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, 25 JUNE 2009

CANBERRA

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HOUSE OF REPRESENTATIVES STANDING

COMMITTEE ON ABORIGINAL AND TORRES STRAIT ISLANDER AFFAIRS

Thursday, 25 June 2009

Members: Mr Debus *(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 Debus, Mr Laming, Ms Rea, Mr Turnour and 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 11.48 am

CHAIR (Mr Debus)—I declare open this public meeting of the House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs inquiry into community stores in remote Aboriginal and Torres Strait communities. I acknowledge the Ngunawal and Ngambri people, the traditional custodians of this land, and we pay our respects to elders past, present and future. The committee also acknowledges the Aboriginal and Torres Strait Islander people who now reside in this area.

These meetings are formal proceedings of the parliament. Everything said should be factual and honest. It can be considered a serious matter to attempt to mislead the committee. I invite witnesses to make comments that will assist us in our inquiry with the intention of making some improvements to the present government administration in relation to remote community stores. This hearing is open to the public. A transcript of what is said will be placed on the committee's website.

[11.49 am]

WOODEN, Mrs Deanne Rae, Nutrition Manager, Heart Foundation

CULLERTON, Ms Katherine, Senior Project Officer, National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan

LEA, Mr Traven Miles, National Aboriginal and Torres Strait Islander Program Manager, Heart Foundation; and Chair, National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan

LEE, Dr Amanda Joan, Member of Steering Committee and Co-Chair of Reference Group, National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan

CHAIR—Today we will hear from NATSINSAP, the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan, and their partners in crime the Heart Foundation. By way of getting proceedings underway, I wonder if one of you would like to make a brief introductory statement before we begin questions.

Ms Cullerton—Is it okay if we all make very brief statements?

CHAIR—It is absolutely fine.

Ms Cullerton—Thank you for the opportunity to present evidence at this inquiry. We also begin by acknowledging the traditional custodians of this land. I would like to start by giving a little bit of background to the NATSINSAP, as you so kindly put it. It is the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan, and it was designed to provide national coordination and cooperation across the country to improve the nutritional status of Aboriginal and Torres Strait Islander people. The strategy is part of a broader nutrition strategy for the whole population called Eat Well Australia, and both of these finish next year. This morning Dr Lee and I are going to be presenting on behalf of the steering committee and also our Indigenous colleagues.

One of the action areas of NATSINSAP is food supply in rural and remote areas, and to date we have done a large amount of work in this area, mainly through the Remote Indigenous Stores and Takeaways project. You may have heard of it; we call it RIST. It has developed a package of nine resources to assist remote stores to stock, promote and monitor the sales of healthy foods. I have a compilation of these resources here, and I believe the Department of Health and Ageing gave you a sample bag with these resources.

Secretary—Yes, we have them.

Ms Cullerton—Great. Great; you have the NATSINSAP ones as well. Those are very rare. These resources have already been used to inform licensing requirements for stores as part of the Northern Territory emergency response and with Outback Stores to develop their core range. We

have already seen some significant changes in purchasing behaviour by stores and customers in some of the stores using these resources, which is great.

I would now like to briefly elaborate on a couple of the points in our submission. Access to nutritious and affordable food is paramount to good health, learning, development and quality of life. There are many determinants of poor nutrition in remote areas, including lack of a quality reliable food supply, poorly maintained housing, poor education and, of course, poverty.

Surveys undertaken across the Northern Territory show that up to 36 per cent of family income is needed to purchase foods in remote communities. This is at least double the 17 per cent of income that the average Australian spends on food. The differential is even greater when we look at healthy food compared to unhealthy food. So, for example, the fruit and veg you can purchase in a remote store are usually 30 to 38 per cent more expensive than in a city store whereas a high-fat or a high-sugar take-away item is only 23 per cent higher. Deanne will talk a little bit more about that in her presentation. Therefore we feel that we really need to be addressing this price differential and, in particular, the price differential between cheaper unhealthy choices and the more expensive healthy choices.

With the Universal Declaration of Human Rights stating that everyone has the right to a standard of living adequate for the health and wellbeing of themselves and their family including food our main contention is that remote Indigenous stores need to be considered essential community services just like a school or a health clinic. Some may be economically viable now or with assistance from a store group but, for those that are not, we need a fundamental rethink of the viability of the small business profit-generating store model. Substantial and ongoing government funding will be necessary to support interventions that ensure a healthy and affordable food supply for these communities and we cannot just rely on nutrition education to improve healthy eating in these places.

In order to achieve that we feel that we need to undertake an economic analysis to determine the population threshold required to sustain the viability of a remote community store and invest in strategies to ensure the store viability and equity in cost and availability of basic healthy foods compared to your capital city prices. There are a number of things we could do there such as subsidising transport or the cost of wages for store managers or grants for purchasing infrastructure, for example, combi ovens instead of deep fryers, fruit and vegetable display fridges or point of sale scanning equipment. All of these strategies have been used in different stores throughout Australia very effectively to increase sales of fruit and vegetables and other healthy items.

Just briefly in relation to outback stores and other store group models we support the establishment and the ongoing operations for store groups such as outback stores, ALPA, Mai Wiru, that provide for economies of scale and systematic and efficient retail operations. These sorts of store groups prevent the typical boom and bust cycle that many privately run stores experience. However, it is critical if government provides support to the stores as essential services then health and nutrition need to be high on the agenda with real and measurable targets and outcomes.

We would like to see the development, monitoring and reporting of nutrition policies for all remote stores with clear targets on the sales of key indicator foods, such as fruit and vegetables

and soft drinks. The engagement of nutrition experts within store groups are a real important catalyst for change and influencing the supply and demand of healthy food. We would also like to see the promotion of these RIST resources in all remote stores across Australia. They are being rolled out now through the different states and territories, but we would like to see the comprehensive rollout of the resources. We would also love to see a health representative and an Indigenous representative on the store group boards. This is currently not the case with outback stores at the moment. There are only retail experts on the outback stores board. The NATSINSAP expires next year and we would like to see the development of new goals and targets and secured funding for the next phase to ensure a coordinated approach to Indigenous nutrition issues including remote food supply issues.

Dr Lee—I would like to follow on from Katherine in talking about the impact of these issues and health and economic outcomes in communities. First I would like to acknowledge the traditional custodians of the land on which we are meeting today. I would also like to thank the committee. We have been reading through the transcripts and have been really impressed with the degree of understanding, interest and knowledge that the committee has shown in this area. We are very excited by the opportunity to present to you today.

The basic point I want to get over is that nutrition is absolutely central to the health of Aboriginal and Torres Strait Islander Australians. Nutrition is associated with at least 16 per cent of the burden of disease seen in these communities which is about twice the rate of the burden of disease due to the impact of cigarette smoking, but it is a very unrecognised and underaddressed area. It is not going to be possible to improve Indigenous health without addressing nutrition and improving nutrition and growth of children but also nutritional status right through the lifespan of Aboriginal and Torres Strait Islander people. It is probably the single most important preventable thing we can do to reduce the gap in mortality and morbidity that we are seeing.

Importantly, there are already really good examples of positive improvements that have been seen in some isolated communities, so we know what can happen where communities can take control of food demand and food supply issues in their communities. There have been examples of where that has happened within very short times. For example, in a community I was working in, Minjilang, in the late 1980s—this is how long this knowledge goes back—there was improved biochemistry, haematology, and anthropometry in just 12 months through improvements to the food supply and working with the community to improve demand for healthy foods. That project cost $60,000 in those times, but it halved the risk of early death in that community in such a short time. Unfortunately these projects do not ever get funded into the long term and they are rarely picked up by other communities. We know basically what needs to happen in these communities, but we just need increased reach of the programs and increased dose—to use some medical terms—about getting the projects out.

Just last month we were asked to write an editorial for the *Medical Journal of Australia* on just these points—what needs to be done to improve the nutrition and health of Aboriginal and Torres Strait Islander people in Australia. With your permission, Chair, I would like to table that editorial today.

I think one of the new pieces of knowledge that we have is an understanding, as Katherine has alluded to, of the price differential between the costs of healthy and unhealthy food. When people are struggling to buy food and when people are hungry, as we have all seen in these

communities, it is easier and cheaper to fill up on junk. This is particularly important when we are talking about new initiatives such as income management. If we are keeping back half of people's welfare payments to spend on food, we need to make sure that healthy food is available and affordable in those communities, because otherwise all we are going to be doing is filling people up on sweet, sugary drinks and takeaways and it is going to add to the health inequalities we are already seeing. So there is some caution there about the provision of healthy foods.

We also need to trial economic interventions that will help make these foods more affordable. There are some structural examples that have been used overseas, particularly the Women, Infants, and Children program in the US and some other suggestions that have been trialled by some smaller store groups, as we have seen in the submissions—for example, freight subsidisation or subsidisation of payments to operate the store and cover overheads, which are very cheap but which actually can lead to massive return on that investment by adding to health outcomes. We need to trial those, again so that inadvertently negative consequences may not arise.

In summary, we know what needs to be done but we have really been for many years lacking the will. We are particularly excited at this opportunity to present before the committee because of one opportunity that was not taken up. Under the COAG Indigenous health reform agenda, nutrition issues have surprisingly and unfortunately just not been included in the final outcomes. We just do not understand how we are going to close the gap on Indigenous health in Australia without nutrition being central to the solutions, particularly as we know what those solutions are already likely to comprise. Thank you very much for the opportunity to speak today.

Mr Lea—I will introduce myself appropriately. I am Traven Lea. I am a descendant of the Wuli-wuli, Darambal and Djirubal people from the south-east Queensland corridor. I am currently in a position within the Heart Foundation. It is really important to note that, over the last five years in the Aboriginal-Torres Strait Islander affairs arena, there has been a major boost in this domain and the backdrop has dramatically changed in relation to investment, particularly through the COAG type of national partnership announcements. More important to note is the strategic intent and the commitment that has been witnessed over the last five years in relation to addressing Aboriginal-Torres Islander affairs. That has to be applauded. I think the new mantra out there in relation to Aboriginal-Torres Strait Islander affairs is that this is everybody's business; this is all of Australia's business. It also provides us with an opportunity to work outside of the parameters that a lot of us have worked within and have been stifled and hobbled by.

If there is one call from me, from an Aboriginal person's point of view, it is to be able to require people to bring their best to the table in addressing all issues around Aboriginal-Torres Strait Islander affairs. I will not go too much into the nutrition area, because Amanda and Katherine certainly have captured that. My specialisation is around the Indigenous population. So if there is one call from me, it is to maintain this commitment, this set of ideologies, that will require all Australians—mainstream, community controlled and discrete communities—to bring their best to the table and come there as honest brokers to address what we have been witnessing for many, many decades.

In relation to the Heart Foundation, we are an NGO which is 50 years old and has charitable status. One of the critical elements of the Heart Foundation being involved in this area is that the

Heart Foundation's vision is for all Australians to have the best cardiovascular health in the world. To do that we need to look at the most vulnerable population, and the Aboriginal-Torres Strait Islander population certainly fits that mould. What the Heart Foundation intends to do is bring our best to the table—to bring our capabilities, our intellect and our networks to the table—hence the submission we put forward to this inquiry. I will now hand over to my colleague to talk specifically about some of the key points.

Mrs Wooden—Thanks, Traven. The Heart Foundation is interested in cardiovascular health. Prevention or prolonging the development of cardiovascular disease really should be the first strategy that is used. We are interested in the treatment, access to services and those sorts of thing for the Australian population, including Indigenous people. However, prevention and treatment is always the first step. Addressing food supply issues is an essential strategy to achieve this. The Heart Foundation has more than 20 years experience in influencing the nutritional profile of the Australian food supply. The food supply to Indigenous populations living in remote communities has been identified as an area of concern for the Heart Foundation because of the links between good nutrition and the prevention of chronic disease and cardiovascular disease in particular. Improvements to the food supply to remote areas are essential, and all the Heart Foundation recommendations around this are outlined in our submission.

I want to cover two specific issues today in looking at the issue of community stores in the context of the whole, broader community and the socioeconomic conditions in those communities. For example, if you take the issue of level of income, as described by our colleagues from NATSINSAP, there is a so-called theory of the economics of food choice, which I believe has been mentioned previously in these hearings. This theory states that people's dietary decisions, when made within the context of sustained budgetary constraints, are driven by maximising energy or calorie value for money. This theory has been used by researchers up in Arnhem Land to explain how inexpensive and highly energy-dense food items, such as sugar, white flour, white bread and milk powder, provide nearly 50 per cent of the energy through that food supply while at the same time intakes of more expensive but more nutrient-dense foods, such as fresh fruits and vegetables, were very low. If I could I would like to table a graph produced by Julie Brimblecombe of the Menzies School of Health Research for everyone to refer to. This graph depicts graphically the inverse relationship between energy-density and the cost of food per calorie.

The second socioeconomic barrier that I would like to briefly mention is the lack of household infrastructure for people living in these communities. A study published last year found that only six per cent of households had adequate storage and cooking facilities. In combination with high levels of household overcrowding, this leads to a situation, as Mandy discussed, where it is much easier to rely on local take-away for family meals, which invariably serve unhealthy meals.

Finally, the Heart Foundation would like to make the point that currently Australia lacks a comprehensive food and nutrition strategy, with no effective monitoring and surveillance in place. Coupled with almost no complete data on food pricing in Indigenous communities in remote areas, it would seem near impossible to meet the terms of reference for this inquiry. So we would like to make call for improved monitoring and surveillance and monitoring and evaluation of any interventions which would help to evaluate any outcomes from this inquiry.

CHAIR—Thank you for the precision and density of the statements that you have made. It is appropriate now that we should have a more informal discussion. Would colleagues like to ask questions?

Mrs VALE—I have got one or two. I was interested in the research you have done on the lack of household infrastructure, Deanne. This is something I did not fully appreciate until we actually went to the APY lands. It was something that came as quite a shock. The government has obviously provided houses for Indigenous families but except for an oven and a kitchen sink, and of course the bathroom, there is nothing else. There was no table or chairs, very few benches, no refrigeration. It was not provided. I know there is always a discussion about how much government should provide but if you are going to provide people with houses and these people are on welfare, you might as well do the thing completely. So a lot of the families, and I cannot recall the name of the place we went to—

Ms REA—Amata.

Mrs VALE—Amata I think it was, where the families used the general store as their storage pantry, if you like, as their cupboard, because they did not have any refrigeration in some of the family homes. They actually had to buy it as they wanted their food. We all know that if a mother has to market like this in our community you spend so much more of your weekly food allowance. The idea is that if you can have a budget and buy once a week and store it at home, you are going to spend less money. We know the research has been done on that. But these mothers had to go almost for every meal to the store. If nutrition is your priority, this is not the way forward. It was something that really shocked me because I did not fully appreciate it. Even buying things like utensils, like frying pans, like utilities that you expect in any kitchen that I think young brides in our culture actually get as a kitchen tea, that sort of stuff. But these people do not have that and they have to try to use their small amount of income to supply these things. They have really been behind the eight ball for a long time. Have you made recommendations on the lack of household infrastructure and how that can be addressed?

Mrs Wooden—That would need to be addressed around addressing the poverty and the household overcrowding. That is a broader socioeconomic barrier to improving nutrition.

Mrs VALE—You say that the COAG Indigenous health agenda did not have nutrition on its list. That is amazing, isn't it?

Dr Lee—There are developmental targets that were included under the HREOC targets, particularly related to affordability of food, but I believe quite a few other nutrition targets were originally mooted but in the final reform agenda none of those have been included.

Mrs VALE—You mentioned a program that seemed to work very well in a community back in 1988.

Dr Lee—It was from 1989 to 1991 in Minjilang in the Northern Territory—an island off the coast of Arnhem Land. It was a controlled study that showed doubling of fruit and vegetables in the first three months of that project which was continued and sustained and then a spillover to the control community with really rigorous medical assessment of dietary and physiological changes in the community during that time. It has been replicated in Loomah, in the Western

Australian north, and there are other examples, for example, Hermannsburg in Central Australia where the same approaches were tried. There were issues there with access to Alice Springs and we know that these programs have maximum traction where there are already alcohol management programs in place. So there are a number of enablers and a number of leverage points that are quite known about the potential for uptake of these types of programs in other communities, but we have never been able to secure funding to roll them out.

Mrs VALE—Is there always a nutritionist on the ground to actually guide these programs through?

Dr Lee—No.

Mrs VALE—But it still worked anyway.

Dr Lee—The common model is fly-in fly-out health services. We just need someone with nutrition expertise. It does not need to be a nutritionist but it needs to be someone who understands those issues. The main factor for success is engagement with the community and community control over the interventions that are trialled.

Mrs VALE—And guidance I should imagine.

CHAIR—A doctor with some particular knowledge—what sort of people?

Dr Lee—A mother, a health worker, a community change agent, anyone in that community that has the respect of the community but is able to respond to community wishes and knowledge and build on that past understanding to enable them to influence the store, and the uptake of the food.

Mrs VALE—So they need some status within the community?

Dr Lee—That is right. So the most successful models have been where community elders and women—

Mrs VALE—Grandmothers perhaps?

Dr Lee—Yes.

CHAIR—Perhaps it is the moment to ask a question I was going to ask a little later in proceedings. We had just recently evidence from General John Sanderson, the former head of the Army and former governor of Western Australia who is engaged with a foundation in Western Australia. He wanted to tell us that he thought that we needed to consider this issue in the context of the development of a whole community and in the context of improving the capacity of leadership within individual communities. It does sound to me as if you are implicitly saying the same thing.

Dr Lee—That is right.

CHAIR—Could you talk about that a little more?

Dr Lee—Trevor may wish to—

CHAIR—Each one of you has touched on that subject.

Mr Lea—It is always an interesting philosophy around overall community development. You see those models at play in the health field with population health as well. But they also require a parallel type of approach in relation to more succinct strategies. It is the same as the concept: if you build it, they will come. There are patterns in confusion to be honest. At times I think we try to build up and do too much. Once you go down this community development model or mode you start to highlight and indicate other areas that you need to address, but that actually takes you away from the critical component that you should be targeting. A bit of a mistake for decades and decades in relation to Aboriginal and Torres Strait Islander affairs is that once somebody engages in this area they see the whole landscape and they say: 'It's too busy for me. What can I do?' What I would say is: 'Do what you do best. Focus on what you do best. Do your little bit on your turf.' Of course the other things have a play but if you do not focus on your turf, you will stumble and fail. That is what we have been witnessing in Aboriginal and Torres Strait Islander affairs for decades and decades. People see the whole landscape and get spooked and rightfully so.

Mr LAMING—If I might add, when there are so many concurrent purpose incentives going on, that just one well-meaning intervention into the causal web usually just gets swallowed up. But thinking possibly as to where our recommendations are heading, there is basically a supply axis that leads you all the way to having fresh fruit and veg in a community store. From there on it is all demand. Demand is driven essentially by cost and quality. If I take them one at a time we are trying to understand the best way in that supply chain to have fresh fruit and vegetables in those stores. Is that a freight credit? Where in the chain do we intervene and is that more or less cost efficient than at demand level within the store? You then have these two issues. How do we compress down Brimblecomb's curve so that there is no cost difference in energy density?

I would like to know if you had completely free fresh fruit and vegetables in Indigenous stores how much consumption would increase. I would like the answer. Continuing the observation, is there a way that we can set up a system of credit such that if one is purchasing shelf-stable healthy foods, they obtain a credit for fresh fruit and veg over here or is it just easier for us to distribute $20 fresh fruit and vegetable vouchers to every household through the local government agent? Maybe that is administratively cheaper. I am after some ideas but the point that I am noting is that within the stores themselves once fresh fruit and veg is affordable and accessible then you guys can take over potentially with the choices, but you cannot do that without the supply chain and you cannot do it without it being affordable. So in those three areas our big question is: where are the most efficient interventions?

Mr Lea—I would like Deanne to start around the top end and reformulation, if that is okay.

Mrs Wooden—Yes, one of the areas that the Heart Foundation works in is upstream in the food supply, advocating for reformulation of the food supply, reducing saturated fats, trans-fatty acids and sodium and increasing the fibre content of the Australian food supply. That is where we start our work. Looking at remote Indigenous food supply, the freight issue is a big problem because it adds significantly to the cost of the food in these communities. However, if you are looking at a store level, something that is essential if you are to improve the food supply is to

actually have a nutrition policy in the store and to have that policy monitored and evaluated over time and to train the store managers and workers in nutrition and nutrition policy and, if it is an independent store, to train the store committee as well to understand that that is important. Just giving people in the community a voucher for $20 worth of fruit and vegetables will not necessarily improve the supply. It can do because there is more capacity in the community to purchase those fruits and vegetables, but you need to take a whole-of-store approach and a nutrition policy is the best way to do that.

Mr LAMING—Just disentangling again and taking the antecedent consequence, first of all we have got to get it to the store with quality and in an affordable way. What is your intervention in the supply chain that you think is the most efficient? Is it wasteful to go straight to a freight supplier and offer stores a freight credit so that, if you bring in a hundred bucks worth of fruit and veg, you get a hundred bucks worth of free credit the next time you order? What do you do just to get it into the store? Could you start from there?

Ms Cullerton—I think that is a wonderful idea. Another cost-effective way of doing it is to utilise group freight-buying software. This is something that does not cost the government any money but it consolidates all of the community stores in an area and looks at how they can be efficient. You have probably heard this but we have a problem where this community will get a delivery coming from Adelaide on one day, it will only be a quarter-full truck, it will go back down to Adelaide the next day and then it will go back up to another store that is close by. If we can consolidate all of those stores purchases into one order, it immediately decreases the cost of freight without any intervention from or cost to the government and it also means more frequent delivery of the produce as well. That is a really simple, efficient solution and we have seen it work. We have seen stores doing that with the distribution of the RIST tools and we have some great examples of that. That is one example. The other one is appropriate infrastructure in a store such as putting in appropriate fruit and vegetable refrigeration units to make sure the stock is attractively displayed and maintains its integrity for a longer period of time.

I do not know if you got to see this in any of the remote stores you went to, but a lot of community remote stores will just display their fruit and vegetables on the top of a bench with no refrigeration at all and it will go off quickly that way. It does not look attractive. I have seen it in eskies, and you have to dig around in the esky to find what you want. If you put in appropriate fruit and vegetable refrigeration units, you might see—as we saw, for example, in Saibai Island up in the Torres Strait—fruit and vegetable purchases increase by 60 per cent. There are numerous examples of that. Just putting in some fruit and vegetable units is a great way.

Out on the APY Lands I believe they have subsidised electricity to the remote stores, and there is freight subsidisation as well. That has resulted in decreased costs. There are numerous strategies that you can look at in terms of that supply side of things. Sometimes store managers have a lot to deal with. Going back to that nutritionist point you were raising before: simply having someone come by and support them to look at these sorts of creative strategies can be really beneficial to store managers. They may be so overwhelmed in just trying to deal with the operation of the store. If they have a support person who can say, ‘How about we sit down and we try and work this out or think of some creative ways to try and improve the supply and increase the demand together?’ it has been shown to really make a difference. Would you like to elaborate on that, Dr Lee?

Dr Lee—I think your simple question is: if you get quality fresh fruit and vegetables in store, will people buy it? All the evidence and all our experience is, yes, they will and they will buy it quickly. The issue is that often fruit and vegetables arrive not on a day when people have been given their welfare cheque or whatever, so they may not have money on that day. We do not need to do much to promote fruit and vegetable consumption in Aboriginal communities. These are people who have lived off the land and have a very fresh, ready supply of fruit and vegetables as a staple component of their diet. Part of the issue is that the quality, when you pick from bush food, is absolutely optimum, and the stuff that is in the store is not. We are actually dealing with really discerning customers here around fruit and vegetable quality, based on a long traditional culture. That is not often understood by store managers. We have all seen, when a plane comes in and there is good quality stuff in the store on a day that people have got money, you need to get out of the way for the rush, and it will all be gone in two hours. Part of my frustration is that you would see that supply go in two hours and there would not be another one for two weeks. So, yes, if we can work out easy, cheap ways to improve supply of fruit and veg it will be consumed regularly and frequently by people.

Mrs Wooden—I would not mind adding to that. As Katherine said, store managers are very busy people, overwhelmed with busy workloads. Often, particularly for independent stores, they are under pressure to produce a profit in their store, so they are reluctant to do anything that is going to threaten that profit. Increasing demand in the community, increasing the capacity by providing fruit and vegetable vouchers for the people in the community, then creates that demand or that ready market, but also the store managers may need some kind of looking at their performance indicators. The sales or the promotion or the stocking of these fruits and vegetables may need to be linked—that might be a key performance indicator for them to give them more incentive to ensure that they include fruits and vegetables on the shelves and promote the sales of fruit and vegetables.

CHAIR—By the way, I think somewhere in your submission you mention the employment of local people in the stores. Could you speak to that a little?

Ms Cullerton—I think it is integral to the future of the community stores. I think we have seen some wonderful examples around the country where local people have been trained and are employed in the stores and are doing a wonderful job, although I think there needs to be appropriate training and support for those people, because you can experience problems if there is not that adequate support and training. I do not know if anybody else would like to add anything.

Mrs Wooden—I would just like to add that one of the major costs for an independent store particularly is the cost of employing the store manager, because they are generally not from that community and they require housing and their wages are generally higher than what other people in the community receive. So, if you were to source that employment locally, where somebody is already living in the community, that could actually be a reduced cost for the store as well. They may have more vested interest in looking after their community if they are actually from the community.

Dr Lee—I think we need to be very cautious, though, because when you have got a store that is being used as a cupboard and you have one person in that community with the key to that cupboard and people are hungry and it is late at night, that person is under enormous pressure. I

really emphasise the degree of support and authority that they need to be able to say no to family members and others who will be wanting access to the food in the store. There are examples where that has gone awry. So the issue is support and authority to help that person.

Mr LAMING—I have one question. Any observations on the success of taking store workers from Indigenous communities and placing them for short periods in shopping centres, in commercial centres, or sending out shopping centre executives to actually work in community stores? Both good ideas? Any observations?

Ms Cullerton—The second one certainly has happened already. A number of the store groups have had utilised that. I know Main Wiru has done it, ALPA has done it, where they have had Coles executives and Woolies executives come out. Was it Main Wiru who had a Coles exec out there for a year training up local people and getting them to work in with the store managers as well. That model seems to work quite well but it needs to be sustained, or there needs to be someone who can keep that support up, as we were saying before. I am not aware of any examples of them going to stores.

Dr Lee—No, but it is a very innovative idea that would really merit some exploration.

CHAIR—Did you have some ideas about the most successful models of stores that you have observed? I am sure you do.

Dr Lee—I think there are a range of possible solutions. We know that from a health and nutrition perspective the models that have been most successful are where there is a grouped purchase component and where the store board comprises retail, health and community representation, those three dimensions. There is a good infrastructure, there is a business plan for the store in place and there is a nutrition and health policy in the store. Those elements—and my colleagues can add if I have left one out—we know are essential. The way they can be delivered is probably variable, but as long as those elements are there their success rate is increased.

Mr LAMING—Most of my questions are answered by your submissions, which are an excellent summary for us.

CHAIR—Very good. On the issue of whether the increased purchases of fruit and vegetables that you have seen occur in particular situations translates into actual consumption. It sounded as if you were saying it did.

Dr Lee—Yes, and we have proved that by haematological measures, by going to the extremes of taking blood every three months in a community to measure the levels of fruit and vegetable related nutrients—vitamin C, alpha- and beta-carotene and folate—and seeing them to skyrocket. In the project I was describing in Minjilang when we first started only 10 per cent of the population community had adequate red blood cell folate. Folate deficiency is associated with spina bifida but it is also associated with increased cancers, birth defects of a range of conditions, and through some mechanisms cardiovascular disease. By the end of that year we had 90 per cent of the people having sufficient red blood cell folate, not from taking vitamin tablets but from eating more fruit and vegetables. So we know that that will improve health.

One of the things I would like to say, though, is that it is not just fruit and veg. We have a huge issue with increased energy density and poor nutrient intake. We have got to reduce the intake of energy-dense nutrients or foods as well. Throwing fruit and veg at the problem will help, because it will displace some of those foods, but we really actively need to discourage heightened reliance on junk.

CHAIR—Can you define junk a little bit? Is it white bread and Coca Cola?

Dr Lee—White bread is fine. Core foods that are traditionally used by the Australian population and that are a part of the *Australian guide to healthy eating* and the NHMRC dietary guidelines are fine. Even bread, which is a processed food, is actually a very important food for a variety of reasons. The foods we mean when we are talking about junk are those foods that add little beyond calories to the diet. They are energy-dense and nutrient-poor. The priority groups are high-sugar foods—and in Aboriginal communities that would be in the form of soft drinks and also sugar itself—and high-fat foods such as takeaway foods, which are commonly consumed in these communities.

Surveys in the past have shown a reliance on them. Fifty per cent of foods in the communities we studied in the eighties—and this has not changed—came from three foods: flour, sugar and meat. The limited variety of diet is of concern, but against that background this price differential means that the extra energy is taken up by energy-dense, low-nutrient foods, or what we call 'junk'. We know from studies that improving fruit and veg would help displace some of those foods, but we need to actively engage in strategies and mechanisms that will not promote those foods. We need to discourage consumption of those foods.

Mr TURNOUR—I have had a look through your submission and I think you have answered most of the issues in your recommendations that I had questions about. I notice in the submission that you effectively recommend that the basics card have options in terms of people being able to quarantine moneys or whatnot for purchase of fruit and vegies.

Ms Cullerton—Yes.

Mr LAMING—Has there been any research done on demand elasticity around what you were talking about? Can we actually provide a compelling figure that is different to mainstream Australia?

Dr Lee—There is little work in the area. The only work that I am aware of is some work by the Arnhemland Progress Association in the early nineties. There is an article published in the Australian journal of public health from that time. Part of the challenge here is that many of these problems have existed for so long that where the investigations have occurred it goes back 20, 30 or 40 years. People looking for solutions now look at references of two or three years ago, so part of this understanding is a historical one. The price elasticity work that was published in the Australian journal of public health in the 1990s showed that we have to be very careful in this area that there is some evidence of a different perception and a different application of price elasticity.

In some work I did at Amata in the 1980s—and Mrs Vale mentioned Amata earlier—we increased the price of a cola drink in the store and halved the price of fruit. All that happened in

that experiment was that people still bought the cola and had less money to buy the fruit. That is why in our submission we are recommending that any economic interventions be trialled before their widespread use, because there could be different mechanisms in play, as you are wisely alluding to, that could actually lead to unintended consequences.

CHAIR—We greatly appreciate the submissions that you have made. The written submissions have given us a most important insight and we thank you and reserve the right to ask you some more questions. I thank everybody for their attendance today.

Resolved (on motion by **Mr Turnour**):

That this committee authorises publication, including publication on the parliamentary database, of the transcript of the evidence given before it at public hearing this day.

Committee adjourned at 12.41 pm