INDIGENOUS HEALTH — CLOSING THE GAP AGREEMENT

Motion

MR R.H. COOK (Kwinana — Deputy Leader of the Opposition) [7.00 pm]: I move —

> That this house calls on the Barnett government to recommit to the Closing the Gap Council of Australian Governments agreement on Indigenous health to provide certainty and continuity to the Indigenous health services that will cease being funded when the current agreement expires.

This will be something of an unusual debate. It is preceded by the government's announcements today and the Minister for Health's answer to questions in Parliament earlier. Therefore, the debate will be informed in part by the comments the minister has already made today. This will also be an unusual debate because it is an issue on which there is a great deal of agreement in this place on both the approach and outlook relating to closing the gap on Indigenous health. This motion is not an exercise in seeking political advantage; it is simply intended to provide the minister with an opportunity to state with absolute clarity the government's intentions for the funding of the Closing the Gap program. I believe the huge disparity Aboriginals and Torres Strait Islanders experience in the health profiles of their communities is the biggest moral issue confronting our society today. We simply raise these issues today to provide the minister with the opportunity to give clarity on them and to reassure those who have been involved in providing Closing the Gap services, and the associated organisations, with the certainty to carry on. In the lead-up to the announcements today, there has been a great deal of uncertainty. The government has previously announced it would extend the funding for three months in the lead-up to the budget, but we are looking for more from the government. We are looking for greater certainty because people in these organisations are starting to look for other jobs and to think about their own financial security and that is having an impact on those Closing the Gap services. This is an opportunity for the minister to clarify the government's position on this program and for the government to provide certainty to those organisations and the community at large.

I provide members with a summary of the sort of health statistics afflicting the Indigenous community. Compared with non-Aboriginal Australians, Aboriginal people have a life expectancy 11.5 years less for men and 9.7 years less for women. Those figures are from the minister's own media release of today, because the statistics I had are a bit older. The mortality rate for Indigenous infants is about three times that of non-Indigenous infants. Indigenous people suffer higher rates of nutrition and diet–related chronic disease. An Indigenous Australian aged 35 to 54 years is between 23 to 37 times more likely to die from type 2 diabetes than a non-Indigenous Australian in the same age group. Up to 75 per cent of Indigenous males die before the age of 65 compared to just 26 per cent of non-Indigenous males. These statistics are very alarming and they made a country stand up and decide it would alter the course of these historic symptoms of a sick community. When I say "community", I do not refer to the Aboriginal community, I am talking about Australia at large, because while we allow these statistics to continue and the community to be afflicted by these sorts of issues, we are all diminished.

In December 2007 COAG committed to closing the gap in life expectancy between Indigenous and non-Indigenous Australians. This is off the back of a long campaign by a range of government and non-government groups that sought to raise the issue of Indigenous health as one of national importance. For my efforts, I was involved in an organisation called Australians for Native Title and Reconciliation, ANTaR, which was one of those foundation organisations, along with Oxfam, the Human Rights and Equal Opportunity Commission and other organisations, that stepped up and said it is time we stopped accepting this issue as part of the Australian experience; it is time we actually did something about this. They called on the government of the time and then ultimately the Rudd federal Labor government to change the course of this country, and so the COAG agreement between the federal government and all state and territory governments was put in place. The COAG agreement on Closing the Gap had six targets to address disadvantage in Indigenous Australians' life expectancy, child mortality, education and employment. They were to close the gap in life expectancy within a generation by 2030; to halve the gap of mortality rates for Indigenous children under five by 2018; to ensure access to early childhood education for all Indigenous four-year-olds in remote communities by 2013; to halve the gap in reading, writing and numeracy achievements for Indigenous children by 2018; to halve the gap for Indigenous students in year 12 or equivalent attainment rates by 2020; and to halve the gap in employment outcomes between Indigenous and other Australians by 2018. They are ambitious and important targets for a nation to aim for. The federal government allocated $1.6 billion over four years as part of the National Partnership Agreement on Closing the Gap on Indigenous Health Outcomes as part of its contribution towards working with all governments across the country towards these targets. At the same time we experienced a change of government in Western Australia, and the incoming Liberal Party, as part of its election commitments, said it would have a health minister it described as —

> … a full-time Health and Indigenous Affairs Minister, whose chief concern will be looking after the health needs of our State and our people, including the special needs of Indigenous Western Australians.

This government therefore came into power with a minister committed to the health portfolio and to the related outcomes that could be achieved in Indigenous health. I said in this place last week that it is disappointing that the current Minister for Health had to surrender the Indigenous portfolio, because for Indigenous health that remains one of the key outcomes for any health minister in Western Australia. Although I am sure that the tourism portfolio gives the minister great respite from the pressures of the health portfolio, I do not see the complementarity of the two portfolios, and I think we would still benefit from having the minister in that portfolio. However, it is not surprising, given he had those two portfolios, that in March 2010 the state government announced its contribution to the Council of Australian Governments national partnership agreement on improving Aboriginal health of $128.4 million over the next four years. I thought that must have been some time ago, because the photograph of the minister in this media release is of a somewhat youthful man —

Dr K.D. Hames: Nothing's changed then!

Mr R.H. COOK: Nothing has changed, as I note that the minister still uses that photo today in his media releases. This must go to the integrity of a government, I think, when it uses such a misguided —

Dr K.D. Hames: I learnt it from Alannah MacTiernan. I saw the photos Alannah used to use in her campaign!

Mr R.H. COOK: Indeed; highly brushed! But I do not think there is a grey hair here on this particular photo used in the minister's media release!

Nevertheless, the government committed $128.4 million as part of its contribution towards the COAG national partnership agreement on Indigenous health. Indeed, it was an important package because it provided fresh moneys for a sector of our community that is struggling significantly. For instance, $22.4 million was at that point dedicated towards extending primary care, chronic disease management and child health in the Kimberley alone. This represented an important initiative. One day I think the minister will reflect on his time in the portfolio and look towards Fiona Stanley Hospital as perhaps his greatest achievement, or at that point the unfinished new children's hospital, or maybe even look fondly down on Albany Hospital as his greatest achievement. I proffer up this theory and idea that it is in fact this government's work in Indigenous health that has been its greatest achievement to date. I told you, Mr Acting Speaker, that this was going to be an unusual debate.

As part of the implementation of the national partnership agreement in Western Australia, we undertook a fairly unique approach that to my understanding has not been replicated in other states. Mr Acting Speaker, you might be aware that right across the country Aboriginal medical services are described as community-controlled health organisations. They are organisations that deliver medical services to Aboriginal communities in a culturally appropriate way and in a culturally appropriate context and environment, and in a way that seeks to reduce that isolation that many Aboriginal people feel from mainstream medical services. This is not an issue about geographic isolation; this is one about cultural isolation. Aboriginals in the metropolitan area share many of the same health demographic statistics as Aboriginal people in remote and regional communities. In Western Australia we undertook a fairly unique approach. The minister might lay claim to the approach or he might give credit for it to the director general—whatever—but we in WA established regional health forums in which there would be an agreement with the Aboriginal community-controlled health organisations about which services were required in their region and how they would deliver those services, and in many cases the money was handed over to those Aboriginal organisations to carry out those services. That did not occur in all cases. There was a bit of complaint about whether the COAG money should have gone to the WA Country Health Service or more generously to the Aboriginal community health organisations. Nevertheless, it was an important initiative that has provided great utility and effectiveness in the rollout of the Closing the Gap program.

I sometimes wonder whether it was in some respect because of the elevation of the head of the Aboriginal office of the Department of Health, which was at that stage headed up by Ken Wyatt. I wonder whether it was his elevation to the House of Representatives that provided the opportunity to do that, because I can remember having some arguments with Ken Wyatt about whether health services should be mainstreamed or whether they should be part of an Aboriginal medical service. Nevertheless, in Western Australia through the regional health forums there was an agreement about the sorts of services that would be required and how they would be delivered.

The importance of that is underscored by a number of references. An article by Holly Schäuble, published on the artsHub website in September 2012, states —

> Culture is not the first (or usually even the last) thing people think of when it comes to addressing poverty, but it has a vital role to play in achieving sustainable development. The beliefs, values, meanings, practices and knowledge systems that are known collectively as 'culture' help affirm identity, maintain social cohesion and sustain livelihoods.

This is essentially what we have done through many of the Closing the Gap services. Having those services delivered by Aboriginal medical services has achieved a culturally appropriate way to deliver them, which has given great strength to their delivery.

The Australian government Office for the Arts refers to the role of culture and the Closing the Gap program. It says —

> A … strong cultural identity is fundamental to Indigenous health and wellbeing, Australian Government initiatives that strengthen Indigenous culture and languages are essential for *Closing the Gap*.
>
> The rich cultural practices, knowledge systems and cultural expressions of Aboriginal and Torres Strait Islander peoples are a source of great strength, resilience and pride.
>
> Strong cultural identity is fundamental to Indigenous health and social and emotional wellbeing.
>
> Initiatives that strengthen Indigenous culture are therefore essential to Closing the Gap, which is a commitment by all Australian governments to work together to improve the lives of Aboriginal and Torres Strait Islander peoples, and in particular, to provide a better future for Aboriginal and Torres Strait Islander children.

That is the important issue at stake. Now more than 300 people are working around the state, many inside Aboriginal medical services that are providing great services to the community. For instance, now primary health care services are being delivered in areas such as Mt Magnet and Wiluna where before there was nothing, and medical services are being rolled out to communities along Gibb River Road.

Dr K.D. Hames: They are not just for Aboriginal people in those places.

Mr R.H. COOK: Indeed, and that is the point I am about to make. In addition to the fact that they provide important services to Aboriginal people, they serve one and all who present at the door. We are therefore, through the national partnership agreement on Indigenous health, extending primary health care services to mainstream Australian communities in addition to providing them to Aboriginal people. That is why this is such an important initiative.

Recently, on 18 April, the commonwealth government announced it would extend its share of the Closing the Gap funding by another $700 million to take it to 2016, or for another four years. The Aboriginal Health Council of WA has called for another $148 million from the state government to continue with its programs.

This motion has a number of intentions. One is to provide the minister with an opportunity to clarify their funding situation, which was done to a certain extent today through his media release and in answers in question time. Recently, in answers to questions from me in this place, the minister used some funny language. On one occasion he said —

> The Treasurer just made a comment during those discussions to say it will be sorted. I have great confidence —
>
> …
>
> I have great confidence that it will be sorted.

We sought more from this. In the media on the weekend, the Aboriginal community health organisations of Western Australia called on the government again to renew its commitment to funding. On that occasion a spokesperson from the government on ABC news on 16 June said that it intended to fund the program. We want more than intentions; we want to see a solid announcement from the government, and we got that in part today when it agreed to provide $31 million of further funding for the Closing the Gap program in WA for another 12 months. Of course, we want to see more. We want to see that program extended by another four years, and we also want to see the government working hand-in-hand with the federal government to renew the national partnership agreement. This will ensure we get the coordination and commitment from governments across the board to continue the good work already done, which will be undermined if we choose to break up this process by separately funding commonwealth and state programs and having some things delivered by the government sector and some by the non-government sector. The beauty of the Closing the Gap program was that it drew together all those organisations and institutions to work on a single strategy. Kids in schools in the south west are now actually getting immunised. Mums and bubs have a dedicated program to ensure they get the prenatal and antenatal care needed. For a change, chronic disease management programs are being taken to communities, where before there was nothing, and that can only be done together.

In June 2010, when the minister was the Minister for Indigenous Affairs, he hit the nail right on the head when he said in his foreword to the report "Closing the Gap in Indigenous Life Outcomes" that —

> To give the best chance of meeting the targets,

That is the Council of Australian Governments targets I described earlier —

> governments will need to work together in partnership with Indigenous people.

Indeed, governments will need to work together. We are all at a crucial stage in the process. We are four years into the program but we are butting our heads against the federal election so there is opportunity everywhere for people to misbehave and lose the historic opportunity provided by the national partnership agreement. I want to see that process continued. This is a historic opportunity to right what was a chronic wrong in our community. This is an important opportunity and we cannot play political games around this issue. This issue transcends politics. This issue unites people on both sides of the chamber. I commend this government for taking forward this issue in the manner it did because it is a unique program that is starting to make a difference. It remains to be seen whether we will meet the targets by 2030. Indeed, the true beneficiaries of this program will not be this government, or the next, or the one after that, but the government after that will start to see changes, and the government after that will start to accrue savings as a result of not needing to provide the same levels of tertiary care because we will have a healthier Indigenous population. This is an important initiative, not for us, not for this government, but for the future, and that is why we are calling on the government today to commit to four years' funding and provide clarity to these organisations. It must commit to working with the federal government for a renewed national partnership agreement and to do so by 1 July this year so we can continue to move and carry forward the good work that has been done and then we can, as a nation, celebrate that point in our history when we said, "No, we are not going to stand for this anymore, we are going to make changes" and we will all, as members of Parliament and as those involved in the public policy process, be able to sit back and think of a job well done.

MS J. FARRER (Kimberley) [7.25 pm]: The Closing the Gap agreement was initiated in 2008 as a national partnership agreement and put in place by the federal government. Four regional operation centres were identified in the Kimberley; one at One Arm Point along the peninsula, home to the Bardi Jawi people; a second one at Beagle Bay, home to the Nyulnyul people; a third at Fitzroy Crossing, West Kimberly, home to the Bunaba, Walmajarri and Wangkatjungka people; and the fourth at Halls Creek, East Kimberley, home to the Kija and Jaru people. Eight building blocks were also identified. These areas were set up to work with the Indigenous people to improve their standards of living and to help make amendments to the Closing the Gap program, as it was known, and X amount of dollars was provided to sort out and identify problems, and to provide solutions and the necessary requirements to make changes in those areas. Apart from working for and providing what was needed for some of the people in those areas, there does not seem to have been too many changes.

One Arm Point straddles the furthest corner of the peninsula, with Beagle Bay covering the other, and in between are the Aboriginal communities of Lombadina and Djarindjin, which are very close in working comparison within the Dampier Peninsula. Fitzroy Valley is a bigger area and quite isolated in the central west Kimberley. Halls Creek is also quite a large area to work with and also quite isolated. Some issues within health do not seem to be serviced properly or regularly, and one of these is mental health and the wellbeing of these people. The Aboriginals know the families who need help in their own homes and communities. Frustration is felt all around, which is why we have suicidal young people and a sense of helplessness felt by families, close mates, partners and young children. Basic services are not located close to these communities. Most services are brought in from larger towns in the form of fortnightly visits by professional people who check on their patients. These patients need counselling and care, and at times it is not given to the victims. There is not enough housing or places for those who are handicapped or have mental health problems, including psychological, psychosocial and suicidal issues. Most family members try to help their fellow friends. For some time we have talked about the need for people to have medical experts working in those areas. If funding is not secured for some of these programs, they just become reports. I urge everyone from the different parties in Parliament to work together with the government bodies that represent Australia and to make sure that the Closing the Gap program works for the people.

DR K.D. HAMES (Dawesville — Minister for Health) [7.29 pm]: I understand the member for Victoria Park was planning to speak, but I will —

Mr R.H. Cook: He's still enjoying the buffet!

Dr K.D. HAMES: It is good to have this opportunity to speak to this motion. I am hoping, for two reasons, that we can talk long enough so that we do not have to vote on it. Firstly, it would be very hard for me to vote against a motion that recommends us supporting the Closing the Gap agreement. But the motion does contain some

errors in the assertion that without that agreement, we would not get the money, which is clearly—as I announced today—not the case.

The member suggested that I might personally take some credit for this program in the future; perhaps when looking back from retirement. I have to say that I do not; there are some things that have been my doing and my responsibility, such as the four-hour rule, which, once I get it running the way I want it to run, is something that I think I will be extremely proud of. But a lot of other people deserve the credit for the Closing the Gap program. While I have been happy to be there to steer the outcomes and programs, it was not my initiative; it was the initiative of the federal and state governments who reached an agreement in 2008. It was also largely the work of our Department of Health, and it was under the guidance of Hon Ken Wyatt, when he was in charge of the Aboriginal health section of the Department of Health, that it was all put together. He put together the discussions with Indigenous communities in particular, and worked out how this could be operated, with the guidance of the directors general who were there through that time, to make sure that we had in place a system that was not only designed, largely—in fact, almost exclusively—by Aboriginal people, but also one in which the service was provided almost exclusively by Aboriginal people.

It would have been easy for us to put all this money into the WA Country Health Service. Part of the agreement with the commonwealth government was that it would provide funds reasonably similar to our own in terms of amount. The member talked about a one-point-something billion dollar commonwealth figure, but our state's contribution—in the order of $120 million, I think—was fairly similar to the commonwealth contribution to Western Australia. The amounts were similar. But we were really left to go in our own direction. The commonwealth government chose what to do with its funds, and the state government likewise chose what to do with its funds. We could have put all of that into country health services, but we decided instead—I guess I had a reasonable involvement in this because I have a great deal of time for the Aboriginal medical health services and the quality of service they provide—to make sure that we directed a lot of those funds through those services as well, so Ken Wyatt and the Department of Health team deserve a lot of credit for the success of this particular program.

The people on the ground also deserve a lot of credit. One of the biggest fans of this program is a guy called Sandy Davies, an Aboriginal guy from Geraldton who is part of the Geraldton Regional Aboriginal Medical Service team and, I might add, a staunch Labor supporter! He speaks effusively about this program and boasts that it is one of the best that has been put in place in Australia for Aboriginal people. He is a massive advocate of the program, which is one of the reasons I put him on the governing council of the northern and remote country health service. He is one of the members of that council because of his knowledge of health services, particularly Aboriginal health services, and his knowledge of this program, how it has been put in place and the opportunities it provides. The money that was announced includes some that still comes under my portfolio as Minister for Health, and some that is under the Minister for Mental Health, because we have huge mental health issues that she has to deal with as part of Closing the Gap.

Of course, this funding is not the only funding that goes towards Indigenous health in this state. There are a number of other funding sources, both commonwealth and state, through Medicare, Closing the Gap commonwealth and state funds, and also through government organisations. In the Department of Health we have large numbers of agreements with service providers that go to a variety of organisations—some to organisations such as the David Wirrpanda Foundation; some to the Cancer Council, which provides a particular service for Aboriginal people in remote communities; and a lot to Aboriginal communities directly. I have been looking at some of these services, and plucked one example from the large list I have, significant numbers of which go towards Aboriginal health. I refer to the Wirraka Maya Health Service Aboriginal Corporation. It has received more than $700 000 in Closing the Gap funding; Indigenous early childhood development funding of around $100 000; and a primary health service that we fund to the order of $700 000. So that one community gets about $1.5 million in funding to provide health services. There are large numbers of others, including organisations like Derbarl Yerrigan, the Kimberley Aboriginal Medical Services Council, and Avon Youth Community and Family Services. These organisations provide services to support Aboriginal people in this state. That is one of the reasons we are not announcing the four years of funding today.

Yes, it was the member for Victoria Park's turn! I just saw a head poke around the corner!

The funding that is going into those services is being announced for just one year because of the huge range of health services that are provided, in many instances, without clearly defined key performance indicators, clearly defined outcomes and clearly defined coordination of services. There are instances in which other government departments, such as Family and Children's Services, will fund health services; perhaps also mental health services. Given that these sorts of services are being provided, I think we need better coordination in the way they operate.

We have formed a committee of ministers as a sub-committee of cabinet that is led by Minister Collier as Minister for Aboriginal Affairs. He chairs a group of us to provide services for Aboriginal people, and there is a range of ministers on that committee. We have agreed to put on the table all the services that we provide to Aboriginal people in this state, in a whole range of areas, not just health, to try to get better coordination and to try to have a better understanding of what gets funds. There are some organisations—I think the David Wirrpanda Foundation is a good example—that get funding from the Department of Sport and Recreation, from Family and Children's Services, from mental health services or from the Department of Health. He does a fantastic job, and not just because he has recently been endorsed as a National Party candidate! I have a great deal of time for David and the work he does, but he gets funding from a lot of sources. Is that the most efficient way to do it? Can we better put together a coordinated program with him and other groups, such as the ones I have already described, which get funding for the provision of Aboriginal services? How should their funding be put together? Does it achieve the best outcomes for Indigenous people? This is not just about who we fund to provide programs and how we fund them; this is all about closing the gap, and even if it does not come under the banner of specific Closing the Gap funding, that is what we seek to do—to close the dreadful gap in outcomes for Indigenous people in terms of their life expectancy; they are well behind now.

We list the difference in life expectancy in years. It is different for men and women, but the gap in life expectancy for one of those categories is in the order of 11 years. Some may say that that is because they are more likely to have a road accident because they drive in the bush, but that is not the major cause of death; the major causes of death are diabetes and heart attacks, as well as mental health issues. Certainly, mental health outcomes are significantly lower, with young people in Aboriginal communities committing suicide at a tragic level. All those things contribute to poor outcomes in Aboriginal people. The difference in life expectancy used to be in the order of 20 years; now it is 11 years. Is that because of the stuff we have done? I do not think so, because we have not been doing it for long enough; we have been doing it for only four years. There has been a strong commitment, not just from our government but from previous governments, to deal with issues such as diabetes, healthy food, the importance of exercise and cigarette smoking in particular to ensure that Aboriginal people are educated about those things that contribute to their poor life outcomes. Funding from the Closing the Gap program makes a significant contribution to helping people in remote communities give up cigarettes. The last funding round provided in the order of $6 million over four years. It has been proposed that this time it be in the order of $8 million over four years. We need to make sure that we keep doing those things to get that gap in life expectancy down to an acceptable level.

Some other things that we will fund include our election commitment on ear health for children in remote Indigenous communities. We announced during the election campaign an $8 million package over four years to reduce the incidence of poor ear health. People often do not recognise that some 30 per cent to 40 per cent, and sometimes more, of children in a particular remote Indigenous community will have impaired hearing. That does not affect just their comfort and their normal lifestyle; they get pain, ear infections, ruptured eardrums and discharge from their ears. They become deaf or have impaired hearing. When they go into a classroom and try to listen to the teacher at the front of the class—Indigenous kids are often at the back of the class because they are fairly shy and withdrawn and do not like to be front and centre—they cannot hear the teacher, so they quickly get bored. Not only do they not learn, they also get bored and become disruptive. They end up not going to school because there is no point as they cannot hear the teacher. It is critically important that we address hearing difficulties in remote Indigenous communities.

That $8 million will allow Aboriginal health workers to be employed in probably half the largest remote communities. I was after more funding. I think there are about 112 permanently established remote communities with populations of 50 or more for which we are responsible under an agreement we have with the commonwealth. Normally, the communities would have a school and a health centre. That $8 million will make a big difference. We will employ a 0.2 or 0.3 full-time equivalent in those schools, and they will run around all day with a tonometer in their pocket. A tonometer measures ear pressure. If a kid has glue ear, there will be a flat recording. Normally, there should be a bell-shaped recording. They will be able to tell whether kids have glue ear or an ear infection. They will have otoscopes so that they can look in the ear. They will be able to download pictures of a child's eardrum to a laptop and then skype the specialists in Perth, who can look at the pictures and tell them what to do. A lot of these Aboriginal health workers are already in the communities, so we will just add 0.2 or 0.3 FTE to their employment, depending on the size of the community. They will be trained in ear health and management. They will be able to take children to surgery, if they need surgery. If the surgery is to be done in Kununurra or Broome, their role will be to coordinate and collect all the children and take them to Kununurra or Broome for surgery, if that is required. They will be an invaluable part of that service. In fact, they are being taught to look not just at ears, but at teeth and eyes as well. They will not have anywhere near the same depth of learning or understanding, but they will be able to do simple things to look after the health of those children. The health requirements of those children will be substantially improved by something as simple as providing a 0.2

FTE in each community to do that particular work. As I have said, this is a program with the commonwealth to close the gap.

As we came towards the last Council of Australian Governments meeting, I asked the Premier to talk to the commonwealth because we had not seen any agreement to renew under the COAG program. I asked where it was. I needed an agreement to help me in my argument to Treasury about the importance of the program and to get commitments for the years to come. There was not an agreement. I think the Premier's office got in touch with the Prime Minister's office. Nothing was on the COAG table, but at that time the commonwealth announced the renewal of funding that it would roll into mainstream funding. It was an excellent move. It was great for me to have that backing to help my argument. The Victorian government announced a commitment of at least one year's funding for it.

Mr R.H. Cook: I think Victoria has said that it will sign a partnership agreement, hasn't it?

Dr K.D. HAMES: Yes, it has. That is one of the issues. We have received a letter in the last couple of weeks from Hon Warren Snowdon, asking us to commit to signing an agreement for the national Closing the Gap program. The commonwealth is working with our health department staff on developing that agreement. I am disappointed that that was not ready for COAG so that COAG could renew the commitment, because I think that is where it should have come from. Nevertheless, I am happy that we are progressing that. He said that we would see it by 1 July, but here we are on 19 June and we have not yet seen any correspondence or documentation apart from that letter. We will need to look at the agreement. It is a very important program, the success of which we will not be able to judge in just four years, or even in eight years, because it is a long-term program.

As a result of us committing to one year and taking all those systems to our subcommittee and pooling them with all the other things that we do in Indigenous health to see how we can do it better, we might get quite a bit of other funding to put into that model. It is such a good model and has worked so well that I think we should grow it, not diminish it. Some of the other ways that I fund things is not as good as the way that the Closing the Gap program is funded. I might try to channel more funds into that program. I do not want anyone to whom I provide funds to get nervous, because I will not do it in a way that reduces the health outcomes for Indigenous people. Every now and then when a government provides lots of funds for a particular service, it needs to make sure that it gets the best value for money and the best outcome for the service that is provided.

Mr R.H. Cook: Is it your intention to look at signing it before the federal election, if not by 1 July?

Dr K.D. HAMES: That will be up to the Premier and cabinet. I guess it will depend on what is in the agreement. I will need to see the agreement. I am not able to make a commitment today. What I can say and what this $31 million shows is that we are strongly committed to the concept of continuing the Closing the Gap program. I cannot see why we would not sign the agreement, because we agreed to the proposal for the last four years. Unless there is something substantially different, I cannot see why we would not continue with it. The $31 million is a strong commitment from this government to continue supporting the Closing the Gap program and getting better health outcomes for Indigenous people. I will finish there to give other members the opportunity —

Ms A.R. Mitchell: My question is not specifically about COAG, but about your previous introduction of swimming pools into a number of communities. Has there been much assessment of that and are they still proving to be of value?

Dr K.D. HAMES: Yes. A lot of assessment has been done; it has improved outcomes. When I was in government last time as Minister for Housing, the then Minister for Health refused to provide any funding for this program, despite my pleas. We managed to receive the funding by grouping together the monies from Lotterywest; the Premier, who was then the Minister for Education; and the Department of Housing, which put in a lot of money. I note that the Minister for Housing is not here, but we funded a whole range of things. Some involved greening and reticulation of remote communities. I had a theory about dust as a cause of recurrent nasal infections leading to recurrent throat, chest and ear infections. It was not just a matter of immersing the kids in water in a swimming pool or being provided as a social thing; it was done for medical reasons. A person's health improved by just reducing the dust in these communities by reticulation and greening. We did that for a lot of other communities. For some communities we provided the swimming pool as well. That was Jigalong, and it was going to be Oombulgurri, but a certain former member from the opposition side of the house kyboshed that to his later regret and apology, I might add. The funding went to Yandeyarra, or Mugarinya as it is known; Jigalong; and Bunnengarra. The government put these pools into those three communities, and it did make an enormous difference.

Fiona Stanley conducted before-and-after research to show what a great outcome it had proven to be. Since then, other assessments suggested that the Telethon Institute did not get the figures quite right in terms of improvement in ear heath. It certainly did improve skin health, throat and chest infections and the like. It is hard

to tell because it is very hard to get direct comparisons. But in my view, it has made an enormous difference, not just because children have improved health outcomes, but the swimming pool became the social centre of the community. There were lots of mums with children playing in the water, whereas otherwise the kids might have been going off and doing other things and, sometimes, through boredom, getting into strife. We had the Royal Life Saving Society as the managers of those pools; it is an incredible organisation. The Royal Life Saving Society is still doing it now some 10 years later. They were expensive pools—that is, a Myrtha pool of Italian design, but they have proved to be very high quality and very long lasting. That has been a great outcome. I am still trying to get one in Balgo, I might add. I am working very hard to get one.

Mr B.S. Wyatt: You're the Deputy Premier; I'm sure you can get one!

Dr K.D. HAMES: Well, yes; it is harder than I thought —

Mr R.H. Cook: Throw your weight around!

Mr B.S. Wyatt: You are the second-most senior minister in the government!

Dr K.D. HAMES: It is harder than I thought it would be, I have to say. For the past two and a half years, I have had $1.5 million put aside for it and still have not got the total amount. They are very expensive; that is the trouble.

Mr B.S. Wyatt: What is the total cost?

Dr K.D. HAMES: They are about $3.5 million, plus the accommodation for the person from the Royal Life Saving Society. As members would know, in some of those remote communities, a house can cost up to $1 million. Therefore, it is some $4.5 million. It is very hard to put that sort of package together, but remote communities are great places to put a swimming pool. Over the years, the Balgo community has gone from strength to strength with great management of its community. They deserve to have a pool out there. It will be a project for the future.

Mr Acting Speaker, I will stop because I know I there is very little time left and another member wants to speak. Thank you very much.

MR D.A. TEMPLEMAN (Mandurah) [7.54 pm]: I will close the gap between now and eight o'clock! We will not go to a vote on this motion, but the debate tonight has given the opposition, particularly the shadow Minister for Health and the member for Kimberley, and the Minister for Health an opportunity to revisit the whole objective of the COAG agreement of 2008. Although we would have hoped for greater clarity from the minister about the government's ongoing commitment to the objectives of the original COAG agreement in signing on for another three years, I agree that the minister has given an indication through today's announcement that there will be an ongoing commitment.

There is no doubt that we face a major challenge and we will need to continue to work very, very hard to achieve the objectives of closing the gap in Indigenous disadvantage. I listened to the member for Kimberley highlight a whole range of issues, particularly in the Kimberley experience. Indeed, the minister was able to highlight a range of ongoing projects that have been established and delivered and are continuing to be delivered aimed at addressing some of these objectives. One of the things I am particularly interested in is the objective regarding access to early childhood education, and the issues around improving reading, writing and numeracy achievements for children by 2018. I am also interested in the secondary schooling sense of halving the gap for Indigenous students in year 12 or the equivalent.

The member for Dawesville is aware—he shares this school with me in many respects—that the Coodanup Community College deserves acknowledgement because of its significant Indigenous population. I am on its school board, and having read its regular reports and updates from the principal, Vicki McKeown, I know that it is in an area that has traditionally and historically had some very significant social and economic issues, but the school is now certainly punching above its weight in delivering positive outcomes. It has addressed a range of issues, particularly as they impact on Indigenous students. I go to the school regularly, not only as a local member but as a member of the board, and I am continually impressed by the young Indigenous men and women in that school, who are tremendous role models for the younger students in the years 8 to 10. The students are also exceptional role models for the young kids who live in the Coodanup area.

I agree with the Deputy Premier, the Minister for Health, Closing the Gap must be an ongoing commitment. The government will not solve or address this gap in three or five years; it has to be a sustained commitment. But I think in terms of Coodanup Community College, as I am sure is the case with other educational institutions throughout the state, there are some very, very positive indicators. I want to pay tribute to the role that schools like Coodanup Community College; Dudley Park Primary School, which also has a significant number of Indigenous students; Riverside Primary School, which has a number of Indigenous students; along with even Greenfields Primary School—they are all schools in the Mandurah area that have a large number of Indigenous

students. I pay tribute to those schools and the role they play in seeking to achieve the Closing the Gap objectives, particularly in education. I highlight the importance of the Dudley Park early intervention centre that is to be established. That is a huge opportunity for Aaron Thomas, the principal of that school, and his staff to create a very important resource that also will be focused on delivering the objectives that we all want to see achieved to close the gap of Indigenous disadvantage.

Debate adjourned, pursuant to standing orders.