. These projects address family homelessness and realign services to integrate best-practice elements with service agreements. There is currently an examination occurring of the viability of rural services which will lead to new service models for some agencies. For example, the Cross Borders project is a successful model working with remote aboriginal communities addressing family violence and this will be further developed.

The important new initiatives in this budget include child protection. The government has made an early and strong commitment to child protection reform in South Australia, following the review of our child protection system by Robyn Layton Q.C., and has committed $58.6 million over the next four years to strengthen our child protection system. I am pleased that the challenge of addressing child abuse and neglect in our community is being addressed by a cross-government approach, which is reflected in the allocation of funding to a number of important initiatives in Justice, Education, Aboriginal services and the human services department. The budget for child protection is aimed at early intervention strategies in order to reduce the need for statutory responses.

These strategies will provide for universal home visiting. There will also be targeted services for families identified (through this universal home visiting program) as high risk, including early intervention in situations where children and families are experiencing difficulties. This will provide significant investment towards children's long-term health and well-being. In addition, the provision of more appropriate and diversified services to children and young people (with high support needs) who are under the guardianship of the minister will be a focus.

A recent new initiative is the development of an independent and specialised team, which will be established to undertake special investigations. Initially, the unit will consider matters involving children in alternative care or in residential care through Family and Youth Services, and, at a later date, will be expanding to include other vulnerable members of the community such as those with a disability. Another extremely important area where the government is addressing need is alternative care, that is, the care of children and young people unable to live with their birth families. These children and young people are amongst some of the most vulnerable groups within our community.

In strengthening and extending services to these children and young people, the government has committed $2 million recurrent new growth funding that will:

- provide a more appropriate and diversified range of services targeted to children and young people with extreme and specialised support needs;
- enhance services that support children and young people being reunited with birth families and/or placed with relative carers;
- provide innovative alternative care models which promote self-determination in Aboriginal communities;
- build capacity, capability and sustainability of the state's family-based foster care population.

Additionally, the government recognises the cost pressures associated with the increasing numbers of children and young people in alternative care and has committed $2 million to offset current costs. These initiatives aimed at improving child protection in South Australia is the beginning of a long journey the community as a whole must take to ensure those most vulnerable are protected from abuse and neglect.

In the area of disability, the government has successfully negotiated the signing of the Commonwealth-State-Territories Disability Agreement. This will mean that South Australians will benefit from additional disability funding which grows, on average, by 5.14 per cent over each of the next five years of the new agreement. Approximately $1.1 billion will be allocated in the state budget over the life of the agreement on disability services. In addition, the commonwealth expects to contribute approximately $212 million in disability employment related services in the same period. Priority areas for the allocation of the extra funding include day services, accommodation support for people with disabilities, family support services and services for Aboriginal people. In addition, the state government has allocated an additional $18.4 million in capital and $5.3 million in recurrent funding over the next four years to enable up to 150 residents of Strathmont Centre to move into community living and for the refurbishment of the remaining four villas on site.

In the area of ageing and community care, during the course of the next financial year the government will be pursuing a number of important policy initiatives. First, the government will develop a whole of government strategy for an ageing South Australia, which will involve discussions with key interest groups and the wider community to ensure that it reflects expectations and aspirations. Secondly, the government will begin work on developing a whole of government strategy regarding employment of older people. Thirdly, the government will continue to participate in discussions regarding the commonwealth's New Strategy for

Community Care. If implemented, this strategy has the potential to have a significant impact on the future planning, management and delivery of a broad range of community care services, including those funded through the Home and Community Care program.

In the 2002-03 financial year, funding of Home and Community Care services in South Australia increased by $7.355 million, that is, from $87.657 million to $95.012 million, an increase of 8.14 per cent. To some extent, the growth in the funding over the past years has been so rapid that the community care system has struggled to implement and deliver planned, expanded or new services on the ground. This problem has been compounded by the cumbersome nature of the planning and funding cycle imposed by the current commonwealth, state and territories Home and Community Care agreement. With this background in mind, 2003-04 will be a period of consolidation in which previously approved projects can be established and consolidated.

Only a fortnight ago, the commonwealth Minister for Ageing, Kevin Andrews, and I announced 70 new and expanded recurrent projects and over 40 one-off and fixed term projects from the 2002-03 budget. These will be progressively implemented over the next 12 months. Indexation will be provided as part of the 2003-04 budget for all existing and expanded services and there will also be some one-off funding available to ensure that worthwhile short-term initiatives can be pursued.

One of the other initiatives which I am pleased to underline is the indexation for non-government organisations. Indexation of the funding of non-government organisations is critical for these organisations to remain viable. The government acknowledges the cost pressures that these organisations face as they strive to provide essential services against increasing demands.

I look forward to the coming year where the government will:

- continue to examine and implement recommendations of the child protection review;
- continue reform measures in the community services area;
- introduce new services to the AP lands;
- strengthen and expand the alternative care system;
- improve the delivery of services to people with a disability; and
- develop further the approaches for dealing with homelessness.

The CHAIRMAN: Do you want to add a statement or proceed straight to questions?

The Hon. DEAN BROWN: No. My first question to the minister relates to both the budget and the staffing levels for FAYS for the coming year. We have heard many statements from the minister about new money for this and that and new staff for this and that, and we had the budget leak the night before the budget about $3 million new money for FAYS in terms of child protection. I refer to page 7.15, which shows that the FAYS budget for this year is $88 million. In fact, in 2001-02 the actual amount spent was $89.3: it was $1.3 million higher two years ago than it is today. I listened with interest to the CEO of the Department of Human Services on ABC radio recently when he said:

> So we're not cutting FAYS staff but we're not actually increasing them at the moment.

Then later in the interview he said:

> I mean the budget papers certainly show that there is less funding for FAYS this year—

That was compared to two years ago. Then Matthew Abraham asked:

> Well, I think if there's less funding then it's a cut isn't it?

The CEO said:

> Well, it's a cut certainly in the budget papers.

As I said, the facts are that there is $1.3 million less for FAYS now than there was two years ago.

The increase in the FAYS budget this year of a mere 3.05 per cent compared with what was spent last year—which, I might add, was a substantial reduction approaching almost $5 million (about 10 per cent)—will not even cover wage increases. How many additional staff will there be to deal with child protection issues within FAYS and from where will those staff come? From where are they being paid, and if it is from within FAYS then where else are the reductions in FAYS? Are there currently substantial vacancies in staff in FAYS, especially in country areas? I received a call from a radio station saying that there are substantial vacancies at Port Lincoln, Port Pirie, and they named about three or four other centres. I would like to know the details of what vacancies occur in FAYS offices in country South Australia. I realise that the minister may not be able to give a detailed answer and that she might need to obtain that information. How many extra staff are being engaged for child protection this year, and from where are they being paid? Obviously, they have to be employed and paid for by FAYS. What other areas are being cut to make way for them?

The Hon. S.W. KEY: I will try to cover all those areas. I might seek assistance from Nerida Saunders, Director, Family and Youth Services. The honourable member's first point involved the budget line and his interpretation of the budget allocation. As members will know, I have answered that question in parliament before, but I am very happy to do it again. Also, the honourable member referred to the radio interview on 891, where the Chief Executive Officer was interviewed. I will start with that, if that is appropriate. It is inappropriate to make a comparison between the actual spending in a particular year and the budget allocation for another year. If you refer to the budget papers, you will follow my argument. If we are to compare like with like, we need to compare the allocated budget for 2003-04 with the allocated budget for 2001-02. In 2001-02, the previous government's budget—the honourable member's government, when he was the minister—was $81.2 million, compared with the allocation of $88.1 million in the current budget. As I understand it, the previous government overspent its budget allocation of $81 million by approximately $8 million. I know I am not in a position to do this, but I would like to rhetorically ask whether all the overspending went into front line child protection. After going through the FAYS budget, I understand that that was not the case.

My understanding is that apparently three components elevated the expenditure above normal expenditure, and they were $1.5 million which was a book loss on the sale of the Lochiel Park property which was transferred to the Lands Management Council. I understand that about $5 million was looked at for that property, but it was $1.5 million less than what was expected. I am also told that there was a $1 million overspend in the salary related expenditure area, and $2 million in expenditure that was brought forward from 2002-03 due to extensive cost pressures associated with client payments. Our government is still negotiating with Treasury on how to repay the brought forward expenditure. So, the previous government did not allocate more to the FAYS

budget in its last year than our government has. However, the net effect of the one-off items for 2001-02 make the comparisons of allocation and the spending very difficult to sustain from the previous government's point of view.

There is also another factor that makes the comparisons between 2001-02 and subsequent years difficult, which is referred to in the performance commentary on page 7.34. Specifically, the family maintenance branch of Family and Youth Services was transferred to the child support agency—the shadow minister may remember this—and revenue of $123 million ceased from 2002-03 onwards. There was a consequent reduction in employee expenses due to targeted separation packages being accepted.

I make a more general observation. It appears that the budgeting processes and financial management in respect of FAYS has been deficient for a number of years. If the shadow minister was going to quote what I said on the radio, he would have also heard that one of the things I discovered on becoming a minister was that there seemed to be questions I could not answer. That was certainly the case in the first budget I negotiated as the Minister for Social Justice, particularly in the FAYS area. It appears to me that the resourcing decisions since 1993-94—and I know the shadow minister may not have had responsibility in those areas (except perhaps as Premier)—have not taken appropriate account of the workload increases faced by Family and Youth Services staff.

The extent of any mismatch between resourcing levels and the demand FAYS services needs to be identified. I have previously told parliament—and I am sure members here will remember this—that cabinet has approved an audit investigation of FAYS, mainly because I found it very difficult to marry up the previous way in which the FAYS budget has been designed. So, the Department of Human Services and Treasury officials will undertake an examination of past budgeting processes and resource allocations. In addition, they will also examine other financial and compliance issues relating to the FAYS operation. As the minister, I want to get to the bottom of why year after year there appears to be little relationship between the budget allocation and the actual spending in FAYS and why there is not the need for the future of the FAYS budget to be propped up year by year by piecemeal solutions. I am keen to make sure that the FAYS budget stands up in its own right and does not have to take allocations from other parts of the DHS budget, which is what I suspect has happened in the past.

Of course, I am also very keen to make sure that, once the audit process is complete, we can take measures so that this will not happen again. That is part of my answer on the budget and why there is a difference between 2001-02, and then the 2002-03 budget. I also need to make another point. There has been not only the closure of the family maintenance branch during 2002 and that being transferred—

The Hon. DEAN BROWN: I think that was done under your government.

The Hon. S.W. KEY: —but there has also been a transfer of the management of the Duke of Edinburgh Trust, and that is now under the support of the Office for Youth. In addition to that, the allocation with regard to alternative care has been transferred out of Family and Youth Services and is now under the umbrella of the community services part of the social justice portfolio. I hope that illuminates some of the reasons for the different allocations that will appear in the budget. As I said, there are two parts to my answer, one of which is that it has been extremely difficult to track the FAYS budget over the past few years, and there has also been some changes as a result of my having responsibility for the social justice portfolio. The honourable member has also asked me a question about staffing, and that was in two parts, as well. One part was concerned with the number of staff and the workload associated with that, and the other part involved specific questions about the rural, remote and regional responsibilities for Family and Youth Services.

The Hon. DEAN BROWN: First, how many officer vacancies are there in country areas? Secondly, how many extra staff have been or will be taken on this year in FAYS for child protection issues?

The Hon. S.W. KEY: I will answer the second part first. One of the jobs we are undertaking—and, again, I have announced this in parliament—is looking at FAYS' workload and the increased demand on FAYS workers. There are a couple of reasons for that. First, we are hoping to follow through with the recommendations of the child protection report, the Robyn Layton report. Also, we are connecting that with the increased number of child protection notifications. As many members would be aware, the number of notifications has gone from 11 651 in 1997-98 to 18 681 in 2001-02. There has been an increase of 7 000 reports or 60 per cent.

Despite what seems to be a healthy economic climate in South Australia, there has been an increase in the number of households that live below the poverty line. As the shadow minister would know, part of the work of Family and Youth Services is to assist families, particularly those who live below the poverty line. The South Australian parliament's Social Development Committee inquiry into poverty reported that South Australia has very high levels of poverty. We are told that some 23.3 per cent of households are below the poverty line compared with 17.9 per cent nationally. Through not only Family and Youth Services, but also, I would argue, all portfolios, particularly Social Justice, we have more of a challenge than ever to try to assist those families.

I am keen to ensure that we work through the Layton report and the recommendations, particularly with regard to child abuse and child neglect, and look at problems for young people, as well. We will be establishing a workload and work level committee to work through those issues. This workload committee will be chaired by the Chief Executive Officer and, once the Public Service Association agrees—I do not know whether it has yet agreed—to not only the terms of reference but also the way in which the inquiry will take place and their involvement in that committee, I will make available the terms of reference.

The honourable member mentioned the Radio 891 comments by the CEO. I support what the CEO has said about Family and Youth Services. Certainly, as far as extra staff that may be needed in Family and Youth Services, it will be something we will work through to ensure that the services we provide, the workload levels, and the number of staff to achieve that will be implemented not in a piecemeal manner but, rather, in a comprehensive way. There is a framework for looking at the number of staff, the type of staff, the sort of training and the location of staff. It will all be part of the workload and work level review. As I said, I can read out what we think the terms of reference will be but, rather than take up time today, once the PSA has agreed, we can make available the terms of reference. In fact, I will make it available to anyone who wishes to respond.

As far as the Layton report is concerned, there is a further consultation period which has not yet expired and which, from memory, is until 28 July to allow for anyone to make

further comment in relation to the recommendations. When the cross portfolio ministerial committee looks at the implementation of the Layton report, we can ensure we do so in a holistic way, rather than in a piecemeal way. That will have implications for not only the services that we provide in relation to child protection but also the staff, probably across government, that we need to deliver on those recommendations. I will pass over to Nerida Saunders, who can answer the work vacancy question that the member asked.

Ms SAUNDERS: I do not have the percentage or the figures in terms of current vacancies across the country areas, but certainly the vacancy levels become an ongoing issue in relation to recruitment and retention of staff in the country. It is part of our ongoing FAYS, as well as across government, involvement to look at the opportunities to attract people to country areas and to sustain them in employment within the communities. That is an ongoing process in which we are involved.

The Hon. DEAN BROWN: If you could get the figures office by office, I would appreciate it.

The Hon. S.W. KEY: I would be happy to do that. The Chief Executive Officer is happy to add to this.

Mr BIRCH: I think the shadow minister asked a question about where, within the department, the funds are coming from in the meantime. If there is an overallocation problem, from what are we cross-subsidising? I cannot point to that within the budget papers, but we have central contingencies that we hold, usually against escalations in program activity across the department. Currently, we are holding the FAYS underallocation against that. It is not something that we want to do for the long term. As the minister indicated, we are hoping that the workload assessment process will indicate what is needed to recalibrate the FAYS budget at that time. At the moment, it is coming from the central contingency, which ordinarily might be used where we have a cost pressure and we do not want to go back to Treasury during the year. We would like to regularise the FAYS budget on a permanent basis.

The Hon. DEAN BROWN: In light of the investigations into the former FAYS manager for allegedly misappropriating substantial amounts of money—and I am sure you know the case, to which we referred in parliament recently—how many other FAYS staff are under investigation for alleged fraud or misappropriation?

The Hon. S.W. KEY: Can you refer me to that in the budget papers?

The Hon. DEAN BROWN: It is under the FAYS budget, page 7.15. We can talk about any activity within the department which requires appropriation or misappropriation.

The CHAIRMAN: Order! Member for Finniss, the requirement is that questions refer to a specific line.

The Hon. DEAN BROWN: If you want to refer to a particular page, we will refer it to page 7.33 and the appropriation there.

The CHAIRMAN: Minister, you were not here this morning, so you did not hear the procedures read out. I point out that questions must be based on lines of expenditure in the budget papers and must be identifiable or referenced. If you are having difficulties identifying them, please ask for further information from the member for Finniss.

The Hon. S.W. KEY: I am happy to provide some information on this matter. I suspect that the shadow minister is alluding to the sums of money which have been identified or alleged and which are of concern. Certainly, there will be an overall audit by Treasury and the departments into the FAYS budget, not only because of the issues that are not easily explainable within the FAYS budget itself but also because we need to revisit the levels of authority of different staff to ensure that we have appropriate checks and balances within all the portfolio areas.

In the FAYS area, the point the shadow minister is making is that we need to ensure we can account for public money that is handed out for people in need. I agree with all that. The point I made in parliament, and the point I make again today, is that we are reviewing protocols that were in place when the shadow minister was the minister. We are happy to do that, because there are a number of question marks about FAYS itself. The CEO is happy to make a comment on the particular instance that the honourable member mentioned and possibly allude to some other issues that have come up recently.

Mr BIRCH: I have to be brief, because it is under investigation, but there are two people being investigated in two separate places in relation to a potential misappropriation of funds. I say 'potential' because they are still under investigation. We are assisting the Anti-Corruption Branch of the South Australia Police in those investigations, and further audits are being undertaken. I would probably not wish to say more than that at this stage, given that there is an investigation.

The Hon. DEAN BROWN: When you say two, does that include the one already raised? These are two additional cases?

Mr BIRCH: The one already raised, I assume, is the one that was raised in parliament. That is one of those two cases and there is one further case, so there are two cases altogether.

The Hon. DEAN BROWN: Is that in a different office?

Mr BIRCH: Yes, a different office.

The Hon. S.W. KEY: As I said, there is the general principle of our needing to revisit the responsibilities and protocols in this area, and they are protocols and checks and balances that I inherited from the previous government. So, yes, we are working towards making sure that we have a more appropriate system in place.

The Hon. DEAN BROWN: My next question relates to the 350, I think, different organisations—in fact, perhaps more than that—which are funded largely, although not entirely, under the FAYS budget.

The Hon. S.W. KEY: I think that the honourable member is referring to the community services budget.

The Hon. DEAN BROWN: Yes, but I am distinguishing there; there are also some under disability and some under ageing.

The Hon. S.W. KEY: And housing.

The Hon. DEAN BROWN: For reasons of simplicity, a large number of organisations are funded under the community services budget and they are largely incorporated bodies with a lot of officers out there. How many community service organisations that receive funding from the state government for key social programs will be required to pay the $135 water tax that has been announced by the government, and what will be the resultant cut in services from all those organisations? Can the minister give some indication of how much money will have to be paid under that tax?

The Hon. S.W. KEY: If the shadow minister finds it acceptable, I will take that on notice. I have been following up on that issue but I do not have an answer for him today.

The Hon. DEAN BROWN: I did a quick sum and thought it could be somewhere between quarter of a million and half a million dollars.

The Hon. S.W. KEY: I am not sure of the figure, but it is certainly something I have taken on board. I do not have an answer today, but I will be happy to provide one.

The Hon. DEAN BROWN: But they have not been exempted from the tax, have they?

The Hon. S.W. KEY: Some have and some have not, I understand. This is why I have taken up the issue, to seek some clarification, and I think it would be inappropriate to answer until I get an accurate response.

The Hon. DEAN BROWN: I realise that trust houses are exempt.

The Hon. S.W. KEY: I am happy to provide the honourable member with an accurate and comprehensive answer, if that is acceptable to him.

Mr CAICA: The minister touched on this subject in answer to the shadow minister's first question, which was actually a multitude of questions. On page 7.34 of Budget Paper 4, under program K8, the area of child protection is detailed. The performance commentary states that improvements are being made to the long-term system response to child protection investigations. Can the minister tell the committee what steps are currently being undertaken in this area?

The Hon. S.W. KEY: I think I tried in my answer to the shadow minister to say that this is a program that we will need to roll out, as they say, over a long period of time. The review report highlighted a number of areas with regard to the FAYS operational service delivery. Also, as the report notes and as we have heard today, there has been an increased demand on the current system, with FAYS experiencing difficulty in meeting that demand. The review, I emphasise, recommended that, instead of a piecemeal approach to extra resources, DHS staff and senior Treasury, with cabinet approval, will undertake a comprehensive budgetary and workload analysis of Family and Youth Services to determine current demand.

Such an analysis is to take account of the socioeconomic and trend data with a view to developing funding models based on agreed formulas. That is recommendation 45 of the Robyn Layton review. Probably, in my answer to the shadow minister I explained that a number of things have been put in place very quickly and are about to be put in place to cover particularly that recommendation. A workload management and fund steering group has been convened to undertake a comprehensive budgetary and workload analysis of FAYS to determine resource requirements. As I said, there are terms of reference, and we are waiting for sign-off from the Public Service Association, in particular, but also for people who will be involved, not the least FAYS workers and managers, to undertake the workload analysis to look at areas of concern and to measure current and forecast service demands.

We are going to undertake an analysis of socioeconomic and trend data with respect to social need and the consequent workload pressures that result for Family and Youth Services. The analysis will review the way in which the services are being delivered, ensure that there is appropriate integration between appropriate agencies and recommend a workload management tool and funding model. It will recommend a sustainable budget for FAYS that is based on the workload management tool and the funding model. I have asked this group to report as soon as possible, because I am greatly concerned about particularly the children under the guardianship of the minister—that is, me—and also the reports that I have had that there may be others that are not receiving attention to the required standards because of workload pressures.

As people here in the chamber today would know, a number of concerns about workload pressures have been raised in the past few days and weeks. As I told the parliament on 5 June, we have now introduced the resource prevention intervention (RPI) system and have again started to collect information about occasions on which Family and Youth Services district centres do not have enough resources to investigate child protection notifications. I remind the honourable member that the RPI system was introduced by senior social workers in 1997 to ensure measurement of unallocated work—so this was the tool being used at that time—and to offer employees protection against excessive workloads.

The Robyn Layton report says that, in response to demand, overload of the use of RPIs increased dramatically from 176 cases in 1997-98 to 1 014 in 1999-2000. As a result, FAYS received an extra $1 million from the government to take on more staff in return for abolishing this system of RPIs. Not being a cynical person, I really question why that may have happened. I am sure it was in good faith, but it seems to me that throwing $1 million at an issue and then asking people to stop using the work measurement tool is a fairly unusual way of fixing an issue. However, as I said, I am not cynical, so I wonder about that.

In 2001-02, the official RPI figure is 294 cases. However, advice I have received certainly suggests that the effect of abolishing the RPI system has resulted in the overload being hidden from view, as many district centres are unwilling to record cases against this code. So, a major problem has been reported to me by workers within FAYS about the fact that this RPI system may have been useful but it disappeared as a statistical mechanism for getting an idea of what was happening with the workload. It seems that it was discouraged when the numbers were getting out of hand. I have not made this up; it can be found in the Robyn Layton report (pages 9.23 and 9.24).

In other words, the previous government had a systematic collection of workload data but, for some reason, this system of collection was abandoned. Now we have a whole lot of reports and claims about what the actual workload is but they cannot be backed up. I am sure that the workers are working very hard and that there is an overload. I have made it quite clear, particularly to the job reps in FAYS, that I am concerned and that we are not only going to get to the bottom of the workload levels and the stress that I believe those workers are under but we are also going to make sure that we have a clear idea of what is happening in Family and Youth Services in terms of the very important issue of the children under my guardianship (as minister) and also what is happening for children and young people in the child protection area.

That is why this steering group is important and needs to get under way so that that information can get back to us so that, as Robyn Layton said, we do not have a piecemeal approach to solving this serious issue; we actually have one that is backed up by information and facts so that we can set up a proper system for the future.

Membership:

Mr O'Brien substituted for Ms Bedford.

Mrs GERAGHTY: On page 2.22 of Budget Paper 3 there is an operating initiative for the Anangu Pitjantjatjara lands of 'improved health and wellbeing for AP communities'. Are there any initiatives particularly for young Aboriginal people?

The Hon. S.W. KEY: I understand that there is an ongoing youth development program placing Anangu youth workers in priority Aboriginal communities. This is another of the programs that is currently being rolled out by the Department of Human Services. Annual funding for this program totals $396 000 and includes a coordinator's position. Youth workers will be recruited and trained for the Amata, Indulkana, Fregon and Pukatja areas. As I said, it will be supported by a coordinator and a Youth Action Advisory Committee, which will include members and representatives from Anangu Education, Nganampa Health and the NPY Women's Council.

The coordinators position is currently being advertised. This will be followed up by the recruitment of youth workers. It is anticipated that the recurrent funding for each of the youth worker positions will be approximately $61 000 per annum. There are also a number of other ways in which the DHS supports the general Aboriginal community. I would like to identify a couple of those areas. First, there is the support for young Aboriginal women. The Aboriginal Service Division of the DHS provided $6 000 funding to the Port Youth Theatre workshops production. It is important to note that the Port Youth Theatre workshop is the only indigenous youth theatre company in the country. I understand that it is to be renamed the Kurrura Indigenous Youth Performing Arts.

The Wicked Sister, an Aboriginal women's emotional health and wellbeing performance project, will be performed at the Tandanya Theatre on 10 and 11 July. I encourage members to attend. There are a number of other projects that we are looking at under the DHS umbrella which are particularly focused on youth. Rather than take up the time of the committee, I am more than happy to furnish the member for Torrens with a more comprehensive list. The CEO tells me that we undertook to provide a more comprehensive list of initiatives, particularly in the Aboriginal services area, to the member for Morphett during the Minister for Health's estimates contribution, so we are more than happy to do that for members here.

Mr O'BRIEN: I refer to Budget Paper 4 (page 7.14), which lists a target for 2003-04 to develop a state carers policy and cross-government implementation plan for South Australia. Will the minister provide details of the plan that she intends to put in place through the Department of Human Services?

The Hon. S.W. KEY: On 22 October last year I announced the formulation of a state carers policy based on a commitment articulated in the Labor Party election platform. I also announced on that day that I would establish a ministerial advisory council on carers and caring and community. There will shortly be an announcement about that body. I believe this is the first time in Australia that there has been a focus by a ministerial advisory council on carers and caring. The policy will detail the government's commitment—and this is one of the things that I want the ministerial advisory council to assist me with—to unpaid family carers who provide personal care for family or friends, frail or aged or who have a disability or some other condition requiring their support.

The government recognises that issues relating to carers are not contained within certain portfolio boundaries. Although I have the lead responsibility for this policy, my cabinet colleagues are aware of their responsibility in this area as well. I look forward to the ministerial advisory council guiding this process, and I will ask the council to provide me with details about engaging carers, care recipients and service providers, and also to look at issues that relate to carers.

We are very lucky in South Australia: we have a very fine network of carers and we also have a number of activities in regional areas. In fact, the members for Morphett and Colton and I were very privileged to be at a function recently at Port Adelaide—one of the many functions that certainly the member for Morphett and I have been to—on the part of the carers association. We have a very good activist group and they are very pleased not only with the support that is shown by all members, certainly the House of Assembly members, to carers in their own region and also with the concept of having a ministerial advisory council that will advise government on specific issues to do with carers and people caring in the community.

The CHAIRMAN: I remind members that if all questions are not asked there is the opportunity to put them on the *Notice Paper* rather than reading them into the record now.

Mrs REDMOND: I will skip the omnibus question and put that on notice in writing, but there are a couple that I want to ask. The first relates to some earlier questions that the minister has answered about the FAYS staff. I was particularly curious as to whether recommendation 39 from the Layton report will be implemented and whether it has been costed in particular. That recommendation is for the DHS to undertake a comprehensive review of all human resource management policies and practices within FAYS. I will not read the whole thing, because it goes on for a long time, but it specifically refers to reducing the number of contract staff, increasing the level of skill of the work force, and the one I am particularly interested in is that DHS develop a business case for Treasury which looks at providing appropriate classification and wage parity for FAYS base grade social worker level in line with other social work staff across DHS. I took it from my reading of the report that for some reason they do not have wage parity at this stage with other social workers, so I want to know whether costings have been done to implement that recommendation to bring those social workers into line with others in DHS.

The Hon. S.W. KEY: The point I was trying to make about the Robyn Layton report is that we have done a lot of work in the portfolio with regard to the future, and this is certainly part of that. That is one of the areas that we are taking on board to look at. I understand that part of what the honourable member has quoted will come under the umbrella of the terms of reference for the work levels and workloads issue. I will ask the CEO to respond to the question about the specific classification levels. I also say that as this work gets done I am more than happy to make sure that members are up to date with our progress in rolling out the report itself.

As Robyn Layton said herself and what is said in the report, this is something we need to do over a period of time. I am still waiting for those public comments to come back—and I am emphasising 'comments'; I am not looking for people to rewrite submissions and start the whole process again. It is important, now that the report has been published and is available both on the web site and certainly in hard copy form, that there be a further opportunity for people to comment. That is why we have extended the consultation

period. I will hand over to the CEO, who might be able to answer you more directly.

Mr BIRCH: First, it is my understanding that there is wages parity in social work. I think what Robyn Layton was particularly referring to is that there is a differential in classification between social workers employed in areas such as child and adolescent mental health services, who often start at a basic grade level of PSO2, and social workers in the FAYS area who start at PSO1. The workload assessment process which the minister refers to and which indicated that terms of reference would be made available goes beyond simply the measurement of workload: it looks into some of the organisational aspects of the classification and work structure, and we expect to pick that up. In answer to your other question, we are undertaking impact statements of all the recommendations of the child protection review to provide to the minister, so that, if the government were to agree to recommendation 38 or 39 there will be some indication of what would be the likely cost implications.

Mrs REDMOND: I have another question on the status of women. Although the minister did not mention that in her opening remarks, I cannot find anywhere else in the budget papers for me to address this question to this minister.

The Hon. S.W. KEY: It is my understanding that there will be an estimates examination process for the status of women, the housing portfolio and also the Office for Youth part of my responsibilities next Tuesday.

The CHAIRMAN: Yes, at 3.30.

Mrs REDMOND: As long as that is on it I do not need to ask that question at the moment.

The Hon. DEAN BROWN: In terms of the disability area, I find it hard to assess these budget papers, and I want to clarify where the state growth funding is for the Commonwealth-State Disability Agreement. Given that you wanted some figures, I look at page 7.6, where it refers to an increase in the commonwealth contribution of $1.72 million.

The Hon. S.W. KEY: I suggest to the honourable member that probably the reference that you are looking for is Budget Paper 3 on page 2.22.

The Hon. DEAN BROWN: That is where it refers to the $350 000? That is the point I want to ask about. In light of that, where is the South Australian government's growth for the new Commonwealth-State Disability Agreement to be found in the budget papers? Why do the budget papers outline only $350 000 in extra state funding, whereas the commonwealth contribution is $1.72 million? How do those figures equate to what the minister said earlier in her opening comment about a 5 per cent increase in funding each year? How can the state government commit to five year funding with the annual average increase of over 5 per cent if these figures are not transparent in the budget papers at present? Why are they not transparent, and will the government make sure that they are transparent?

There is a huge imbalance between what appears to be the commonwealth increase and the state increase, and there does not seem to be any matching funds from the state and, therefore, it does not show up. If you look at page 7.15, disability services, for instance, the increase in funding from one year to the next, even on the budget, is nowhere near over 5 per cent. From last year's budget to this year's budget it is probably 3.8 per cent, or something like that. Certainly, when you look at disability services on page 7.67, there is no increase in state funding from what was spent last year and what is budgeted for this year. So I am having some trouble understanding exactly where those figures have been buried or whether they even exist.

The Hon. S.W. KEY: If this is acceptable, I will start with the answer and I will also ask David Filby to add to my answer. I understand the difficulty in trying to see that in the budget papers. I think one of the points I need to make is that we are about to sign the new agreement, and so the negotiations between the states and territories and the commonwealth minister have been taking place (as the shadow minister would probably know) for quite some time now. It has been only recently that we have been able to come to agreement, and the matter has gone through cabinet. So I think some of my answer is that the timing has been a little difficult with regard to transparency for these particular budget papers.

I think I may have already made this statement in the past, but the state government has agreed to increase the funding for disabled services by 5.14 per cent each year over the next five years, and that will be a total of $97.4 million. In turn, the commonwealth will increase its funding for accommodation and support services by a total of $32 million over the same period. So I am pleased to say that a total of $129 million additional funding over the next five years will be available for a combination of respite services and improved equipment for people with disabilities in South Australia. The commonwealth government has also announced substantial additional funding for specialist disability employment services under the Commonwealth, States and Territories Disability Agreement. This assistance is welcomed by us and will certainly be of benefit to South Australians who want to improve their living standards and also their participation.

So, the South Australian government will spend nearly $100 million extra over the next five years on services for people with disabilities and their families. There are some particular programs: we will be assisting 75 school leavers with intellectual disabilities to access the Moving On post-school program (which the shadow minister would be aware of), which provides supported accommodation and employment opportunities; we will be in a position to build more special community group homes, each housing four people with severe disabilities (as I think would be known), and there are currently 200 people on the waiting list; and we will be in a position to increase the assessment, purchase, repair and reissue of vital rehabilitation equipment. This will help move people out of institutions and into supported community living arrangements and also provide a whole lot of support for children under 16. We will be looking at respite care and increased therapy and behaviour management services for children up to the age of eight years of age.

So there are many more programs we are looking to with this funding and I think that the shadow minister would agree that this is good news in the disability area. So, over the next five years, the total disability services package amounts to more than $1 billion. This is really good news for South Australia. I am sorry that this good news is not particularly apparent in the budget papers but it is because of the mismatch, I suppose, of the ongoing negotiations we have been having, particularly with the commonwealth, but also we have been looking at trying to finalise the negotiations. I am just reminded that the actual agreement—having been involved in these negotiations—started in 2002-03, because there have been extensive discussions and ministerial council meetings. So, it is not the next five years, it is retrospective to 2002-03. Even so, it is still good news in the disability area. It will not mean that we will not have need and it will not mean that we will not have waiting lists, but it will

certainly go a long way towards making services and support in this state much more positive. On the specifics that you have asked, shadow minister, I will get David Filby to illuminate what I have just said.

Dr FILBY: The figures that are represented on page 2.22 are the changes to the forward estimates from next year onwards—necessary in order to match the 5.14 per cent that the minister represented. The reason that the figure in the first year is so low is that there were significant additional monies for disabilities provided in the 2002-03 budget which had further adjustments in the forward estimates in subsequent years, in last year's budget papers. So, it only requires the $349 000 in order to ensure that the 5.14 per cent is found in 2003-04 but larger sums are required in subsequent years to ensure that the full commonwealth matching is provided.

The Hon. DEAN BROWN: Can we have some further clarification on that—and I appreciate what you have given me—because I would appreciate knowing what the increase was then in 2002-03. Have you got the figure there?

Dr FILBY: I do not have the papers with me but we can get it and provide it.

The Hon. DEAN BROWN: If you can get it.

Dr FILBY: We know what the total is.

The Hon. DEAN BROWN: But I notice then that in 2006-07 the increase is $9.425 million. Does this mean that it is somewhat tail-end loaded?

Dr FILBY: The percentage increase is the same percentage for each year: the funds that were provided as growth funds in the 2002-03 budget were predominantly over the following three or four years. So it did not actually pick up all of the last year of the agreement. But we can provide to you the figures that were shown in the 2002-03 budget and, taken in conjunction with the figures represented on page 2.22, they represent the full 5.14 per cent.

The Hon. DEAN BROWN: All right, I would appreciate that.

The CHAIRMAN: Does that conclude your answer to that question?

The Hon. S.W. KEY: Yes. Perhaps the other point I should say is that the commonwealth employment programs of $212 million will be over the same period of time. I do not want there to be a misunderstanding about the commonwealth employment programs. They are obviously very important too.

The Hon. DEAN BROWN: Yes.

The CHAIRMAN: Thank you minister. Member for Finniss, third question.

The Hon. DEAN BROWN: Sorry, the second?

The CHAIRMAN: Third question. The member for Heysen's question was part of this bracket.

The Hon. DEAN BROWN: The third question, then, relates to the post-polio support group. I met with them recently as they have some concerns. They have moved out to the independent living centre on Blacks Road and they are very pleased to be out there. They have gone there with the Communication and Therapy Services and they were with the Crippled Children's Association, as the minister would probably appreciate. They have office space and office support facilities, but they do not have immediate access to physiotherapy services on site. They have indicated to me that Ann Buchan is the physiotherapist with the best professional understanding of post-polio disabilities.

As the minister would understand, this group of people had polio and, because they are now getting older, suddenly they are facing significant disabilities. Ann Buchan happens to be a private physiotherapist. They were told by the minister's department that they could not give the funding to her—they receive $40 000 each year. They would like to engage her services but by using the $40 000. Could some means be established whereby they could engage her as the physiotherapist, if need be through the Independent Living Centre? However, they need a physiotherapist. In terms of a hydrotherapy pool, they could use the Royal Society for the Blind pool. I have also suggested that they approach the Repatriation General Hospital, which allows outsiders to use their pool at a cost of $3 an hour, and they have gone to look at that. Could the minister investigate whether the $40 000 that they are not spending on office support and so on could be used to engage Ann Buchan?

Certainly it would appear to me that there is no difficulty in doing that. Apparently she is an extremely competent physiotherapist with an understanding in this area. They would like some help in trying to resolve this problem because, at this stage, they do not have physiotherapy services.

The Hon. S.W. KEY: I thank the member for a very specific and important question. Many members would have seen the recent reports in the media about concerns for older people who suffered from polio, particularly in their youth. I would certainly be happy to take up the matter and respond to it outside the estimates process. However, for a more specific answer about progress in this area, I will refer to Dr Caudrey.

Dr CAUDREY: Earlier in this financial year, we were approached by the Crippled Children's Association which runs an adult therapy service called Communication and Therapy Services. They said that they wanted to refocus on children and asked us whether we would reauspice their adult therapy services. We undertook to do this, and the most appropriate place to reauspice them was to the Independent Living Centre. That is due to happen on 1 July. One of the small problems associated with it is that theirs is an $800 000 program and only $603 000 is government funding. We have had to negotiate the process of transfer because the Crippled Children's Association was directing its fundraising to its children services.

We believe that, through management rationalisation, we are able to offer a service which is almost as good as what the Crippled Children's Association was offering. It will be at the Royal Society for the Blind site on Blacks Road. There is a pool at that site and there was some earlier discussion about the post-polio program, which is part of an adult therapy service, also transferring with it. Physiotherapists will be employed by the Independent Living Centre. In fact, all bar two of the existing staff of the Communication and Therapy Services of the Crippled Children's Association elected to transfer to the Independent Living Centre. I believe that the other two took packages and decided to work elsewhere. Therefore, there is continuity of staff and it is my understanding that they include the people who were working previously with the post-polio group.

Either Ann Buchan approached us, or a group approached us, about whether Ann Buchan might take over the post-polio service. After discussion, it was resolved that it would transfer with the adult therapy service, and I thought it was by agreement with the post-polio group. We are certainly able to look into whether Ann Buchan is the physiotherapist who is employed with this grant, which is specifically earmarked for post-polio. It is a fairly new program: it has been going

for only about three or four years. It seems to have been a very beneficial program, so we would certainly want it to continue.

The Hon. DEAN BROWN: I will add one small point. There is no ramp into the pool owned by the Royal Society for the Blind. These are people who, because of their disability, cannot get into the pool unless it is through a lifter, which is pretty inconvenient. If a small ramp could be purchased as well, that would help significantly their being able to use the pool.

The Hon. S.W. KEY: We are certainly happy to take that on board. I think Dr Caudrey has answered the member's question, but certainly we can follow up on that as well.

Mr CAICA: Can the minister outline the priorities for the additional disability services expenditure as detailed on page 7.25 of Budget Paper 4, Volume 2?

The Hon. S.W. KEY: It is important to outline that, through the disability budget for 2003-04, $2.5 million additional growth money will be available with priorities for the allocation of new recurrent funds in the areas of community access services, including the moving on project. I think I mentioned earlier that this will include $750 000 for 75 clients who are mostly school leavers with severe multiple disabilities and who cannot gain employment because of their disabilities. There is also an amount of $100 000 for community access services for APN clients, and I am told that 10 clients are on an urgent waiting list for a support package. The amount of $150 000 has been allocated to community access services for BIOC clients, and I am told that 15 clients are on the urgent waiting list for a support package.

In the equipment area in particular, there will be $400 000 for equipment for adults under the Independent Living Equipment Program (ILEP)—again we are besieged by acronyms in the disability area—and again I am advised that 150 clients are on the waiting list. In the family support services for autism association clients, $100 000 has been put aside for 25 clients in need of a support package. In relation to services for Aboriginal people, particularly in the APY lands, $400 000 has been put aside for 25 clients requiring accommodation, respite and day support. In relation to accommodation services for very high need APN clients, $450 000 has been set aside to establish a four person group home. Family support services for the Royal South Australian Deaf Society clients will receive $50 000 for packages for 25 deaf clients.

Family support services for the Crippled Children's Association, including respite and home support, has been allocated $60 000 to look after 12 clients. Family support services for Cora Barclay Centre clients will receive $40 000, and I am advised that that will be of benefit to 16 clients. We are looking at 357 people with disabilities in South Australia being assisted through these different and important programs which I have just outlined.

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

Mr CAICA: I refer to the budget for disability services discussed in Budget Paper 4, Volume 2, program K5.2 (page 7.26). What provision in this budget is made to assist families with children with autism spectrum disorder?

The Hon. S.W. KEY: Following an administrative review of people with autism in South Australia, the Director of Disabilities Services Office (who just happens to be sitting next to me) has been working closely with the Intellectual Disability Services Council and the Autism Association of South Australia in reviewing current services for 1 350 South Australians with autism spectrum disorder. A key finding of the review, which was undertaken by the Disabilities Services Office and involved a number of key parties including Autism SA, IDSC and parents, identified the need for renewed emphasis focused on family support. In response to the need that was identified, there has been an increase in recurrent funding of $100 000, and that has been made to the Autism Association of South Australia to provide improved family support for its clients in 2003-04. In addition, the Disability Services Office is providing funds of $10 000 to the Autism Association of South Australia to develop a new strategic direction, with an emphasis on improving family support.

Ms BEDFORD: My question relates to the SASRAPID autism program. What provision is made in the disability funding for 2003-04 (and this is detailed in Budget Paper 4, Volume 2 (page 7.25), to reduce waiting times for children with autism spectrum disorder accessing SASRAPID program?

The Hon. S.W. KEY: Yet again, we have another acronym! SASRAPID is the South Australian Sport and Recreation Association for People with Integration Difficulties. This organisation provides opportunities for people with integration difficulties to become involved in community sport, recreation and leisure activities. I have received a number of letters from concerned parents of children with autism who have not been able to access the aquatic therapy program which is an excellent early intervention measure. I have observed the SASRAPID program very closely. Indeed, I have tried to beat the person in the next lane to me when I have been swimming. However, she has improved so much that, despite the fact that she is a quarter my age, she quite often beats me when we are doing laps. It is a really important program and it is—and I have observed this from my own experience not just in the pool—also a recreational program that has been very positive with regard to giving people going through the SASRAPID program some confidence and also some coordination in other activities in addition to swimming.

James Rundle, who is the ministerial liaison officer in the disability and youth area, and I went to visit SASRAPID, and I have to say we were really impressed with not only the dedication and the work of the people there but also the vision they have in trying to integrate recreational facilities for people with different disabilities. On the basis of the proposal that they put to us, which I have to say was extremely professional, and also from the advice that I have had from the Disabilities Services Office, the government has agreed to provide an extra $30 000 to this program to provide additional places in the aquatic therapy program, targeting children with autism spectrum disorder. This additional funding will double the number of places available under the program and significantly reduce the waiting lists and obviously assist a number of parents who are quite anxious to get their young people into the program.

One of the things that has been discussed—and the shadow minister alluded to this—is that there has been a hunt to try to find available swimming pools that are easy to access for people going through the SASRAPID program. There is a lot of support in the community, and a number of organisations that have swimming pools have been talking to me about whether they can help with the program by making their swimming pool available. So that would certainly make

it easier for people to access the program and a swimming pool, particularly ones that are under cover.

Mrs REDMOND: The Layton report dedicates a whole chapter, chapter 14, to children and young people with disabilities. In that chapter, Layton cites the United Nations Convention on the Rights of a Child, namely, 'The right of a child with disabilities to enjoy a full and decent life in conditions that ensure dignity, promote self-reliance and facilitate the child's active participation in the community.' She then goes on to make 11 recommendations, those numbered 80 to 90 in the report. How many and which of those recommendations will the government be implementing in the next year? I note that there is an increase in funding but it does not look to me—referring to page 7.25 under disability services, in program K5—as though there is sufficient there to implement those recommendations. Is the minister able to give me an indication as to which, if any, will be implemented?

The Hon. S.W. KEY: I will not make a technical point about the reference that the honourable member has used. Chapter 14 of the Robyn Layton report, 'Children with disabilities' has a number of recommendations, as you have quite rightly pointed out. There are two points I would like to make, one of which is that we are still looking for further comments on the Robyn Layton review through the process I described earlier. There have been advertisements in the paper seeking further comments on particular areas on which people in the community may like to focus. As I understand it, there has been some interest, particularly from services in the disability area, in following through—on a whole lot of levels to do with the protection of children but also on specific programs.

We still probably have a few weeks to go before that part of the consultation is finalised. So, it may not appear in this budget because of the timing. The Layton report was made public in March, so we are still following through with that process. The second thing is that it would be important to consult and work with the various interest groups and organisations, both within government and in the non-government sector, to roll out some of those programs. That would be the other reason why it would not appear in the 2003-04 budget. I will ask the Director of the Disability Services Office whether he has anything to add.

Dr CAUDREY: It is certainly the case that a lot of the disability funding for things such as respite for children and intensive in-home family support and behaviour management programs, things that come from the disability services budget, actually serve to assist the processes around child protection. They assist families to maintain their integrity and to be able to look after a child without the child sending the family into an extreme situation. We work closely with the child protection part of the department to ensure children with disabilities get the same sorts of services as any child who is confronted with a child abuse situation. When a child has very challenging behaviours, for example, autism, then the family often finds itself under extreme stress. For example, children who wake very early in the morning, smear faeces around the house or beat up a younger baby, or things of that kind, under those circumstances any family would be thrown into quite a stressful situation. It is important that we in disability services, with our budget and our programs, work closely with FAYS around child protection issues.

The Hon. S.W. KEY: I will also ask Roxanne Ramsey, who is the executive director, whether she would like to add to what Dr Caudrey has said.

Ms RAMSEY: Thank you, minister. Whilst the government is still considering the review recommendations and what the response will be, a number of recommendations thread throughout the Layton report refer to government and agencies working better together. A number of recommendations refer to the disability sector and Family and Youth Services working together more closely and, in a sense, having seamless services. That is something I do not think anyone will dispute; everyone agrees with it. Those processes are already in train in terms of the disability sector and Family and Youth Services working together much more formally so parents do not have to go from one service to another.

Mrs REDMOND: I cannot point to a specific budget line—in fact, I seek the minister's help on whether there is a specific budget line. In my electorate I have, and I am sure most members in their electorate have, the situation of parents who have raised children with significant disabilities. As the parents age, become frail, or even die, they are concerned to a heartbreaking level as to what will happen to those children who cannot be imposed on siblings. They have been raised in a home environment and they do not wish to institutionalise them. I noted the minister referred to a waiting list of 200 for community placement in supported accommodation. Is there any specific program to start to accommodate those people who have been raised by their parents and who have not cost the state, as they could have cost the state had those parents chosen to institutionalise from the outset? They have chosen to give their children the best they could. They have not institutionalised their child, but they need assistance once they become aged, frail or pass away.

Membership:

Ms Bedford substituted for Mr O'Brien.

The Hon. S.W. KEY: I refer the member to page 7.26 in the budget papers, which refers to performance indicators. It refers to community accommodation and care places, and also institutional and large residential facilities. Certainly, there is reference to the work which we wish to continue and which has been important. I will ask Dr Caudrey to be more specific about some quite exciting programs that we are involved in at the moment.

Dr CAUDREY: In this financial year $2 million was available for supported accommodation for people with intellectual disabilities. In the recent past, there have been considerable sums, both commonwealth and state, to support what has been loosely described as ageing carers—people who have cared for children for a long time but who are getting old. This is a new phenomenon because people with disabilities are living longer; it means they are often outliving their parents in ways that did not used to happen. The whole stress on that situation, where someone has a child now in their 40s or 50s and they are in their 70s or 80s and getting very frail, is the area where we look for the highest priority of access to new supported accommodation money. The $2 million has bought about 40 places of one kind or another.

When parents can no longer care for their children because they have died or have become too frail and the person needs supported accommodation we obviously look for what is described as the least restrictive alternative. If a person is able to live with tenancy support in their own accommodation or to share with a friend, then we put in the support to assist that process. Unfortunately, many people require a high level of support and then we put three, four or five people in a group

home. We are constantly juggling the highest priorities. Among the 200 people on waiting lists, there are quite harrowing cases of people who have been caring for a long time. We have to try to work out who is the highest priority. Often the highest priority is the person whose parents have just died. They have to be dealt with and they have to be provided with a home.

Mrs REDMOND: Do you have any evidence as to how many of those people we have in the state? Some people to whom I have spoken are concerned that they are not on the record books, because they have been raised in the home. Do we know how many people we have to accommodate?

Dr CAUDREY: We know how many people have come forward to go onto the IDSC waiting list—that is over 200 people. Whenever we provide accommodation for 10, 20 or 30 people, another 10, 20 or 30 people replace them. We do not know the situations where people have not come forward and said that they want a supported accommodation place, although we believe that people, who are getting older and who are aware of the pressure that is upon them, tend to put their name down with IDSC. Often people, knowing there is a waiting list, will put their name down quite early. They will prepare for it. They will say, 'We don't really want something now but we know we will need something in five years or 10 years, so we will get in now so we can be on the waiting list.' There is quite a heavy demand.

The Hon. DEAN BROWN: My question is in relation to the report done in 1999 called the 1424 South Australians Report. This report, which was done by project consultant Vic Symons, related to deinstitutionalisation of those people living in institutions. It went through a number of major government institutions, including Julia Farr, Minda, IDSC and Bedford Industries. What is the government's current position on the recommendations in that report on deinstitutionalisation? I know you mentioned something in your opening remarks. It was a little hard to catch all the comments there, but what is the government's policy towards that? Is the government committed to deinstitutionalisation? What is the estimated cost of implementing such a plan? Do you envisage that Julia Farr would close as part that? What about private organisations such as Minda and Bedford Industries? I think Balyana, which is part of Bedford Industries, would be affected, as well.

The Hon. S.W. KEY: I am just wondering what the reference in the budget is from the member for Finniss. I suggest to him that it might be page 7.88.

The Hon. DEAN BROWN: It comes under the disability line, and the minister mentioned it in her opening remarks. It is page 7.88, although it is a little wider than that, because I also mentioned Minda and Bedford. Page 7.88 covers IDSC and Julia Farr.

The Hon. S.W. KEY: I am quite happy to give the honourable member a general response but perhaps refer again to Dr Caudrey for some of the more detailed part of the question that the honourable member asks. Interestingly, I was at Balyana last week and had the opportunity again to look through what I think are very good facilities there, both for people starting to move out of institutions into their own self-contained units through to some of the group home work that is being done there. I think it is a very positive example that Bedford is looking at people with disabilities in a very holistic way, encouraging those people to be as independent as possible.

We are working in a whole lot of areas with regard to increasing the number of community-based accommodation places for people with severe and profound disabilities. As members will know, South Australia is behind other states and territories with regard to moving people from institutions into community-based accommodation, although that is still happening. People in this chamber may be aware that in May 2003 we had 940 residents in five institutional facilities. There is a high priority on assisting people with disabilities to reside in community settings by promoting alternatives to institutional living. When I say that, I am assured from talking to a number of people considering community accommodation that this is done by virtue of offering a choice, not by pushing people out of institutions.

I suspect that a number of people who live in institutions will continue to live there because that is their home and that is where they feel most comfortable. What we are trying to do, and I think this has been an ongoing philosophy, is to offer residents who wish it the opportunity to relocate in smaller community-based settings. As the funds become available—and Dr Caudrey partly answered this in his last answer to the member for Heysen's question—we have been looking at strategies to prevent inappropriate admissions to institutions. We have been looking at admission protocols and committees to make sure that clients are admitted to an institution only as a last resort. I think the member for Heysen raised the very important question about parents and people who have had ongoing care responsibilities. This is also connected with what the options for those people end up being.

In the previous two years, 2000-01 and 2001-02, 52 people moved from institutional care to community-based services; 25 people moved from the Julia Farr Services campus at Fullarton into community accommodation; and 27 people moved from the Strathmont Centre into community accommodation, allowing for the closure of one of the villas on that campus. The other strategy, to support people in smaller community-based accommodation, has involved getting disability agencies to work in partnership with the generic aged-care providers to support people with disabilities who are ageing in their homes. There has also been $2 million of new accommodation funding provided for people with intellectual disability, used to support an extra 50 clients in the community.

One of the targets for the Disability Services Office is to work with Minda to move another 25 people into community-based accommodation and also to assist 150 clients to move off the Strathmont campus into community-based accommodation options. The sort of money that we are talking about here is $18.4 million capital over four years, plus $3.5 million extra recurrent by 2006-07. We are hoping that in 2003-04 another 25 people will be relocated from the Julia Farr Centre into community-based services, and the Disability Services Office is also working with various housing authorities to improve planning for disability accommodation in the State Housing Plan framework.

Referring back to the member for Heysen's question, there are a number of quite exciting proposals from the Disability Services Office, as well as the other parts of the portfolio, because I think they do all link up very well to work together, particularly in housing, to come up with some alternative accommodation places that may involve partnerships with the non-government sector and with the private sector and private individuals. So, we are looking at a whole range of alternatives to try to make real the whole proposal that people should live in community-based accommodation and that we actually do have some real choices for people in that accom-

modation. But, I will ask Dr Caudrey to answer your more specific questions.

Dr CAUDREY: I would just add that the Vic Symons report into 1 424 South Australians in 1999 was dealing with the over 1 000 people who were living in disability institutions at that time, but he also included in that report the people who were living in mental health institutions, Glenside and Hillcrest, which were still open at that time. So, it is wider than what we would normally call disability services. Of course, since then a number of people have moved into the community and we are now down to 940, and at the end of the Strathmont process it will be 790. So, progress is being made. Only 56 per cent of our disability accommodation is community-based in South Australia, which is the lowest state of Australia. Some states have completely deinstitutionalised, so there is still some work to do in terms of moving towards community options.

A lot of people in institutions want to move: a lot of people do not want to move. But one thing that tends to be the case is that people, when asked whether they would like to go into an institution in the first place, mostly choose not to. As the honourable member said earlier, people really want to stay in whatever environment they are used to, where there is the least restriction they can possibly have.

The Hon. S.W. KEY: There is an additional point I wanted to make about the whole area of respite care. I think that both the member for Finniss and the member for Heysen have alluded to accommodation and to future accommodation for people with disabilities, particularly when their carers are finding that they cannot provide that care any more. A lot of work has been done in conjunction with the commonwealth with regard to providing carer respite, and I think it is important to note that part of the previous commonwealth, state and territories disability agreement was directed at respite services through a whole range of programs. I am told that the current figures are not available until July 2003, so that is information I would be happy to provide, particularly to the member for Heysen, if that better answers her question.

I am told that in 2001-02 Home and Community Care services provided 155 211 hours of respite. This is the other part of the caring package that I guess we need to bear in mind. Throughout the commonwealth Department for the Ageing and the ageing and community care programs for 2003-04, one of the things that is being looked at is the gaps and difficulties that occur between those portfolios, to try to make sure that we have a better respite and support system. Again, this is one of the things across the Social Justice portfolio that we will look at to make sure that we match needs with services and vice versa.

Mrs GERAGHTY: I refer to Budget Paper 4, Volume 2 (page 7.26), sub-program K5.1. How will this funding reduce the waiting periods for the provision of equipment for people with disabilities under the Independent Living Equipment Program?

The Hon. S.W. KEY: The Independent Living Equipment Program is very close to home for me at the moment, because my father and I are about to visit this area. So, I not only have a ministerial interest in this area but also a personal interest, which I probably should declare. The member for Finniss and I had an opportunity recently in his electorate to look at some of the gophers that are available, and he was very adept at operating these machines. Many of us, particularly House of Assembly members, have had issues raised with us from time to time about the provision of equipment for people with disabilities. This is a big issue. When one looks at the demographics and the number of people who need assistance, one sees that it is a very important program.

A refocus on the Independent Living recruitment program was completed recently by the Disability Services Office, and that is currently being implemented. I am sure all House of Assembly members will be relieved to hear that a more streamlined service is required because of the waiting lists of clients. The government, through the Disability Services portfolio, has provided extra resources to employ a project officer/coordinator to assist in the implementation of this program, and we have also allocated $6 330 000 in recurrent and one-off funding to make sure that we can reduce the waiting list for adult equipment in this area.

I think this is a considerable resource that is being put into looking at this waiting list issue. There is also one-off funding of $970 000 for equipment and $150 000 for continence services—a total of $1 120 000. Continence services are provided to, in particular, the Crippled Children's Association, for equipment specifically for children. I am advised that the waiting list in the children's equipment area has also been improved. We recognise this as a very big issue, and we are putting considerable resources into it, because we understand the need for and the importance of the Independent Living Equipment Program.

Ms BEDFORD: I refer to Budget Paper 4, Volume 2 (page 7.88), program K10. What is the government doing to reduce the cost of administration expenses for government agencies operating within the disability sector?

The Hon. S.W. KEY: The first point I want to make is that we are very aware that there are varying administration costs for different government agencies in the disability field. There is a commitment to reduce overheads to maximise funding available for people with disabilities. So, obviously it makes good sense to have this as a priority. With this in mind, it is planned that all corporate services within the government disability sector will be consolidated to provide a cost-efficient arrangement. This will include: accounts, payroll, IT, training, and human resources.

This is something that the whole of government is looking at as well, because it is not just the disability area that needs to rethink all of this. To this end, a shared corporate services management arrangement is being explored across all government services in the disability sector. This will include: IDSC, Julia Farr Services, the Independent Living Centre, and Options Coordination. The aim is to reduce administration costs for government service provider agencies to less than 10 per cent of gross operational budgets.

Julia Farr Services currently operates with administration expenses in the order of 14.1 per cent, which is $4.63 million of the gross operational budget of $32.78 million. So, we anticipate through the consolidation and sharing of these services that expenditure on administration can be minimised. Expenditure on client services will obviously be an area that we will increase and maximise. We believe that, by going through this process, agencies will be in a better position to provide services and get waiting lists down, something which really needs to happen as urgently as possible.

The Hon. DEAN BROWN: One of my constituents would like to know what has been the expenditure during the last financial year on the Century Options Agency.

The Hon. S.W. KEY: I am more than happy to supply that information for the honourable member.

The CHAIRMAN: We will now move to the ageing line.

The Hon. S.W. KEY: I will ask Mr Chris Overland, the Director of Ageing and Community Services, to join us at the table.

The CHAIRMAN: Does the minister have an opening statement?

The Hon. S.W. KEY: Like the member for Finniss, I tried to coordinate the six areas for which I am responsible in my opening statement. I am not sure whether the shadow minister has an opening statement, but I do not in this area.

The Hon. DEAN BROWN: I wish to ask a question about the administration of retirement villages under the Department of Human Services. I bring up this matter under ageing because it is to do with ageing, and it comes under page 7.27 of the budget. As you know, we have carried out a review of the regulations, and when I was minister I initiated a review of the act itself, but there is considerable concern over some of the regulations. I refer in particular to one that has been raised with me—schedule 3, sections 5 and 6 of the regulations under the act—and that is the one that requires consultation with residents. I have had correspondence and a subsequent discussion with a resident of Fernleigh in the southern suburbs.

When that retirement village has a proposal they put it together on a one page sheet, send it out to the residents and put down at the bottom that they agree or do not agree with the above proposal. They get it back and those who are absent or who do not return it are taken as accepting it. It is only those who actually send back a formal objection who are taken as objecting. Because the majority are not returned because the residents are away or do not bother to return it, all these proposals tend to go through. The regulations are quite clear. It is not supposed to be a survey: it is supposed to be consultation, and there is no consultation.

This has a significant financial impact on the residents. For instance, the cost of a bus they wanted to purchase was put down against this and shared up amongst the residents, and various maintenance programs on the place were carried out in exactly the same way. Other matters include automatic gates and additional security lighting, where the $28 000 cost was shared amongst the residents. You can imagine. I can give you a number of examples that I have here, including $28 000 for that, some maintenance on 44 units at a cost of $2 500 per unit, $36 000 for another project and $33 000 for another project. So, there is a considerable financial implication in all of this and it is being passed on to the residents in a clearly unsatisfactory manner. I will quote what is said, as follows:

> Nowhere in the rules..is this more apparent that there is no rule suggesting what the administrative authority is forcing upon the residents of this village. It would seem that the administering authority can make rules that are not included in my contract and are harsh to the extreme. Allowing the administering authority this latitude in applying infringements of the Act and Regulations then the residents are not protected and it would be tantamount to allowing the administering authority free rein for whatever the administering authority wanted to do.

That was one particular complaint. I have another complaint, and I will not go into too many details, but I referred this one to you as minister concerning the Palm Gardens retirement village and what had occurred there. I have other examples, so there now is quite a significant occurrence within the community of residents who feel—and with complete justification—that they are being very harshly dealt with indeed by the owners and managers of the various retirement villages.

It would appear that, despite the review of the regulations, those regulations are not being appropriately administered and the residents feel they are not getting appropriate protection because, when they have complained to the department, the department has taken no action at all. I would first ask that you make sure that the regulations are appropriately administered. Secondly, where is the review of the act now and when will that review be available? If I remember rightly, we wrote out and asked for consultation or submissions on the review in about November 2001. That is at least a good 18 months ago. Where are the results of that survey? What were the general outcomes from it and what consultation is taking place generally so that we can progress towards legislative change of the act, as opposed to the regulations?

The Hon. S.W. KEY: The shadow minister raises a number of questions as well as specific examples. I agree with him that this is a very serious situation. I am told that there have been a number of calls and complaints, probably in the time when minister Lawson had responsibility and later the current shadow minister for this area. Apparently, in the past four years there have been about 2 300 calls on the retirement village area, and 75 per cent of them are related to financial and contractual issues. These have been followed up. There are still a number of active cases and I would suspect that they may include the two organisations that you have mentioned.

I am also aware of matters through the ministerial advisory committee. I might need to be corrected here; I think I have the same people on the ministerial advisory committee as you and the Hon. Rob Lawson had as ministers, and I know they have been working with the ageing and community services portfolio to try to get to a stage where we have a proposal for an act and regulations. The timetable that is being looked at at the moment is that after some further consultation and work that needs to be done we would be hoping to have a bill available for 2004. So, as I understand it, the timetable is still working ahead, as was intended.

As far as the specific issues are concerned, the member for Finniss is saying that there have been complaints with no action, so I probably need some more specific information from you so I can check it and respond directly to those claims that you are making. I agree that, obviously, if we have an act and regulations they need to be appropriately administered, and if that is not happening then that needs to be followed up, so I am happy to undertake to do that as well. It might be helpful if I ask Chris Overland as the director responsible for this area to respond to some of the points the shadow minister has made. On a bigger picture level it would probably be more appropriate if I got back to the member on those specific examples he has raised and any others he would like to furnish me with.

Mr OVERLAND: I think I have heard of the particular case you are alluding to through correspondence with the department and the minister. It would be fair to say that, in an industry with over 330 retirement villages and about 15 000 residents overall, we get remarkably few complaints, but we do have problems with a very small number of villages, one of which you have alluded to and one of which your colleague made an aside about.

The Hon. Dean Brown interjecting:

Mr OVERLAND: I think that may be the one.

The Hon. DEAN BROWN: That is probably the worst in the state, without dispute—or was; I am not sure whether it has changed.

Mr OVERLAND: That facility is the one where we have pursued legal action. One of the issues that comes up periodically is consultation with residents, and from time to time we do have problems with administering authorities where we think that they have strained the idea of reasonable consultation pretty hard. On the other side of the coin, we also have residents from time to time whose view about what constitutes reasonable consultation seems to be very onerous indeed. So, the department tries as best it can to conciliate where those sorts of disputes arise, but I have to accept that we never quite seem to get that right in the view of one or other of the parties. In relation to any future legislation, one of the aims will be to ensure that embedded within it is an improved power to administer the regulations more effectively than is currently available to us. All I can say is that, where we believe there has been a clear breach of the act or the contractual conditions that apply, we always pursue that.

The Hon. DEAN BROWN: Can I also clarify a couple of other points that I had asked to be looked at. With the pressure in the building industry at present and the large amount of building taking place, I am getting an increasing number of complaints from residents who are promised a retirement home by a particular date but who, some four or five months later—in sheer financial desperation—move into a partly completed home, having been urged to do so by the manager or owner of the retirement village. They are moving in and then finding it virtually impossible to get rectification of any building problems, or entirely unsatisfactory conditions, that might occur.

In one case, after heavy rain earlier this year, the resident went to step outside their house and found that there was a lake of about six inches of water right around the entire home because the promised paving and other work had not been finished. Again, that is an issue that needs to be dealt with because once the resident moves in there is just about no protection at all for them. They cannot financially afford to stay out and rent other accommodation when they are committed to a village. In many cases they have sold their home to move into a retirement village, expecting to be in there by a particular date and there is at least a six month gap in some of these cases. I ask that that be looked at as well.

Whilst I think it is fair to say that generally the majority of the managers or owners have a good attitude and want to abide by the principles of the acts and the regulations, when a breach occurs or when an opportunity for a breach occurs, some of them are taking advantage of that quite significantly and to their own financial advantage, perhaps against the interests of the residents. I think it is an area where, because older people are exposed within the community, it is very important that we make sure there is adequate protection for those people to achieve a fair outcome in any dispute that might occur. The matter I raised earlier concerning Fernleigh is a classic example where it would appear that the manager/owner continues to do whatever they like and put the cost of that out to the residents, causing significant financial hardship.

The Hon. S.W. KEY: I thank the shadow minister for that information, and we will certainly take that on as one of the important issues that needs to be dealt with. I have just received information to say that there is a meeting of the Retirement Village Act review scheduled for July. There is a discussion paper that is going to that meeting that I understand has been put together fairly recently, and the update on the discussion and the consultation that has been taking place that Mr Overland has just reported went on the internet yesterday. I think it would be helpful if members could access this, and we can provide an internet address. I will ask the CEO to provide that address.

Mr BIRCH: It is: http://www.dhs.sa.gov.au. In the menu you will find the various mechanisms to then get to that particular site, and it will be under 'Ageing'.

The Hon. DEAN BROWN: You can even take a photograph of the CEO off it! I have a copy here somewhere.

Mr BIRCH: I think I am in there.

The Hon. DEAN BROWN: I did not recognise him initially.

The Hon. S.W. KEY: Is it a very good photo, or a very bad photo?

Mr BIRCH: I have deteriorated in the last 15 years!

The Hon. S.W. KEY: It goes with the job!

The Hon. DEAN BROWN: I wish to ask a question about HACC funding. Minister, as we know, although the federal budget has offered HACC funding at 8.6 per cent, you have taken it up at, I think, 2.4 per cent of the additional funding offered. Of course, under HACC the federal government only matches what the state governments match, even though the federal government is putting 62¢ of every dollar in and the state government is putting only 38¢ of every dollar in. You issued a statement saying that you had adjusted HACC funding to ensure that it covered the rate of inflation at 2.5 per cent. That was covered in a press release you issued on 9 June. I point out that the budget documents that we have before us say that the inflation rate for the last year in South Australia has been 5 per cent and the projected inflation rate, according to the budget documents, for the coming year is 3 per cent. So, in fact, it is significantly less even than the inflation rate, let alone the 6 per cent wage increase we have had in the last year.

However, my main concern is that you have missed out on $3.1 million this year and, as you would understand as minister, whatever is the base this year becomes the new base for next year. So, if you miss out on $3.1 million because you have not matched it this year, you miss out on $3.1 million next year. Did your cabinet colleagues, and in particular the Treasurer, understand that when the decision was made not to match the HACC funds this year?

The Hon. S.W. KEY: It would be inappropriate for me to discuss at an estimates hearing the discussions in the cabinet room, so I will not be doing that. I also think that it is important to go back to the base of the question that you asked which is about the inflation rate. I do note, however, that included in the many media releases that came out responding to minister Kevin Andrews' and my joint media release on the HACC program, was a release from at least one of your colleagues, the Hon Barry Wakelin MP, who identified his delight at the increased funding for the Port Lincoln-Whyalla Home and Community Care area and welcomed the announcement that was made by minister Andrews and myself, and he also said that this was a really important initiative. But putting that to one side—

The Hon. DEAN BROWN: If I could have clarification on that, because I have seen that press release. That was for the 2002-03 HACC funding, and I am referring to 2003-04, which is what this budget is all about.

The Hon. S.W. KEY: Certainly. I thank the member for allowing me an opportunity to clarify the government's position in this area. As members would know, the 2002-03 financial year funding for HACC services in South Australia increased by $7.355 million, from $87.657 million to $95 million and $12 million, with an increase of 8.4 per cent. The

funding increase for HACC services will become available progressively during the next 12 months. The shadow minister would also know from the time when he was the minister for ageing and community care (preceded by the Hon. Rob Lawson) that there were a number of programs under the ageing and community care area, some 17 programs I think. One of the issues that has certainly been exacerbated in this past year is that the release of the 2002-03 HACC money was announced a fortnight ago, despite the fact that we are now discussing the 2003-04 financial year. There is a problem with the federal system's not matching up with the state system.

In this next year, we will be expending $95.012 million for the 2002-03 programs with an inflation rate—and I will get to the level of the inflation rate in a minute. We are always behind a year. As I understand it, minister Andrews is conducting a community services review because not only do the financial years not match up—and I am told by other ministers that this is a problem in other states and territories as well, so it is not just South Australia that is affected—but also the HACC funding, along with 16 other programs, are up for review at the moment and are being looked at by the commonwealth government. In South Australia's case, we have been working for some time to try to ensure that we match the services with the need in the community.

It is important to stress that in this next year we will be operating under the previous financial agreement that we had. As I said, we put in an extra $7.355 million. That is the first point. What the state government has decided to do for this next round of funding is to ensure that we index the funding by 2.5 per cent, and obviously there is a difference of opinion about what the appropriate inflation rate would be. I do not think that I am in a position at the moment to argue about inflation rates. I do not have that information in front of me, but I am certainly—

The Hon. Dean Brown interjecting:

The Hon. S.W. KEY: I am saying that I am not in a position at the moment to argue that point. While we have an opportunity to review the system, it is really important to ensure that we do not double up in particular services, which is the risk we have at the moment. In Budget Paper 3, page 8.2, the South Australian CPI for 2003-04 is estimated at 3 per cent, which is the point that the honourable member is making. I will not comment on that because I have not been briefed on the inflation rate argument. I am happy to have that debate, but I will not have it without having the information. Anyway, the point that I am making is that the Home and Community Care program is complex, as the honourable member knows.

We are seeking to make sure that, because there are 17 programs and there is also a number of state programs, we match up the need with the services. That is what we will be doing in the next year. With regard to the question you have asked me about whether this will be ongoing, my understanding is that the agreement we have in South Australia is up for negotiation now. So, there is an opportunity again for the state to reconsider what our matching requirements will be in the future, if there is the same process after the community services review.

The point to emphasise—and we should separate this out from the media information that has been about—is that there will be no cuts to services, because we are operating under the previous financial year's funding. I said we have increased that funding. We could have problems—and this is where the shadow minister is correct—in the 2003-04 area if we do not look again at the amount of funds we need to fund the programs that the sector deems to be important. So I agree on one level with the shadow minister, but I am saying that, basically in this next year, as we roll out the previous financial year's HACC programs, there will not be cuts to services. The critical issue for me and the one that we are looking at as a government is the waiting lists for services, and that is where, again, we need to match up what we can provide and what we need to do that adequately. We are really using the next year to re-evaluate our area. We will not be driven by the commonwealth with regard to our priorities, and we will need to work out for the next round—if there still is a HACC round and there still is the same system—what the state contribution will be.

I have been really concerned at some of the media reports about what the matching will or will not mean. As I said, I concede that there will be issues if we do not match in the next financial year. To have information in the media about the fact that there will be a big issue with Meals on Wheels and the number of meals delivered is irresponsible. I am really concerned at that and at the rumour that some of the other services in the aged and community care area will be cut any minute now, because of the negotiations we have had in the HACC area.

In summary, I am saying that, yes, we have made the decision as a government to put our priorities in other areas. It is true to say that we have done that. We have made a decision to make sure that the inflation rate is there, so there is indexation. We are really reconsidering the whole aged and community care area and our relationship with the commonwealth government. The Home and Community Care (HACC) area is one of 17 programs that are being reviewed not only federally but also by us about what sort of services the state should provide in conjunction with the commonwealth. Some really hard work is being done to make sure that we are not only cutting services but addressing that link between needs and the services being provided. I hope that answers the many different questions the honourable member asked me.

The Hon. DEAN BROWN: I am very concerned—and I have had this confirmed by the federal minister in a personal discussion with him—that, not only do we lose the $3.1 million this year but, even if there is a new agreement next year, South Australia will not be able to come along and suddenly expect to pick up what has been lost this past year in the base. In fact, I can recall very vividly that when I became Premier in 1993, the previous Labor government had missed out on the base on a number of years.

Therefore, our base was sitting substantially below that of other states on an expected basis because it had not been matched in previous years. I forget the exact year—it was about 1995 or 1996—that one of the other states equally did not match that year, and by putting in extra money we were able to clawback what it had failed to match, because separate funds were sitting in the commonwealth area. I am told that if South Australia does not take it up this year it is more than likely to be allocated to another state—in fact, the name of the state has been mentioned to me—and that South Australia will lose it permanently in the base. So, just believing that another round of agreements is coming up for renegotiation does not mean that the money will be there because automatically it becomes part of the base for the next year.

You could well sit there for 10 years, or longer, without being able to clawback or reclaim that $3.1 million of federal funds that would be lost in the coming year and every

subsequent year. With every justification, I think that is why organisations such as COTA and many others have expressed a strong view on this. I personally saw what occurred in 1992-93 and the high costs we were paying in South Australia for that, and I would not like to see that inflicted on this state again.

The Hon. S.W. KEY: I understand the point that the shadow minister is making. I have tried to explain the rationale, certainly on the state government, with regard to the 2003-04 matching. I am advised that the inflation rate figure of 2.5 has come from the commonwealth. I do not feel that at this stage I can get into a debate about inflation rates. I do not have the information. I am acting on the information that has been supplied to me. I do understand the point that the shadow minister is making. The information that I have, and certainly the decision that has been made by the state government, is that this is for the 2003-04 round for HACC. Without going over the whole argument again, because I do not think I need to repeat myself, we are told there is the opportunity.

Obviously, the shadow minister has a different opportunity to speak directly with the federal minister about this matter, but we are told that one of the things that will come out of the community care review is a different way of looking at funding, because the current system of having 17 different line items is fairly clumsy. There is some suggestion that, because of the way in which it is administered—and this is not to be negative about the commonwealth—it may be that people are missing out on services, rather than making sure that the services have the best access and equity component to them. We will go through the process to try to ensure that we come out with the best possible result.

The other point I make—and this is my final point in this area—is that the state government will not be dictated to by the commonwealth government on how much money we will spend in the aged-care area. There have been a number of offers in the different parts of my portfolio over the past 14 or 15 months that seem like reasonable offers from the commonwealth but, if we were in the business of matching them, whatever the matching arrangements may be in those different offers, the priorities for government would be completely skewed because we do not have the finances to back up those matching arrangements in every case. We have had to go back to the drawing board to reconsider what we are able to do, what our priorities are and, as responsibly as possible, certainly in the six portfolios for which I have responsibility, make hard decisions about where our priorities will be.

I need to emphasise that the Treasurer, and certainly my other cabinet colleagues, are looking at the home and community care funding, which is part of a whole area in the ageing and community care area, for the next financial year. We may have a different view as a result of the community services review and other factors.

Mr HANNA: I would like to follow on with another question about HACC funding, from a slightly different angle. There may be something the minister can add. In the answers the minister has just given there was a suggestion that there would not be cuts to services, but I have been informed of a number of examples where these types of services have recently been cut. For example, I have a couple where the husband was severely disabled and was essentially told that, because of the lack of resources for continuing care in the home, he would need to go into a nursing home, and his wife was distressed at being separated from him, but that is the option they took.

In another example there is a woman in her fifties, disabled, and where she had had fortnightly cleaning provided that was extended out to monthly cleaning, although there was no change in her condition. For someone who took pride in her home, the bottom line is that her toilet was being cleaned no more than once a month and she was distressed about that. Before I put the question I would like to read from the letter provided by the Carers Association, dated 16 June. I am not sure whether the minister has a copy of that. It is clearly a plea for greater state funding in the Home and Community Care area. I will just read out four eloquent paragraphs, as follows:

> Labor's 2002 election policy called for increased HACC funding. This budget restricts that growth. Why? We don't know. Not providing for HACC growth funding lacks logic. This is the first time for many years that HACC growth funding will not be matched. This shortfall is not readily caught up since growth funds become part of the following year's base, with next year's growth built on that base. It is a compounding loss. The federal government provides 62 cents for every 38 cents that the state puts up. That's pretty good matching. The budget decision leaves over $3 million of commonwealth money on the table. This money should be providing the in-home assistance carers need through home nursing, home help, personal care, respite, home maintenance and other support to the frail aged, people with disabilities and the chronically ill in their care.
>
> That money will go to other states to match any left on the table by South Australia. The need which HACC services are designed to meet does not go away because the services aren't there or can't meet demand. That need builds up and turns into pressure on our hospital system through extra outpatient visits, through extra admissions to hospital and through longer stays, because there are insufficient nursing and home care services to enable patients to be discharged home.

I know that the minister is concerned about people in their home in need of that sort of care: I know that she is genuine about that. Why, then, would the minister not support putting in sufficient state funding to get the maximum amount of commonwealth matching funding for what I put to her is unmet need?

The Hon. S.W. KEY: I am just wondering what the reference was in the budget papers for that question.

Mr HANNA: Pages 7.27 and 7.28 of Budget Paper 4, Volume 2.

The Hon. S.W. KEY: I would like to make two points. I am not sure whether the honourable member has written to me or contacted my office about the two cases he noted, but I am more than happy to follow those up. There could be some commonwealth support reasons or package reasons why, in those two examples that the honourable member raised, those people have made the choices they have made or have been forced to make. I do not know: I would need more information. There could be a lot of reasons why those—what I think are very serious cases—have come about. I invite all members to make sure they supply that information so that we can provide a speedy response on those matters.

Concerning the point made by the Carers Association, I cannot recall seeing the document dated 16 June, but I am in regular contact with the Carers Association. The member may not have been here earlier when I mentioned that I am very impressed with and very supportive of the Carers Association. I obviously value their point of view, as I do that of the other agencies, including the Council for the Ageing. A number of organisations, in addition to the shadow minister, have made a point about the HACC funding matching issue for 2003-04. I really think that the answer I would give to the

honourable member's question would be the same as the fairly long one that I gave to the member for Finniss. This is an area that we are looking at in 2003-04.

I obviously hope to be in a position for the next budget round to put up arguments ensuring that, as best we can, we match the services with the need in the state, but that we are not bullied by the commonwealth into taking particular positions because it seems to have an offer that we should not pass up. I have found, as I said earlier (and I am not sure whether the member was here for that answer), that sometimes all that is offered is not as generous as it seems. Notwithstanding that, I think the last point that the member made about unmet need is precisely the point that I am also making: we need to make sure that we advance the unmet need question. I think that is the point that the member for Finniss raised as well. I take that matter on board. I agree with the member, but we will work through how we try to address that on a state basis.

I emphasise again that, under the funding we are considering at the moment, we have over 70 new and expanded recurrent projects and over 40 one-off and fixed-term projects. These include the expansion of the metropolitan domiciliary care services for an additional 1 600 clients, particularly those residing in the northern metropolitan area; the expansion of the local government Home Assist programs, providing home maintenance and modification services across a number of metropolitan and country areas; the establishment of metropolitan indigenous home support services for 50 elders; the expansion of Home and Community Care services for frail, older people who reside in rural and remote areas such as Yorke Peninsula, Kangaroo Island and Eyre Peninsula; a range of projects to expand basic home and community supports for frail, older people, including people with dementia and their carers from the Italian, Greek, Polish, Hungarian, Ukrainian, Maltese and Vietnamese communities, as well as other small, ageing ethnic communities.

Funding also has been approved to expand Ethnic Link advocacy services in the Riverland. They are just some of the highlights from the present Home and Community Care program. I would just like to add that, apparently, today I received in my office the reference to which the member for Mitchell has alluded.

Mrs GERAGHTY: With respect to table K6.1 on page 7.28, what emphasis is being placed on service provision to older people in regional South Australia?

The Hon. S.W. KEY: The provision of appropriate services to older people in all South Australian communities is, as I mentioned earlier when I detailed some of the projects that are available through the Home and Community Care program, very important to this government. We are not just talking about the metropolitan area; we are also talking about country and rural and remote areas. I am sure that the member for Finniss, in particular, would appreciate that.

The context of the discussion is that, according to Productivity Commission data, some 26 per cent of the state's older population lives in a rural or remote area, compared with the national average of 29.8 per cent. Whilst there are no national figures available detailing expenditure at a reasonable level, the most recently available South Australian Home and Community Care data for the financial year 2001-02 suggests that there is a higher rate than the state average of expenditure in most non-metropolitan Home and Community Care planning areas.

With regard to service provision to people aged 70 or older, the same year's data shows that the number of reported hours per 1 000 people is higher overall in South Australia than the national average. For rural areas it is slightly ahead of the national average, whilst for remote areas we are significantly lower. I remember when I was in opposition talking about agrarian socialism that happened in rural areas. Interestingly, the Productivity Commission report supports me in that, particularly with regard to rural areas and Home and Community Care in 2000-01.

Whilst I will scrutinise the situation in some detail in the coming months, I am advised that the overall balance of funding is broadly acceptable. There are some communities which definitely need more attention. Remote areas such as the Northern-Far West region and the AP lands have been raised with me in this regard, including the situation with respect to Aboriginal communities. The 2002-03 HACC plan to be implemented in 2003-04 (as I have stressed many times tonight) seeks to address this problem. In the recently signed off 2002-03 round, for example, about 28.1 per cent of the HACC funding ($26.4 million) was targeted to non-metropolitan planning areas; the other 71.9 per cent ($61.3 million) is going to metropolitan areas.

Moreover, the per capita funding average for country regions was greater than 1 085, compared to the metropolitan average of 1 017. I hope metropolitan members take note of that. Four planning areas had funding levels below the state average of 1 108 per potential client; two of these were in the country and two metropolitan. They were in order of priority: Northern Metropolitan, Southern Metropolitan, South-Eastern Hills, and Mallee and Southern. I am not sure what the member for Colton and I would make of that as we are both from the western suburbs.

It will be of particular interest to the member for Finniss that the Southern Fleurieu region does comparatively well in fund distribution. It currently receives approximately $1 458 100 in HACC funding, including $550 000 in new funding in the 2002-03 round. This new funding was allocated to the following organisations: the South Coast District Hospital Inc; the Southern Fleurieu Health Service Home Help, $150 000 recurrent; the Southern Fleurieu Health Service South Coast Carers Support, $200 000 (fixed term); the Southern Fleurieu Health Service Aboriginal Home Care Program, $100 000 recurrent; the City of Victor Harbor Southern Fleurieu Positive Ageing Project, $100 000 (two year fixed term).

The Hon. Dean Brown interjecting:

The Hon. S.W. KEY: I have had this discussion with a number of the member for Finniss's colleagues in country regions. They are very well aware of this too; in fact, they pointed it out to me. Other regional locations that have received project funding in this round include the Southern Yorke Peninsula, the Gumeracha region, Mount Gambier, the Lower North, Gawler, the Murray Mallee and Port Lincoln. Two Aboriginal community projects have also been funded. Strategies to improve regional funding equity have been and are being developed. The intention over time is to reduce any inequities in the overall system, and I thank those country members for bringing this to my attention.

The CHAIRMAN: The time agreed for examination of these lines has now expired. There being no further questions, I declare the examination suspended until 24 June. This line remains open. I thank the minister and her advisers for their participation; and, for those of you who have been here since

early this morning, thank you very much for your assistance and forbearance.

ADJOURNMENT

At 9.01 p.m. the committee adjourned until Friday 20 June at 9.30 a.m.