COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON ABORIGINAL AND TORRES STRAIT ISLANDER AFFAIRS

Reference: Community stores in remote Aboriginal and Torres Strait Islander communities

THURSDAY, 28 MAY 2009

CANBERRA

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HOUSE OF REPRESENTATIVES STANDING

COMMITTEE ON ABORIGINAL AND TORRES STRAIT ISLANDER AFFAIRS

Thursday, 28 May 2009

Members: Mr Marles *(Chair)*, Mr Laming *(Deputy Chair)*, Mr Abbott, Ms Campbell, Mr Katter, Ms Rea, Mr Kelvin Thomson, Mr Trevor, Mr Turnour and Mrs Vale

Members in attendance: Mr Laming, Mr Marles, Ms Rea, Mr Turnour, Mrs Vale

Terms of reference for the inquiry:

To inquire into and report on:

The operation of local community stores in remote Aboriginal and Torres Strait Islander communities, with a particular focus on:

- food supply, quality, cost and competition issues;
- the effectiveness of the Outback Stores model, and other private, public and community store models; and
- the impact of these factors on the health and economic outcomes of communities.

WITNESSES

Committee met at 12.28 pm

CATCHATOOR, Ms Helen, Acting Assistant Secretary, Rural Health Services and Policy Branch, Department of Health and Ageing

COLEBORNE, Ms Michaela, Director, Strategic Policy Section, Policy and Budget Branch, Office for Aboriginal and Torres Strait Islander Health, Department of Health and Ageing

ISAAC-TOUA, Dr Geetha, Medical Adviser, Office for Aboriginal and Torres Strait Islander Health, Department of Health and Ageing

PEACHEY, Ms Cath, Assistant Secretary, Healthy Living Branch, Population Health Division, Department of Health and Ageing

PODESTA, Ms Lesley, First Assistant Secretary, Office for Aboriginal and Torres Strait Islander Health, Department of Health and Ageing

QUICK, Ms Alma, Director, Rural Primary Health Section, Rural Health Services and Policy Branch, Department of Health and Ageing

CHAIR (Mr Marles)—Welcome, everyone, to this hearing of the House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs in our inquiry into community stores in remote Aboriginal and Torres Strait Islander communities. I acknowledge the Ngunawal people and the Ngambri people, the traditional custodians of the land on which we are meeting today, and pay our respects to their elders, past, present and future. We also acknowledge the present Aboriginal and Torres Strait Islander people who now reside in this area.

These are formal proceedings of the Commonwealth parliament and everything that is said needs to be factual and honest. It is a serious matter to attempt to mislead the committee. We invite the witnesses to make comments that will assist us in our inquiry with the intention of making improvements to the current government administration of community stores. This hearing is open to the public and the transcript of what is said will be placed on the committee's website. Today we are hearing from the Department of Health and Ageing.

I note that this is National Reconciliation Week, which had as part of it Sorry Day, which was on Tuesday, 26 May, when there was a nice ceremony that I was a part of involving the Sorry Day Committee, the Speaker of the parliament and the minister. Let me hand it over to our witnesses today. Lesley, do you want to make an opening statement? Then we will fire some questions.

Ms Podesta—Thank you for agreeing to have us back here today. You indicated that there were a number of points that you wished to seek further information about, so we have prepared an opening statement covering those points and, with your permission, we thought that was probably the most efficient way to handle that.

CHAIR—Yes.

Ms Podesta—We will cover the burden of disease study, specific information on particular health issues suffered by Indigenous people in remote areas and their relationship to nutrition, the Menzies School of Health Research study on electronic monitoring of food sales, the Mai Wiru healthy stores project on the Anangu Pitjantjatjara lands, the Remote Indigenous Stores and Takeaways Project, the extent to which community stores contribute to nutrition and the percentage of food sourced in the community store. We will attempt to give you as much information on these matters as we can. Before I begin, I would like to make a correction to the record. At the last hearing I indicated that the contribution of excess alcohol to the health gap was 6.8 per cent, and I wish to correct that; it is four per cent. My apologies.

As we said last time, Indigenous health is an issue for our entire portfolio, so it is very important that all of our colleagues here with responsibility are able to answer and address the questions. We do not look at Indigenous health just within the Office for Aboriginal and Torres Strait Islander Health. The first issue I thought I would go to is a question that you sought information about last time, which is about what the burden of disease is and how it relates to low fruit and vegetable consumption. Research indicates that low fruit and vegetable consumption accounts for approximately 3.5 per cent of the total burden of disease—that is, mortality and morbidity—amongst Indigenous people in Australia. Addressing low fruit and vegetable intake is an essential part of any strategy to close the gap. Of the total health gap, five per cent is attributable to low fruit and vegetable intake. To put this into perspective, tobacco and excess alcohol contribute 17 per cent and four per cent. The burden of disease for Aboriginal and Torres Strait Islander people from low fruit and vegetable consumption is 1.6 times higher in remote areas than in non-remote areas. If you want us to give information on how we calculate that, we are happy to do that; otherwise I will keep going on the particular issues.

CHAIR—There must be some formula that you have; perhaps you can just send that in.

Ms Podesta—We will; we will give you information on how we calculate that. We use a study that we fund the University of Queensland to undertake. It is the Vos study; it is called *The burden of disease and injury in Aboriginal and Torres Strait Islander peoples*. It was published in 2003.

Mr TURNOUR—Just to clarify that, five per cent is the percentage of the 18-year life expectancy gap that you attribute to—

Ms Podesta—Of the total health gap, yes, five per cent is attributable to fruit and vegetable intake.

CHAIR—You said 17 per cent is smoking and four per cent is alcohol.

Ms Podesta—Yes, tobacco is a 17 per cent contributor and alcohol is a four per cent contributor.

Mr TURNOUR—Can we get the whole hundred percent outlined?

Ms Podesta—We can give you the whole breakdown.

Dr Isaac-Toua—I think we actually did give a copy of the burden of disease study last time, but we are happy to leave another copy.

Mr TURNOUR—If we have it in the system, don't do that.

Ms REA—That table would be good; we will not read the whole study, but—

Ms Podesta—We will give you the table and how it is calculated on disability life years.

Ms REA—Thank you.

Ms Podesta—Mr Laming is very familiar with this one. On specific data on the health of Aboriginal and Torres Strait Islander people in remote communities and relationship to nutrition, there are a number of issues that relate specifically to nutrition. The first one is heart and circulatory disease. Fourteen per cent of Indigenous Australians in remote areas reported heart and circulatory conditions, compared to 11 per cent of those living in non-remote areas. After adjusting for the age difference between those two populations, we can confidently say that Indigenous Australians are 30 per cent more likely to report heart and circulatory problems than non-Indigenous Australians. So for those living in remote areas it is a particular issue.

Cases of self-reported diabetes and high sugar levels are higher for Indigenous Australians living in remote areas. That is approximately nine per cent compared to those living in non-remote areas, where it is approximately five per cent. Approximately three times as many Indigenous Australians reported diabetes or high sugar levels as non-Indigenous Australians. We just recently had this discussion; we have a real epidemic.

Mrs VALE—Sorry Ms Podesta, what was that figure?

Ms Podesta—Approximately three times as many Indigenous Australians reported. On overweight and obesity, 59 per cent of Indigenous Australians living in remote areas were overweight or obese. However, this did not particularly vary for non-remote, where the proportion was also about 60 per cent. After adjusting for differences in age structure, Indigenous Australian adults were twice as likely to be obese as non-Indigenous Australian adults. So there is not a great difference between remote and non-remote but a significant difference between Indigenous and non-Indigenous status.

Mr TURNOUR—Do we have those figures for Torres Strait to compare to Aboriginal Australian differences?

Ms Podesta—We might be able to get that.

Ms REA—Do we have figures for children?

Ms Peachey—I don't believe that we do.

Ms Podesta—We will check and take that on notice.

Ms REA—I think it would be interesting to compare obesity in children as well.

Ms Podesta—I do not think the health performance framework, the 2008 report, breaks it down by age, but we will check that.

Ms REA—Thanks.

Ms Podesta—On self-assessed health status, interestingly, Indigenous Australians were almost twice as likely as non-Indigenous Australians to report their health as fair or poor. However, a higher proportion of Indigenous Australians in non-remote areas reported fair or poor health status compared with those living in remote areas. So that is interesting. Whilst, on the one hand we know that people living in remote areas do have higher levels of morbidity and acute conditions, as self-reported, more people in non-remote areas report themselves as having poor or fair health. We think this is potentially influenced by whether their health conditions have actually been diagnosed and also what the health status of their community is. People tend to say whether they think they are healthy compared to the people around them. So maybe people might not be thinking that they are as sick as they possibly are.

The incidence of end-stage renal disease is greatest in very remote and remote areas, where it is 18 and 20 times as high as for other Australians in the same areas.

CHAIR—In the same areas?

Ms Podesta—In the same areas. Compared to a non-Indigenous person living in the same part of the country, the heart rates for Indigenous people are still much, much greater.

CHAIR—Right, okay.

Ms Podesta—In outer regional areas the incidence amongst Indigenous Australians is 14 times as high as for non-Indigenous Australians. In major cities and inner regional areas it is four to six times as high. This is genuinely an Indigenous disease. We still have high rates of renal disease in other parts of the country, but as you go into remote Australia it is an absolute critical issue for very large numbers. We can talk a little bit more about that but, essentially, in some parts of Australia we almost have a diaspora of people who cannot live in community any more. In some communities nearly everyone over the age of 50 who is alive is either in town or with their partner in town on dialysis.

And, of course, there are decayed, missing and filled teeth. Across a range of measures, Aboriginal and Torres Strait Islander children living in rural areas tend to have the poorest level of oral health, followed by Aboriginal and Torres Strait Islander children living in metropolitan areas, with non-Indigenous children in remote, rural and metropolitan areas having the best oral health.

CHAIR—Why do we know that about children and not the others?

Ms Podesta—Because we have dental surveys on children.

CHAIR—So it is a different survey.

Ms Podesta—It is different, yes. Across all age groups, rural Indigenous children had greater decayed, missing and filled teeth scores than their metropolitan counterparts, but rural and metropolitan non-Indigenous decayed, missing and filled teeth scores were relatively similar. The mean dental decayed, missing and filled teeth scores increase with increasing age for all children, with the steepest gradient occurring amongst rural Indigenous children. Essentially what that means is that Indigenous children living in rural Australia have relatively poor oral health as they are young and it gets worse and worse as they get older.

So what is the relationship to nutrition? We have given you all of the headline ones. Many of the causal factors contributing to the ill health of Aboriginal and Torres Strait Islander people are diet related diseases, such as heart disease, type 2 diabetes and renal disease. We understand through the health performance framework that fruit and vegetables may be less accessible to Indigenous Australians in remote areas. In remote areas, 20 per cent of indigenous Australians aged 12 years and over reported no usual daily fruit intake, compared to 12 per cent in non-remote areas. The disparity is even greater for vegetables, where 15 per cent of Indigenous people in remote areas reported no usual daily intake, compared to two per cent in non-remote areas.

Diet related diseases are caused by a combination interaction of environmental, behavioural, biological, social and hereditary factors. There is a substantial quantity of evidence that associates diet excess and imbalance with chronic disease. The particular relevance in Indigenous communities are factors such as socioeconomic status and environment. Other risk factors include insulin resistance, glucose intolerance, central obesity, hypertension, high blood triglycerides, prenatal and postnatal nutrition and childhood nutrition. Good maternal nutrition and healthy infant and childhood growth are fundamental to the achievement and maintenance of health throughout the life cycle.

We are really concerned with nutritional status during pregnancy. It is one of the major factors that have been associated with low birth weight in babies. Growth retardation amongst Indigenous infants up to the age of four to six months has been consistently noted in all of our studies. Relatively poor growth has also been shown to persist in older children, although overweight and obesity are also increasing. Of particular interest, I think, is the research that has recently been undertaken in North Queensland by McDermott, Ligh and Campbell that cites that high prevalence and incidence of central obesity, diabetes, poor nutrition, high rates of alcohol use, tobacco smoking, together with a young maternal age are providing a very poor uterine environment for many Indigenous Australian babies and contributing to a high perinatal morbidity and future disability. We have spoken at some length about this previously with this committee. There are some genuine issues around access to nutrition and other factors which are contributing to a life cycle impact for Indigenous children in remote areas. This is because of the poor nutritional status of young mothers who are conceiving early. The uterine environment for their children is poor and it contributes to an ongoing cycle of presenting problems—in the first instance, it being hard to pacify babies but leading to a whole range of other factors around their growth status, their brain development and their physical development.

On average, the cost of a food basket in remote Northern Territory stores was 29 per cent more expensive than in a Darwin supermarket and 19 per cent more expensive than in a Darwin corner store. The percentage of family income required to purchase the basket of food was 28 per cent in a Darwin supermarket and 36 per cent in the remote stores.

CHAIR—Can I just ask, what—

Ms Podesta—This is from the *Market basket survey of remote community stores in the Northern Territory* undertaken in 2006, and we are happy to give you that information. The cost of a healthy food access basket continues to be considerably higher in very remote stores throughout Queensland, especially in those towns more than 2,000 kilometres from Brisbane. In 2006 the mean costs of the healthy food access basket was $107.81. It was 24 per cent higher in very remote stores in Queensland but $145.57, which is 32 per cent higher, in very remote stores more than 2000 kilometres from Brisbane compared with the same basket in major cities. You probably know this already.

CHAIR—That is all right; you go for it.

Mr LAMING—I think you said 24 and 32. Both are at remote Queensland stores and one is 1,000 kilometres and one is 2,000 kilometres out?

Ms Podesta—Yes. The further out you got, the more expensive it became, and the cost of healthy food has increased more than the cost of less nutritious alternatives.

Transport is the other critical factor for remote Australians. In remote areas, 14 per cent of Indigenous Australians were more likely to report not having used transport in the previous two weeks and 74 per cent gave no service available as the main reason they did not use public transport, compared to two per cent and 25 per cent respectively for non-Indigenous Australians.

In 2006 in non-remote areas, 75 per cent of Aboriginal households reported having at least one vehicle, compared to 52 per cent in remote areas. In contrast, access to motor vehicles in other Australian households was similar in both remote and non-remote areas—about 87 and 90 per cent. This is a critical factor because if there is only one source of food, the capacity to make other choices is very limited in remote communities. Do you want to ask particular questions now about this aspect, or do you want me to go on?

Mr TURNOUR—I have some questions about this aspect. The cost of living is obviously a major focus of this inquiry. We have heard evidence previously that people's ability to cook food at home, their living conditions and the number of families in homes is also part of that, as are also the access to refrigeration and the like. Have you done any work on that? As part of the inquiry, while the cost of living is obviously important for you to raise, there are actually other issues that may prevent people from eating healthily at home.

Ms Peachey—Cost is a key issue in Indigenous communities; it is also a key issue in many other communities: low socioeconomic and rural and remote. I guess it is a whole-of-government issue and the role for Health is really in trying to educate and influence people to make healthy choices in their particular circumstances.

Mr TURNOUR—The issue I am asking you about is that, if we had cheaper or similarly priced food, would people then change their habits and start eating healthily, or are some of the other issues in terms of overcrowding in housing, access to refrigeration and all those sorts of issues, as important?

Ms Podesta—There is no question that cost of food is a significant determinant but improving people's nutritional knowledge and motivation is critical and their access to functional housing is also vital to be able to address this. Our performance framework report in 2008 found the proportion of our Indigenous households in discreet Indigenous communities that reported they did not have working facilities for storing or preparing food was much higher in remote areas. It was about 16.7 per cent and in non-remote areas it was about 2.5. About one in five houses cannot store or prepare food. We know that there is a real education gap around being able to understand the need to store and prepare food.

CHAIR—One in five where?

Ms Podesta—In remote communities in discrete communities. That was our health performance framework and self-reported information.

CHAIR—On the basis of what we have heard, that seems to be quite a low figure. We have taken a lot of evidence around this and it does seem to be an issue. You are absolutely correct in that costs and motivation are key issues, but it is also about what kinds of facilities are at home to cook food and to keep it. There are communities we have gone to where the evidence really has been that basically no-one has a fridge and they are effectively using the community store as a fridge. That is, they purchase two or three times a day.

Ms Podesta—On the spot, yes.

CHAIR—But it is not just refrigeration. We had one—

Mrs VALE—It is even more basic than that. It is even the fact that they do not have any utensils. Like, to even do an omelette, they do not have a frying pan. Are you aware of what is provided in the remote communities when a house is provided?

Ms Podesta—No, we do not do housing, I am sorry.

Mrs VALE—But, as a health professional, are you aware of what, especially the women, get when it comes to actually learning how to work with a white diet? One of the things that we actually learnt too was how much people in remote communities can access bush tucker, and with the calicivirus and the fact of the gun laws that we have imposed upon them, which is right that we would do—

Ms Podesta—They cannot have rabbits.

Mrs VALE—They cannot have rabbits any more. They do not have chickens; they do not grow their own vegetables. It is interesting to hear about teaching people how to make appropriate choices but, hey, they have got to have choices to start with. Just to add to what you were saying, Jim, the fact is that it is not just refrigeration; it is just basic utensils to actually prepare food with.

Ms Podesta—We are very conscious of it. We have been to a number of communities. They are different. They are not all the same and there are certainly some remote communities with functional kitchens. There are some that do not have them, and they do not have a tradition of

functional kitchens. There are also communities which have insecure power supplies. There have been some efforts around kitchens which are provided—communal is not the right word—on a shared basis and supported and linked to stores or the health services, and we have been part of those initiatives. We also put a significant investment into the nutritionist program which worked with the Outback Stores. That has been a health initiative, and that has been important in helping people make choices. So there is a gradient of how people's lives are.

CHAIR—Has some survey work been done then around that question about the functionality of kitchens in these communities?

Ms Podesta—There has been some work undertaken. The health performance framework reports on all of the data that is publicly available, so the data that I quoted you, the 16.7, is an analysis of the publicly available and validated data on working kitchens. We work fairly closely with the Housing for Health program. I am sure you have been briefed on Housing for Health, which is to look at functionality of housing. You have?

CHAIR—Not yet.

Ms Podesta—Housing for Health is a significant initiative. It is primarily around remote housing repair, and it is about functionality. It starts on the basis of asking: will this house kill a person? So it looks at electricity, at washing, at ablutions, at storing food, and at preparing food to make a house that is safe for people to live in.

Mr TURNOUR—We have heard stuff, but if you have got some evidence base, that would be really helpful in those areas. You have obviously started to give us a good breakdown of that life expectancy gap. You spoke about the percentage of fruit and vegetables at five per cent, you had tobacco at 17 per cent and you had alcohol at four per cent. From a government point of view, I would be interested to get an idea about the breakdown of the Indigenous health budget and whether there has been any look at how the budget is being expended as compared to the issues in terms of the life expectancy gap. Tobacco is an issue at 17 per cent. Are we really focussed in that area in terms of the level of work that we are doing there, given the significant impact it has? Similarly, in this area of where we are specifically focussed around, fruit and vegetables and the like, and availability of food and the ability to prepare that, where are we at in terms of the breakdown of our engagement on these issues? I know that we spend most of our money on the acute end, but one of the things we would like to do is move more to primary healthcare, and I think it would be helpful if we get could some transparency about the issues and if you could provide some information that aligns with that and provides us that.

Ms Podesta—Thank you for that. The Office of Aboriginal and Torres Strait Islander Health's primary mission is primary healthcare, and of the half a billion dollars that we look after, the overwhelming majority of that money goes to primary healthcare services. Our service activity reporting breaks down the transactions, the visits and the services that those services provide, so we can certainly give you some analysis based on our service activity reporting of what primary healthcare provision looks after what. Health Services make their own decision based on the needs and the profile of their communities, what they have focused on, but government has also identified some additional interventions. Particularly, as you know, there have been very big announcements recently about tobacco, so there has been over the top of the broad based primary healthcare funding some specific interventions around particular areas.

Mr TURNOUR—Would it be fair to say as a generalisation though that we would still have to spend the majority of our health budget in, for example, diabetes on the people who have diabetes, and not necessarily on the prevention end?

Dr Isaac-Toua—The community controlled sector in Indigenous health concentrates on providing primary health care services which includes the spectrum. So you would be looking at screening, prevention—

Mr TURNOUR—Yes, but the question I am asking is that if you go to a community, you have a clinic there, you have the community and you have a whole range of different things. The vast majority of funding, as a generalisation I would think, would be still spent trying to fix people who already are sick rather than—

Ms Podesta—In terms of health economics there is no question that when someone has a high level of acuity the costs of treating and supporting them are very high so there is genuinely a sensible approach which says that if you are able to identify a better investment in prevention and treatment and early diagnosis, then some of the high-end costs for people who have unmanaged diabetes, acute renal disease, et cetera can be reduced. The question is: What is the situation now? We probably cannot answer that, but we can certainly give you an indication of some of the trends. The new package that was announced as part of COAG, the Chronic Disease Management package, is absolutely predicated on the thesis that the most efficient and effective way to manage some of the explosion around chronic disease is to get much earlier diagnosis, much earlier treatment and to focus on prevention. So the new $1.6 billion COAG package for closing the gap is absolutely based on exactly that reasoning.

Mr TURNOUR—Did you want to add to that?

Dr Isaac-Toua—Not just with prevention and screening for early disease but also with minimising progression of disease. That is one area that the primary health care service focuses on. Even if someone is then diagnosed with diabetes, it is about managing their diabetes so that they do not progress and go into end-stage renal disease earlier. So that is one of the areas that the primary health care services are focusing on as well.

Mr TURNOUR—That leads me to the next question quite nicely. In terms of those new areas, is there any ability to look at how we could improve and make hot food more affordable and actually tackle some of these other areas in terms of the ability to cook, nutritional education and the like?

Ms Peachey—Not specifically in the COAG National Partnership on Preventive Health. The government established a preventive health task force to develop a strategy. That was established in April last year and will report next month to Minister Roxon. There are three areas of focus for the task force around obesity, tobacco and harmful alcohol consumption. I know in relation to obesity prevention the taskforce is looking specifically at issues relating to Indigenous nutrition and obesity and they will consider issues around cost, availability, access, and infrastructure—those types of things. That will be delivered next month.

Mr TURNOUR—I suppose the point I am making is that we can spend a lot of money with educators and those sorts of people, but if you are saying five per cent or whatnot about costs

and accessibility to do that, maybe there are some arguments for subsidies or the like to actually address that issue. If you are just tackling the educational end, but you actually do not have the ability to actually cook food or buy it at affordable prices, then you can actually spend a lot of money and not get an outcome anyway. It is von Liebig's law of the minimum, I think, in some of the nutritional, agricultural areas and that is the point that Ms Vale was making I think as well. Anyway Chair, I think I have probably taken up a lot of time.

CHAIR—Why don't we keep going.

Ms Podesta—Would you like us to brief you on the Menzies School of Health Research. I think you were interested in the work on electronic monitoring of food sales.

CHAIR—Yes.

Ms Podesta—This is research that was published in the 18 May edition of the *Medical Journal of Australia*. It is a research project undertaken in 2005 to examine the relationship between dietary quality, energy density and energy cost of food in remote Aboriginal Australian communities with the aim of explaining the persistent poor dietary patterns reported for Indigenous populations over decades despite efforts to improve dietary quality and why people keep buying energy dense food that is not particularly good for them.

For a three-month period in 2005, food and non-alcoholic beverage supply data from food outlets available was collected. The data was used to compare the energy density of foods with their energy costs. The community food outlets included a community store, two convenience shops—which were takeaways—a school canteen and a government sponsored aged care program which provided fresh weekly food parcels to 16 residents. The results of the study showed that the population was found to be high in the consumption of refined carbohydrates and low in the consumption of fresh fruit and vegetables.

Foods with high energy density were associated with lower costs and contributed disproportionately to energy availability. That diet pattern is consistent with that reported for economically marginalised groups in Australia and other affluent Western societies. The conclusion of the study is that the energy cost differential between energy-dense, nutrient-poor food and energy-dilute, nutrient-rich foods influences the capacity of Aboriginal people who live in remote communities, to attain a healthy diet. It is consistent with the economics of food choice theory whereby people on low incomes maximise energy availability per dollar in their food purchasing patterns. It has particular relevance for developing nutritional policy and strategies in Aboriginal communities where poor nutrition is a major determinant of preventable chronic disease. The studies show that low income is a powerful driver of food choice. The facts are compounded in remote communities by high costs of perishable food such as meat, fruit and vegetables. We are happy to table the *MJA* study for you, but you asked specifically whether we could give you additional information at today's meeting.

CHAIR—So the conclusion to all that is that the—

Ms Podesta—If you are poor, you will buy cheaper energy-rich food and that it is actually a rational decision by people with a limited amount of money. People are choosing energy-dense

food which unfortunately does not have high nutritional value because of the relative costs. We are going to brief you on the Mai Wiru project on the Anangu Pitjantjatjara lands.

Ms Catchatoor—The Mai Wiru good food policy was developed and signed off in 2001 and that was through FaCSIA at the time. The department in February 2004 approved funding under the Regional Health Services Program for the Nganampa Health Council to develop a strategic implementation plan for the Mai Wiru healthy stores project and to implement the plan. We had a two phase approach. The first phase was to develop a strategic implementation plan to give effect to the Mai Wiru regional stores policy and that was from 2004 to 2005. The second phase was to provide about $1.5 million to implement the project which involved negotiation with grocery suppliers for a coordinated approach to the freight system and to address issues to provide nutrition tools like handbooks and promotional material and training with Indigenous store workers. MOUs were signed with eight community councils and eight stores were established with Anangu store managers and some staff in a traineeship program funded by DEWR at the time.

A public health nutritionist was recruited in April 2006 and I think that helped to make a difference in the actual implementation. The assistance of the public health nutritionist has shown some positive improvements to the diet of community. We will be looking at future funding for the Mai Wiru stores project for 2009-10. We did renew some funding for 2008-09 as well and we do receive reports from Nganampa Health Council which are showing that there have been benefits from this project and we are looking at continuing the funding into 2009-10. I think the Nganampa Health Council is looking at future arrangements and how that might be managed, maybe under another auspice because they are seeing their role not so much as managing the stores project into the future. We are looking at funding them for another year to help them transition.

Ms Podesta—The outcome from the investment has been that we have been able to demonstrate by working in the Anangu Pitjantjatjara lands with the health service that you can invest in knowledge and systems and change the way people purchase to stock the stores. They have been able to have a regional purchasing arrangement which has reduced the prices generally and, with the nutritionist and the health service working to support the stores, the community has taken up the options for better food.

One of the really tangible examples now, and I have been to the lands many, many times, is that you would walk into a store and the cold drink at the door would be Coca Cola; the fridge is now stocked with cold water. It is just an example. There is more availability of fresh food and people are making choices to buy fruit and vegetables. This has been a long-term partnership with Nganampa Health service on the lands. It was the COAG trial site for health and we have had a long commitment to this area. We have been able to demonstrate with the data that people are making better choices, there is better availability of food and you can change culture, management and organisation. These are certainly improvements but I think we wanted to draw this to the committee's attention to show that they are not all failed states and, while there are certainly a range of challenges, there are interventions that are possible and which we know will change stocking and buying behaviour.

CHAIR—So you have data which compares before and after stocking?

Ms Podesta—Yes, we have information from the health service about the choices people are making. Through the health service we have just invested in an electronic monitoring system with the stores. They have been doing surveys with the stores but they will now be able to electronically monitor precisely the purchases and they will know exactly what has changed because they did the surveys before the monitoring systems were in place. They will be able to have very accurate data on the changes. Mai Wiru won the National Heart Foundation award for changes at a community level.

CHAIR—I think what we are interested in is as much hard data as we can get about that. We heard from the Mai Wiru project when we were in Alice and indeed when we went out to the APY Lands. John Tregenza I think is the—

Ms Podesta—Stephan Rainow.

CHAIR—It does sound really interesting. We were told the story about Amata where the community has made the decision not to stock full-strength Coke at all. All of that sounds good, so it would be really good to get whatever hard data around that.

Ms Podesta—We will give you what we've got.

CHAIR—I lost track a bit when you were talking. What is the future of the funding for it?

Ms Catchatoor—We are looking at another year's funding.

CHAIR—You talked about a transition into what?

Ms Catchatoor—The health council is looking at future arrangements because they do not see their role ongoing.

Ms Quick—Nganampa Health have taken this on board since 2004. In discussions with us they recognise that this issue of supporting the stores with business system support and that sort of stuff, is not their core business and Nganampa Health want to find an alternative arrangement—some sort of community management arrangement on the APY Lands to take on the management of the healthy stores policy as such. They see themselves more as a health organisation; they see that they would have a role ongoing perhaps in monitoring compliance with it, but the stores policy, the employment, the HR practices, those sorts of thing that support a healthy stores policy, would be better overseen and managed by a more appropriate organisation.

CHAIR—Do you imagine funding for the organisation going forward?

Ms Quick—For us? Our involvement is on the health side. We have funded Nganampa Health to get it thus far. This financial year we will be agreeing to provide an additional year's funding to help with that transition. Nganampa Health want to find another provider for the healthy stores and our interest will probably remain around the nutritionist.

Ms Podesta—We had a very high level meeting about the project between a number of departments to talk through the future. The health service is very clear and their committee has

made a decision that they have done this. It is a population health measure but they have a number of other issues on health that they have to direct their resources to.

Mrs VALE—Ms Podesta, if I could ask you this while the bells are going, do you see that it has actually had a positive impact?

Ms Podesta—I think it is a fantastic project.

Mrs VALE—Do you think that it could be possible to roll out this model across other areas?

Ms Podesta—Absolutely.

CHAIR—We can keep going. Mr Laming will take the chair. Ms Rea and I need to go, but we will be back in a moment.

ACTING CHAIR (Mr Laming)—Thank you.

Ms Podesta—We wanted to brief the committee on the remote Indigenous store and takeaway project.

ACTING CHAIR—Right.

Ms Peachey—I want to pick up on Ms Vale's comments. It is not just about influencing people's choices but it is about what is available to them if they are using the remote community store and takeaway as their fridge or their kitchen.

Mrs VALE—That is what we found in the two remote communities that the chair and I went to. They just did not have any other facilities.

Ms Peachey—The remote Indigenous stores and takeaways project is a major achievement of the National Aboriginal and Torres Strait Islander Nutrition Strategy Action Plan, lovingly known as NATSINSAP. That largely aims to improve access to good quality, healthy foods for Aboriginal and Torres Strait Islander communities. These guidelines and resources were developed and implemented across a number of remote community store and takeaway trial sites. Have you seen the resources before? I have brought a bit of a show bag that you can keep.

Mrs VALE—No, I have not. These are beautiful.

Ms Peachey—Basically, the resources included things like guidelines for stocking healthy food in remote community stores, so it is a checklist of the minimum range of core foods that should be stocked in the store regardless of the size of the store. There is a fruit and vegetable quantity spreadsheet. It is a tool that helps stores to calculate the quantities of fresh fruit and vegetables required to meet the nutrition recommendations of the community being served.

The resources include marketing ideas for healthy food and remote community stores. That resource outlines how to promote healthy food and drink in a community store setting. There is healthy fast food. This provides solutions for supplying, say, affordable and healthy takeaway options. There are great ideas, particularly where access to fresh fruit, vegetables and fish is not

available. They have lots of options around how you can try and counter that. There is a freight improvement tool kit which is a guide for store managers as well as others involved in the food supply chain, to improve the transport of healthy foods. There is a checklist for stores and takeaways that can be used by store managers to assess their capacity to provide healthy food and drink options.

There are strategies around how you maximise the shelf life of fruit and vegetables and a keeping track of healthy food resource, which is an electronic store food sales monitoring tool. It is designed by the Menzies School of Health Research and it uses scanned sales data to assess and monitor the community's consumption of healthy foods.

Ms Podesta—Which is what we will put into the Mai Wiru stores.

Ms Peachey—The Heart Foundation has also developed a buyer's guide which lists healthier products to assist stores when they are ordering.

Mrs VALE—Are the stores' managers under any obligation to actually fulfil exactly these recommendations?

Ms Peachey—No, they are not.

Mrs VALE—When so much depends on it—when the health of the whole community depends on how the store is run—that to me was the big shock. As an ordinary Australian mum to actually get there and see the whole health of this community depends on the management of this one store.

Ms Peachey—I can say that these resources were only launched at the beginning of last year and states and territories have been working quite hard to roll these out. Some of the states are providing nutritionists to work in stores to assist them in using these tools. There were seven pilot sites that undertook some training around the use of these resources in 2007. They were largely in the Northern Territory, Queensland, Western Australia, South Australia and New South Wales. These resources have just been taken up by FaHCSIA.

Mrs VALE—As an organisation, do the Outback Stores operate under this?

Ms Peachey—They have also basically taken up these resources and they are using them to develop store policies. It is a new resource, but the uptake has been great. We are currently evaluating the overarching strategy, the NATSINSAP, and the use of these resources will be part of that evaluation.

Mrs VALE—How important do you see is the nutritionist as being part of the team for the Mai Wiru policy?

Ms Catchatoor—I think the reports from the Nganampa Health Council have shown that the public health nutritionist employed has helped to make a difference. We have just got some results that they have included in their report to us, if you want me to go through those. The sort of activities have been discussion with the community stores about healthy food line items which apparently has led to the promotion of healthier items in the stores; provision of healthy kids

food packs; substitution of some products—for example, having the Heart Foundation tick for bread and meat pies for example. Meat pies are popular, but they have the better option.

Mrs VALE—Where I saw that operating it did seem to be appreciated. Also some of those snack packs with cheese and dried foods.

Ms Catchatoor—More healthy choices, still snacks and things.

Ms Podesta—We are funding nutritionists in a range of programs now and the feedback that we have had is that this is about trying to influence the choices that are made for stocking and for purchasing. At the best, nutritionists that have been working in communities have made a big difference about being able to show people that substitution by nutrient-rich food of nutrient-poor food does not change taste. That is really critical. People have had to find good tasting, interesting, attractive, nutrient-rich food. That is where primarily the nutritionists have been very important. I know this will sound crazy, but a really good example is that a pie is a very popular item and one of the nutritionists had spent a lot of time identifying the best pies in terms of lower fat, high-protein content that was able to be shipped, had a longer shelf life—

Mrs VALE—Low salt?

Ms Podesta—Low salt. They found it, they sourced it and then they had to promote why they were getting rid of X brand and why they were going to introduce Y brand. That is a change management process. People are attached to certain things—such as petrol and a whole lot of other things that people buy. Trying to introduce a better for you product, and with a high acceptance level, that is what the nutritionists do well when they are skilled.

Mrs VALE—One to one.

Ms REA—I was about to ask a question before we were interrupted. I am not sure whether it may have been covered by Ms Vale's questions but I hear, obviously from a health perspective, the data that Richard asked for in terms of the evidence of changing diet and better products in the shops, all of that is good. From our perspective though in this inquiry, I guess we need to go one step back and ask the question about what it is that has generated that change in purchasing policy and that change in attitude. These could be really no-brainer questions but is it simply the management of the store; is it the personality of the people managing the stores; is it the nutritionist alone regardless of what the management or governance structure of the store is; is it necessarily the fact that it is a community based decision? What are the key factors that you have observed that have created these outcomes—because we all know better food is going to create a healthier community. Obviously that data is important but from our perspective we want to know the management model in community stores that is actually going to enable that to happen.

Ms Podesta—We expected that you might want to know that.

Ms REA—That is good.

Ms Podesta—We did look very much at why Mai Wiru is beginning to produce some results. I will leave aside the issue of voluntary income management. That has not been introduced on

the Anangu Pitjantjatjara lands, but there is certainly some information from our colleagues in FaHCSIA that that is having an impact.

Ms REA—Maybe you can give us some information.

Ms Podesta—Will I leave it?

CHAIR—No, you keep going.

Ms Podesta—Okay. What we know from Mai Wiru is that improved governance has made a difference; management and monitoring of the individual stores by the health service through the project; working to improve the individual store viability so that they do not have economic reasons to stock profit-rich foods; investing in the skill of the staff, access to data to inform the public health nutrition policies and activities is critical and service, pricing and food security for customers. All of those factors are important factors that have made Mai Wiru have differences in purchasing and behaviours.

ACTING CHAIR—Is there any economic data on demand elasticity as price of fresh food changes? Has anyone done any work on that?

Dr Isaac-Toua—I couldn't answer that.

Ms Peachey—I am not sure that the ACCC might have looked at that when they established their grocery website. We could follow up and provide you with further advice on that.

Dr Isaac-Toua—I have actually had a chat with a health economist about this issue about looking at the cost efficiency of nutrition supplies to remote communities and it is a very hard area to actually work with because there are so many other contributing factors that are difficult to measure like the environmental factors that we have been talking about. There is some modelling that has been done on the Mai Wiru project from one of the institutes and I could send you that information if that helps.

ACTING CHAIR—That really is an absolutely vital precursor to being able to talk about making fresh food more affordable, if it is just the affordability line.

Ms Podesta—I think that we would say that it is a factor but it is not the only factor and that, while affordability influences, knowledge skill and a range of other areas are equally important.

Dr Isaac-Toua—In an economic model some of those other factors are difficult to actually measure.

Mr TURNOUR—In your introductory comments you talked about an individual's understanding of their health and that people thought they were healthier than they may have been.

Ms Podesta—Self reported health status?

Mr TURNOUR—Yes. It is the classic example of where we run advertising on television that frightens people about what might happen to them if they do not stop smoking. Obviously that does not necessarily work when you still have that 70 per cent gap in the Indigenous community. Are doing any work in terms of the awareness, particularly in relation to diabetes and the need to eat healthily, whether there is a real understanding in communities and whether we need to do more work in that area? Are we doing any work to raise awareness about drinking Coca Cola and eating high-density energy foods and diabetes? Do people have a clear understanding of that in communities and if not, can we do more work in that area?

Ms Peachey—I could tell you that, as part of the Measure Up campaign, which you may have seen on TV with the fellow walking down the tape measure, an Indigenous strategy was attached to that called Tomorrow People. That was really based on simple, key messages regarding the importance of healthy eating and physical activity. The Tomorrow People campaign had print and radio, and a whole range of resources attached to it, and they had been distributed to Indigenous organisations and Indigenous communities, and medical services. That only commenced last year and, in addition to the sorts of on-the-ground activities we have done with the national nutrition strategy for Indigenous people, that is the first real investment I think of recent times to start to commence that work. That campaign has just been evaluated now and the results have not been reported yet. I understand there is a very high awareness that people have got the understanding between waist measurement and risk of chronic disease. The reports that I am hearing is that the 'how to' still needs a lot more strengthening in how people can change their lifestyle to reduce their risk of developing chronic disease. In Indigenous communities it is even harder again and we have to probably work community by community.

Ms Podesta—The big new chronic disease management program is predicated on that just under 10 per cent of adult Indigenous people in this country have an annual health check and that we are working to a minimum of 40 per cent. The idea behind that is that people will have a very thorough and full health check, which will identify their current health status and the risk factors. As a result of the health check, their practitioner will be in a position to refer the Aboriginal person without cost to the types of services and supports they need to change. We know that we are going to have to focus on tobacco; it is such a high risk issue for Indigenous people. More than 50 per cent of Indigenous people smoke; it is killing people. Dietary change is also critical. So the funding in the new COAG measure provides prevention and lifestyle support change. That includes things such as exercise programs, dietary and nutritional advice, and services for people as a result of the diagnoses after their health check of what they need to do to change.

There is also a big community awareness campaign around risk factors of chronic disease, so you will see lots and lots of localised, culturally specific campaigns based on the types and groups of people—some directed to young mums, some directed to teenagers, some directed to older men. It is not going to be pan-Aboriginal, every Aboriginal person is the same—it does not work—but big information and promotion campaigns around risk factors and changing behaviours, because undoubtedly nutrition is going to need to be one of the things that changes.

The new program does not include money to subsidise food choices but it does include flexible funding within the health system for the pharmaceutical or other services that people may require. For example, if they have high cholesterol levels, there will be subsidy of PBS items to help get that under control.

Mrs VALE—Lesley, has there been any research done with how much money of an Indigenous person's income is actually spent on cigarettes?

Ms Podesta—I am sorry but I do not know. I would have to take that on notice.

Mrs VALE—When you consider how bad it is and the impact of it, there is a certain amount of income that is received into an Indigenous household. I was wondering if there is anything on exactly how much money—

Ms Podesta—We will take that on notice. We possibly have that data.

Mrs VALE—You probably would, I would have thought.

Ms Podesta—I did not bring it for the nutrition hearing, but we probably do.

Mrs VALE—Have you found in Indigenous remote communities that once people get to a certain age—is this what you were saying earlier on—that they have a certain health issue, like end-stage renal failure, and they then end up in a local community?

Ms Podesta—No. Most people, if they are still alive and require dialysis, need to go to a regional centre—like Alice Springs, Cairns or Broome. They need to relocate because they need dialysis two or three times a week. We are finding that increasingly in smaller communities anyone much over the age of 50 is either on dialysis or their partner is on dialysis, and they are living in town now. It has two effects. One, accommodation in town is pretty tough; so people are not living in great accommodation. Two, the cost is higher because it is in town.

Mrs VALE—Is that higher cost to the person or to the government?

Ms Podesta—To the person. There is some subsidised accommodation but not always. If you choose to move into town because of your health needs, it is like any other Australian person: you relocate because you need to be near a hospital. You may be eligible for subsidised housing and you may not. It may be available and it may not. But there is also an impact in the communities where the older people have left. You have very few older people left now and issues around governance and stability are having an impact. There is a much higher number of young people and not so many older people. That is having a particular impact in some remote communities with high levels of renal disease. We call it a diaspora, basically.

Mrs VALE—Trying to look objectively at this, and with no emotion at all, it appears to me that these communities are quite toxic.

Ms Podesta—I think there are some very dysfunctional communities.

Mrs VALE—If that is the case, the communities themselves and the lifestyle that is imposed on people because they live there seem to be killing people.

Ms Podesta—There is a range of views. There is some data that shows that people who live in some remote communities have higher levels of health. Overall that is not correct. Overall, the health status of people who live in very remote communities is poorer, but certainly there is

some research that some remote communities—and it appears to be linked to connections to culture, economic activity and social cohesion—have higher levels of health. That is a number of PhD theses, I think, to be able to identify what the differences are.

Mrs VALE—We found that there was virtually no growing of fresh fruit. There were no market gardens or fresh fruits or vegetables, and there were no chickens, pigs or anything like which you would find in a traditional community in, say, Africa or Indonesia. There was none of that sort of self-sufficiency in any of these remote communities.

Ms Podesta—Market gardens have not fared well.

Mrs VALE—No. There had been a history of them. Nearly every community we went to could remember that there was one somewhere down the road that somebody operated some time ago in their recent history. But when we went there there were no market gardens operating.

Ms Podesta—It would not be our view that it would be a good investment at the moment given the history.

Mrs VALE—Really?

Ms Podesta—We have not seen any examples of sustained market gardening projects which were supplementing food in any community in the long term. There has certainly been one-off funding of those projects. The sustainability is an issue. I think it just goes back to social cohesion, leadership and governance and managing those things properly. Communities have had too many one-off good ideas, or people who were going to turn up and be there for six months.

Mrs VALE—They are exhausted, are they?

Ms Podesta—It is about looking at evidence of things that have shown to work. Without putting Mai Wiru on a pedestal—and I do not in any way—Mai Wiru was a very well based initiative with strong leadership within the community, hosted by a very stable and professional organisation. They are some of the reasons it has been successful.

Mrs VALE—And the women seem to like it.

Ms Podesta—Yes, women do like it.

CHAIR—I am confused about whether Mai Wiru has ongoing funding or whether there is—

Ms Podesta—It is not a question of ongoing funding in the slightest. We are very, very committed to Mai Wiru. The health service that hosted it have indicated that they no longer wish to host it.

CHAIR—And they gave that evidence.

Ms Podesta—There is a process now to identify an alternative provider. Once that is done, the process of how that will be supported needs to be determined between government departments.

I cannot pre-empt government decisions, but we in no way are getting away from that. We are in the position where the health service have said, 'We are not prepared to keep doing this.' I am sure they told you that there is a discussion now between Outback Stores and how that might go. The departments who are responsible for the respective areas are talking and working cooperatively around that. So it is not a case of we are withdrawing funding; it is a case of the communities themselves working through a consultation and a decision-making process about how they do it and then we will respond appropriately.

CHAIR—I am conscious of time, and I am not sure how much we have got through the stuff you wanted to present.

Ms Podesta—We have finished our presentation.

Mr TURNOUR—Just picking up on the Mai Wiru issue, obviously you are going through a transition to look at trying to making it more sustainable. In the longer run, obviously government would like to see stores and relationships with the communities not require government support. Effectively, people should be able to transition to a healthier lifestyle without government support. Are you doing any evaluation—and you mentioned some of them—as part of this? I know you have done it with the trial. But, in terms of the transition, I think it would be worthwhile going forward to get an idea about the key issues and learnings in terms of the transition process. For example, if we do an intervention or an engagement in another community, we can maybe start that process off earlier on if it is through a health service and you recognise that it needs to move beyond the health service in the future.

Ms Catchatoor—At this stage we are not planning an evaluation as such.

Mr TURNOUR—But can you understand my question in relation to that?

Ms Catchatoor—Yes.

Mr TURNOUR—I understand the health thing and that that is now someone else's responsibility. But one of the things that communities get frustrated with with government, and government and opposition backbenchers, is that we still have responsibility to go across things. If we can actually work out how to learn across the government agency and we transition that that would be fantastic.

Ms Podesta—The Nganampa health service are a very professional organisation. Part of their response in the transition will be to document how and why the strategies have been put in place. We will put on the record that we will make available to you how that process is documented. I cannot imagine in any way that Nganampa would not do that. That is the way they operate now.

Ms Quick—I think in fact Nganampa have expressed an interest in maintaining a compliance monitoring role once the transition has happened. In our discussions with them, they have said that they see would have a role in that. Perhaps they have mentioned that to you.

Ms Podesta—I know that, for the health committee of Nganampa, it was quite an agonising decision that they made to step back. But they also see the level of demand on them as a health service to run things that are not primarily what they are there for. It is about sustainability, from

their point of view. Nganampa health service are the longest running, most successful remote Aboriginal health service pretty much in the country. They are an extraordinarily good health service. One of the reasons they are very good is that they understand the limitations of what they can and cannot do. They have hosted this project for some time and it is on a very sound footing now. Given the work that is happening with Outback Stores, they see there is an opportunity now to transition this. I think that is one of the reasons they are successful: they do their work properly and professionally.

Mr TURNOUR—Chair, it might be worthwhile for us to pick this up with Outback Stores when we hear from them in a few weeks time.

CHAIR—Yes. This may have been covered while I was out, and please let me know if that is the case. One thing I think has come through loud and clear in our inquiry so far is the significant role that store managers have on the quality of the store. There seems to me a pretty direct correlation between the quality of the store manager and the quality of the store. Do you have any comment on the health awareness of store managers and their awareness of the issues of nutrition and the need to have good nutrition policies? Have Mai Wiru done anything about that? Do they do any training of store managers?

Ms Podesta—They do. We did cover this to some degree. Staff skill levels is critical. Access to good data and feedback about nutrition policies is critical. Governance, management and monitoring of individual stores are all critical aspects, and Mai Wiru has been successful because there has been an emphasis placed on all of those aspects. The capacity, understanding, knowledge and commitment of the store manager and the committees of the stores are a vital part of changing behaviour.

CHAIR—At a broader level, has there been any discussion within your department about how you might apply training across store managers?

Ms Podesta—Health does not look after stores, by and large. Mai Wiru is a project that health auspiced because we did it through our health service. We do not generally work with all of the stores as a health department. Our colleagues in FaHCSIA look after the stores. We invested in the Outback Stores project with nutritionists. We have been funding the nutritionists through Outback Stores for some time to increase awareness and understanding of nutrition. I cannot comment on the work that they have done with the store managers.

CHAIR—So you are saying that the Department of Health and Ageing are not doing that?

Ms Podesta—No. That is a FaHCSIA role.

CHAIR—You made a comment about the market gardens, and I understand why you said what you said. I think it is fair to say that the evidence that we have received so far is that, if you measure the self-sustainability of these communities and you then ask what impact community stores have had on that over a long period of time, it would that it has given rise in general terms to a reduction in self-sustainability. Do you agree with that proposition? If you do agree with it, how do we not tackle things like market gardens and other programs?

Ms Podesta—I do not think that we could answer that. We know that the impact of a store failure is significant and that the health services are always extraordinarily alarmed when a store closes for a period of time, because in many cases there is no other source of food and, because of the transport issues, there is no other way for people to get out and get food. We do not look after the issue of whether people are self-sustaining within local communities.

CHAIR—I only asked that because you made a comment in relation to the market gardens.

Ms Podesta—We have stepped back from funding through our public health money any further investments in market gardens. For a period of time some public health care money was put into market gardens. Our analysis of that has been that there has been no sustained evidence of market gardens having any longevity. Through some of the shared responsibility agreements, we looked at some of the work that we did around evidence of good investments and we could not see evidence that investments through public health care in market gardens had had a long-term impact. It is not just a personal view. In terms of systematic change, I guess we would say that systematic changes around managing stores, making them more stable and better skilled, being able to subsidise the cost of freight to get the price differentials down a bit and encouraging people's awareness are the systematic changes that we have been able to see some evidence on. We have not been able to see that sort of evidence about investing in market gardening activities. We would be very happy if there were, but we have not been able to see it.

CHAIR—Thank you very much for the evidence you have given us today.

Resolved (on motion by **Ms Rea**):

That this committee authorises publication of the transcript of the evidence given before it at public hearing this day.

Committee adjourned at 1.41 pm