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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Reference: Obesity in Australia

WEDNESDAY, 10 SEPTEMBER 2008

DUBBO

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Wednesday, 10 September 2008

Members: Mr Georganas *(Chair)*, Mr Andrews *(Deputy Chair)*, Mr Bidgood, Mr Coulton, Ms Hall, Mrs Irwin, Ms King, Mrs May, Mr Morrison and Ms Rishworth

Members in attendance: Mr Coulton, Ms Hall and Ms Rishworth

Terms of reference for the inquiry:

To inquire into and report on:

The increasing prevalence of obesity in the Australian population, focusing on future implications for Australia's health system.

The Committee will recommend what governments, industry, individuals and the broader community can do to prevent and manage the obesity epidemic in children, youth and adults.

WITNESSES

CANT, Mr Greg, Acting Principal, St Pius X Primary School 27

CORBY, Mrs Christine, Chief Executive Officer, Walgett Aboriginal Medical Service 1

DUNCAN, Ms Skye, Health Service Coordinator, Walgett Aboriginal Medical Service 1

FERNANDO, Mr Peter, Deputy Chief Executive Officer, Walgett Aboriginal Medical Service 1

GABB, Mrs Myra, Teacher, St Pius X Primary School 27

GILMORE, Ms Kylie, Program Practice Manager, Walgett Aboriginal Medical Service 1

HARRIS, Professor Bruce, Program Coordinator and Counsellor, School of Rural Health, National Rural Health Alliance 15

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Committee met at 1.58 pm

CORBY, Mrs Christine, Chief Executive Officer, Walgett Aboriginal Medical Service

DUNCAN, Ms Skye, Health Service Coordinator, Walgett Aboriginal Medical Service

FERNANDO, Mr Peter, Deputy Chief Executive Officer, Walgett Aboriginal Medical Service

GILMORE, Ms Kylie, Program Practice Manager, Walgett Aboriginal Medical Service

ACTING CHAIR (Ms Hall)—I declare open this public hearing into obesity in Australia at Dubbo. This is the fifth public hearing for this inquiry being conducted by the House of Representatives Standing Committee on Health and Ageing. It is well known that Australia has one of the highest obesity rates in the Western World, and for that matter within the world. A 2007 OECD report indicated that 21.7 per cent of adults in Australia are obese. The Australasian Society for the Study of Obesity reports that around 25 per cent of Australian children are currently overweight or obese. These are not figures to be proud of.

In its 2006 report on the economic cost of obesity, Access Economics calculated that annually the financial cost of obesity in Australia is in the region of $3.7 billion. This figure rises to a staggering $21 billion if the net cost of lost wellbeing is included. You can see it is pretty significant.

Today the committee will hear evidence from representatives of the Walgett Aboriginal Medical Service about programs they are running in the Walgett community and representatives of the National Rural Health Alliance to hear how being overweight and obesity is impacting on rural and regional communities across Australia, and we will hear about a Fruit First policy from St Pius X Primary School. This morning the committee visited the Betty Orth Memorial Unit to see firsthand the facilities used to treat diabetes. I must say committee members were very impressed with what they saw. As well as treating diabetes, the unit treats other related conditions associated with obesity. We also attended the Delroy Campus of the Dubbo College to learn about its healthy canteen. The hearing is open to the public and a transcript of what is said will be placed on the committee's website. If you would like further details about the inquiry or the transcript, please ask any of the committee staff after the hearing.

I welcome representatives of the Walgett Aboriginal Medical Service to give evidence. Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the Commonwealth parliament. Giving false or misleading evidence is a serious matter and may be regarded as contempt of parliament. With those cheerful words, I now ask you to give a brief introductory statement before we proceed to questions.

Mrs Corby —Thank you very much. Walgett Aboriginal Medical Service has been operating since 1986. We cover a vast range of services and cover many communities in different shires and area health services, not just Walgett. We provide services to non-Aboriginal people and our statistics show that about 40 per cent of our clientele are non-Aboriginal people. We provide clinical services, a dentist, a doctor, nursing staff, Aboriginal health workers and a dispensary

assistant service through the Section 100 scheme funded by the Commonwealth. In our program team managed by Kylie, we cover drug and alcohol, mental health, family health, children's services, sexual health and a public health worker—is that it?

Ms Gilmore—Yes, ear health and eye health.

Mrs Corby —Thank you. With Skye and the chronic disease team, we have a Family Centre Primary Health Care Program. It is a regional program funded by the Commonwealth—the only program in the state, actually. It has just started rolling out this year. We have the Healthy for Life Program, which is copied in our brief today to you, and we also have visiting specialists, like our cardiologist, our podiatrist, our respiratory physician—

Ms Duncan—And a diabetic educator.

Mrs Corby —That is about it.

Ms Duncan—Yes.

Mrs Corby —We also manage Brewarrina Aboriginal Health Service, where we have a team of about half a dozen people and provide a smaller on-site service there. Our organisation has been operating for quite a long time. We are accredited. Back in 1998, I think it was, we were the first Aboriginal Medical Service in New South Wales to receive accreditation both by the GPA accreditation plus and quality management services, which is the Commonwealth arm of Quality Improvement Council. We undertook our third review cycle last year so we are reviewing in another three years time.

We believe we have pioneered a lot of programs and we are here today to focus on good health for Aboriginal and non-Aboriginal people, and good health for people living in rural New South Wales. We would like to address the Health for Life Program, which Skye will speak about, but we would also like to present to you another cookbook that we are going to launch on 25 September in Walgett. You are all cordially invited, if we have your addresses.

With the launch of our second cookbook, we are going to have an Aboriginal chef named Mark Olive. You may know of him; he has been on the ABC in the *Outback Café* series. He will launch the cookbook in Walgett, so you are invited to attend. The resources are: a profile of our services, the brief about the Healthy for Life Program, and the cookbook which will be officially launched on 25 September.

ACTING CHAIR—I state for the record that I have visited your health service. I think I still have a copy of your first cookbook. The committee I was a member of at the time was the House of Representatives Standing Committee on Family and Community Affairs. The committee were all very impressed by what we saw at the Walgett AMS. I know that you do good work there. I know that you have done good work in the past. We will get this exhibition formally endorsed at the conclusion of the hearing today.

Mr COULTON—Thanks for coming down. I was hoping that we could have gone up and seen for ourselves, but unfortunately the logistics of getting the committee to Walgett made that

a bit difficult. Perhaps it might be an opportunity for Skye to talk about her program, which will probably be more in line with what we are interested in today.

Ms Duncan—No worries. I run the Healthy for Life Program, which is targeted at Aboriginal people to improve their health. We focus on three main diseases, which are diabetes type 2, chronic heart disease and asthma. We also work to improve child and maternal health. Through this, we have discovered that obesity is a major problem with the diabetic type 2 clients and the chronic heart disease clients. We were quite lucky in August to successfully manage to secure two people to help us out. One is a nutritionist and the other one is an exercise physiologist. They tackle the problems that occur with clients who have these diseases. Hopefully we will be able to see some improvement in their health with improvements in things like weight, blood pressures and HbA 1cs coming down in the next six months when we report again. We should be able to see some good changes.

Mr COULTON—What particular age group are you targeting?

Ms Duncan—We target all age groups from the antenates to the children to the elderly Aboriginal people with chronic disease. We are getting a few younger people coming in with diabetes type 2 and heart disease. And of course, asthma is across the board, from kids and older people.

Mr COULTON—This is a great booklet we have here. Do you feel like you are cutting through with your message?

Ms Duncan—We have seen an improvement since Healthy for Life started, in terms of people accessing the services to get things like adult health assessments and care plans done, with the nutritionist and the exercise physiologist working full time with us. Prior to this we were relying on locum staff to come in, which obviously does not provide consistency of care, and I have some great ideas for their programs. They work across the Bila Muuji Upper Sector Consortium, so they visit four services. One of the things with the nutritionist is that she is hoping to run things like shopping tours so that people can see what they can buy in their own supermarket instead of someone saying that they should get all sorts of things that are not sold at the Walgett supermarket or the Bourke supermarket. She will be taking them through all that.

Also there are a lot of people who do not realise that canned and frozen vegies are just as good as fresh. If the quality is poor at Walgett because it is the day before the truck comes in with the vegies, it is more than okay to get a tin of pears, or a fresh pear. She will be educating people on that as well as how to read labels. It is appropriate for their disease, if they have chronic heart disease and high cholesterol, to have foods that will help to lower their cholesterol levels and contain not as much saturated fat. That is appropriate for the diabetics as well.

Mr COULTON—When I was up at Walgett a months or two ago, you were talking about the possibility of starting up a garden. How is that going? What is your proposal there?

Mr Fernando—With the market garden, it is at the stage where we are still in the early planting of it. As Skye was saying, with some of the vegetables and fruit, we have a large parcel of land behind the building that we own now that currently is not used for anything. We are in the early stages of looking around at what gardens are out there, how we set it up, and what we

need to set up, as in tractors, trucks and equipment. We are setting up the greenhouse as well so that we can grow our own from seeds and bring them right through.

There is also soil and we are planning what we will do about that. One of the ideas we floated coming across in the car this morning was maybe, instead of just having the program Healthy for Life, we should give people fruit and vegetables as well as an incentive to look after themselves. You could move that on to diabetic people, who cannot afford to buy fresh fruit and vegetables every week, but only every fortnight.

Mr COULTON—You were hoping that was also a place where the elders and the older people could interact with the young ones as well. That was part of your idea as well?

Mrs Corby —Yes.

Mr Fernando—Yes, that as well, and the cookbook, gardening, and teaching—to show how we use some of the vegetables, particularly how we used to use them back then, and show them how we can use them in a soup these days. We can also transfer what the kids are learning at school in home economics back to the old people and show them how it is done these days. We could see which ones are similar because some of the dietary meals back in the old people's day were not really aimed at diabetics.

Mrs Corby —Yes.

Mr Fernando—We are sort of changing the attitude to food by showing what is in a damper and how you can make that better by using wholegrain flour instead of plain flour. There might be a slightly different taste in the bread, but it is the same sort of bread that they are used to.

Mrs Corby —With the recent changes of the CDEP in Walgett, the Walgett CDEP is now managed by the Murdi Paaki Regional Enterprise. We had a formal meeting with the management of the CDEP and they are now looking at working with us to develop the garden that Peter has mentioned at Euragai, using those who are the participants there.

Mr COULTON—Oh, okay.

Mrs Corby —There has been solid planning, but it is just a matter of making it all work together to complement the seasons and getting our area of ground fenced, which is the first priority. The second priority is deciding what to plant for the season that is coming around. We are very mindful that, even though it is spring, it will soon be summer.

Mr Fernando—With the market garden, what we foresee is that we will be able to show people how to grow quick and easy vegetables at home inside buckets or inside bins, or in a small garden patch in your own backyard. These are just simple things where you can plant a whole lot of potato peels and you get potatoes out of those sorts of things. With just a small parcel of your land in your backyard, you can dig it up and put some fertilizer in it and you will get some potatoes for the winter time instead of paying $5 or $7 for 10 kilograms. You can have them in your own backyard. We are planning just little things like that with the market gardening.

ACTING CHAIR—Your Healthy for Life Program is obviously broken up into different stages of life. How structured is that break-up? What sort of programs do you have in place for each of those stages—for instance, the maternal and birth or baby programs? What sort of programs do you have in place for that and for the young adults?

Ms Duncan—I will let Kylie answer the maternal side of things.

Ms Gilmore—With the maternal side of it, as you know we are trying to become breast-feeding accredited. We are actively promoting breast-feeding within the community for the infants right up until six months at least.

ACTING CHAIR—What level of breast-feeding exists currently in the community?

Ms Gilmore—Unfortunately, it is very low. One of the reasons for that is because there is not enough trained staff within our remote communities to support women to breastfeed fully when they come home. There is a lack of access to pumps to express, correct refrigeration et cetera. All of that impacts on the ability of a new mum to breastfeed for a long period of time. As the child is getting older, the other problem we have with children from zero to two years of age is that it is very difficult to target them. We do not have a child and family health nurse. That is why there is a lot in this cookbook specifically to do with that age group.

As children get older, we are very fortunate that with the nutritionists and the Eat Well Program we have gone into all of the three preschools as well as the long day care centre. The day care centre and the one preschool are now nut-free, egg-free and sugar-free totally. Parents have to follow those rules, and that is across the board now.

With the schools, we have the breakfast program at the school, which we support, for children aged from zero to 5 to 6. We support that with toast and cereals. We also have the dental consultant involved because we run a dental program as well in conjunction with the breakfast program. We provide cereals and baked beans in winter, and toast and juice in the summer.

Ms Duncan—Weet-Bix and things like that.

Ms Gilmore—Through the Eat Well Program, which developed the cookbook, we found that we reviewed the breakfast program. That is how we came to introduce the baked beans because we found there was a lack of iron in the diet. Unfortunately that program is now finished, so we are hoping that the Healthy for Life team will pick up where we were with that. We ran a breakfast program for high school for 12 months. We supported that, but we no longer support that. We are currently looking at trying to get one at the Catholic school as well as at the public school so that, across the board, we are targeting as many age groups as we can through the school system and through the preschool system. We are constantly running colouring competitions to just show the kids that fruit and vegies are okay: It is okay to eat them. We actively promote that at all our health promotional events. We try to choose healthy options. We do not have cakes. We do not have sweets. It is water or 100 per cent juice.

Mrs Corby —Recently one of the preschools walked through our dental clinic. That was this month I think.

Ms Gilmore—No, that was not dental. That was the shire family day care centre, Christine, from Lightening Ridge, all the way through Walgett shire, across the district.

ACTING CHAIR—So what about the older age groups?

Ms Gilmore—The high school?

ACTING CHAIR—No, not only high schools. Do you target your adults and older people with the Health for Life Program? Does it go across all age groups, or are you only targeting—

Ms Gilmore—No, I think with the Eat Well Program, how we chose to do that through the Eat Well Program—Skye will talk about the Healthy for Life Program—and our way of addressing that was deciding the first thing we had to do was have staff on the ground who could provide the information. We brought in the specialist services as part of that program and had the Aboriginal health workers and registered nurses from across the area trained in imparting the same information. The information that was going out there was the same. It was correct and it was up to date. That way, as people came into the clinic as part of a program team or part of Goonimoo, which is our early childhood services, they could be targeted and given healthy choices in eating and have a brief intervention there.

A level of education also was provided in the sense that if an individual Aboriginal health worker or registered nurse had decided that they could implement a program appropriately into a school, and it was the right opportunity, they could write the program and put the program into the school. That has only gone into the primary school at the moment, but we are looking at the high school as well.

ACTING CHAIR—Would you like to pick up with the later life stages?

Ms Duncan—Yes. At the moment, we take referrals from doctors and other members of our team. We also advertise all of our things on our Message on Hold, which is our telephone service, the web page, the radio, flyers, word of mouth and things like that, to get people involved with different programs that we run. Further to what Kylie said about the schools, we are also looking at going into all the schools once a year to do Healthy Kids checks to do that early intervention and hopefully to prevent diabetes type 2 and things like that later on in their life.

I forgot to mention earlier that the exercise physiologist is setting up an exercise room at the AMS and we are also starting a cardiac rehabilitation program. We have our cardiologist visit from Sydney two days every month and he is very keen to refer just about all of his patients to some cardiac rehabilitation and the nutritionist to try to get them back on track and let them lead a better quality of life.

Ms Gilmore—I forgot to mention something as part of the Eat Well Program. We also went into a local elders group and also held just a general community program. Our nutritionist, who has come on board as one of our employees now, which is great, though she was not at that time, and our family health worker presented a program on health eating options. They went through and showed them how to budget and that it was okay to buy canned fruit, as already explained. They also went into the elders group and did a cooking demonstration on some of the foods—the

damper, for example—and how they could make it healthier. That was part of the program as well.

ACTING CHAIR—I noticed in the briefing notes we received that there was program called Pit Stop that you have been involved in. Would you like to give us a bit more information on that and the follow-up that has taken place since the Pit Stop Program began?

Ms Gilmore—The Pit Stop Program is a joint program between the Bourke, Walgett, Brewarrina, and Coonamble regional AMSs, the Outback Division of General Practice and the Greater Western Area Health Service. It is specifically designed to target men, associating various stations with parts of your body. It originated in South Australia and the Outback Division brought the training out and paid for the training to come out to Brewarrina, which the majority of the male staff within the area went to. The first program ran in Brewarrina, which was reasonably successful, I understand. Walgett AMS hosted the second program, which was extremely successful. We were very proud about how that went. On from that, it went out to Lightening Ridge. Since then it has rolled out to Sheepyard, which is on the opal fields. Just recently it won a New South Wales Aboriginal Health award.

It is a great program because it is a screening process. You are looking for chronic diseases and you can be looking at eyes and ears, which men sometimes do not go to have checked. It is designed to target people who would not normally go to a doctor. One of the problems we have discovered is that it does not always bring in the people you want it to bring in. We found that most people who had come through the program had been seen within the last 12 months by a GP, but we were hoping it would target other people as well. There are minor adjustments. We are currently working on implementing that across the region.

I understand that across New South Wales there is a lot of interest in the Pit Stop Program. Our staff have been invited to participate and help to implement it into other areas. It has a nutritional section in it. Across the board, with all of the stations, whatever you do regarding health, everything comes back to what you eat and the lifestyle you live. When you are going through the stations, there is information on drug and alcohol and how they affect your diet and your health, and you go to eyes or ears. With eyes, it is diabetes and smoking. There is always information on health stands. We provide food. Walgett provided a luncheon for the participants as well as the people who were on the stations. We made sure that the lunch was healthy. We were saying, ‘Well, this is what you can have. You don’t have to have the pie. You can have a nice lean chop or a piece of steak with a salad.’

The other thing that we have also found through general clinic work, although maybe not through Pit Stop—Skye would probably say this too—one of the biggest problems we find is the cost associated with buying foods in regional and remote areas. It is a lot more expensive than it is in, for example, Dubbo. Often for some families, especially families that may be on a low income, it often cheaper for them to buy $2 worth of chips and gravy to feed the whole family as opposed to buying a piece of meat or some mince and making spaghetti. That is extremely sad, but that is one of the problems.

Ms Duncan—I will comment on that as well. People do not have cars or cannot afford the fuel at the price that it is at the moment. I go over the Narrabri, which is a two-hour drive, or down to Dubbo every couple of weeks and do a really big shop. People who do not have a car

and the money for the fuel just cannot do it. They have to put up with what we get, which at times is quite poor quality and expensive.

Mr COULTON—Just before we leave this topic, you mentioned the camps, Sheepyard and Grawin and ones like that. Have you noticed a difference because of the lack of running water, sanitation and the conditions that those people in those camps live in? For the benefit of other members of this committee, the population in that area would be in the hundreds if not thousands. People live in the opal camps. Have you noticed a difference in people of those areas compared to the ones in town who have access perhaps to a proper kitchen and running water?

Ms Duncan—I think there is a lot of chronic disease out there. There are quite high alcohol rates and drug rates as well as smoking. They live in a very dusty environment, so they have a lot of breathing difficulties. They also have to travel. I think Walgett and Lightning Ridge are about the same distance, which is about 78 kilometres, so to get things like medicines and things like that is difficult. We provide a GP service out there once a month. It is an outreach clinic where the doctor and the nurse goes out there. But even to get their medicines, obviously they still have to travel either to Walgett or to Lightning Ridge to get their tablets. There is quite a high rate of chronic disease.

Ms Gilmore—We have a monthly podiatrist as well.

Ms Duncan—Actually, it is every second month. There is a podiatry service for diabetics out there as well.

ACTING CHAIR—I am interested in the sharing of resources between your AMS and the area health services. You have two area health services, or do you have more than two area health services that you cover?

Mrs Corby —The nature of our funding crosses over different area health service boundaries. We are predominantly in GWAHS but we go up to the Hunter-New England with our eye program, in particular.

ACTING CHAIR—Do you share resources between yourself and the area health services? Is there a sharing of resources, or do you tend to operate purely with your own resources and the area health service operates with its resources? Is there a crossover and a working together, or is there a bit of a silo mentality?

Mrs Corby —We try not to work alone. Both GWAS and the division would recognise that. Having said that, particularly with oral health, we have a very good relationship with Jenni Floyd, who heads the oral health unit here within GWAS. With Brewarrina in particular, they are very supportive of the Aboriginal Health Service that has been operating for the past three years under our management, so we are very fortunate there.

Ms Duncan—They want to build better relationships with you.

Mrs Corby —Yes.

Ms Gilmore—Outback Division provides us with a midwife when we do not have one—once a fortnight. Pit Stop is also the prime example of how partnerships work with more one organisation.

ACTING CHAIR—That is what I meant; for example, partnerships.

Ms Gilmore—There is a partnership agreement. When we have visiting services come in, we have MOUs, et cetera. We also have MOUs with most of our preschools as well—preschools and schools. The other one, Eat Well, was another WAMS-GWAHS project. Even though WAMS held the funding, it was the GWAHS nutritionist and the GWAHS dietician from Parkes and Forbes who supported us to implement that program. At that time we did not have the staffing through the Healthy for Life Program. I would say there is definitely a partnership there and we share the resources. Mental health is another area in which the resources are shared a lot, as well as now child and family health, and sexual assault.

Ms Duncan—Diabetes is in there as well.

ACTING CHAIR—And diabetes? She assists you there?

Ms Duncan—Yes, she comes across from the Greater Western Area Health Service at Lightening Ridge.

ACTING CHAIR—Thank you.

Ms RISHWORTH—My question is a bit broader. Throughout this inquiry we have heard a lot of people talk about the difficulties of translating information into action and making that transition. Obviously by providing people with recipes is a step towards that. I am interested in what other things you have found that allow that to translate. You have spoken about labelling and teaching people to read labels, but I am interested in how often you monitor people you are seeing. Are there other things that you do to help that information, which is all very well to read, to translate that into weight loss?

Ms Gilmore—On the maternal side of it, one of the things we do is go into the local high school when invited, if they require us up there, and do a young mums group. We are physically going up there, picking them up, teaching them how to budget and we take them to the grocery store. We demonstrate how to cook recipes and how to freeze vegetables, et cetera, and prepare them for a week in advance and correctly store them. There is that side of it. When we went to the elders group it was definitely more hands on as opposed to, 'You need to read the label.' It was like teaching them about the healthy heart tick and everything like that, and sitting down with them so that they could feel and taste the foods, and know the difference in the foods.

Mrs Corby —The Kids Excel at the primary school.

Ms Gilmore—Yes. The Kids Excel Program runs the Fruito Program through the primary school as well as at one of the preschools. They provide fruit at morning tea. They, particularly the coordinator, are very committed to working with the AMS to ensure that the kids know what is healthy by getting us in and running programs within the school and teaching them. What we

found is that if you can feel the fruit and taste the fruit, it is much better than just looking at it in a book or colouring it in.

Ms RISHWORTH—Absolutely.

Ms Gilmore—One of the best ideas I ever saw was at one of the preschools where they made a huge vegetable man as part of a competition. It was absolutely incredible. I should have brought some photographs, but I never thought of it. That was their way of introducing the kids to some vegetables that they may not be eating. They did that by making it into a man first and then they cooked it, piece by piece.

Ms Duncan—I will just add that the nutritionist who just started in August was running a program yesterday at Brewarrina with the preschool there. If it is successful, she will take it to Walgett and to Bourke. It is called Eat a Rainbow and involves going to the Brewarrina Foodworks store—I am not sure what it is called—and purchasing food there, such fruit and vegies that you would find, and then getting the kids to pick a colour out of the rainbow and eating food of that colour. I think for blue or indigo, they had blueberries. They also had some capsicum and things like that so that they could actually taste while they are there. Hopefully they would go back and tell their mums and dads that they liked it and ask them to get it when they shop.

Ms RISHWORTH—I would like to follow up on that translation as well from the school programs.

Ms Duncan—Yes, to encourage to bring that home and tell their families.

Ms RISHWORTH—Yes. I have just another question to follow up on that. We have been listening to very broad things. What things would make your job easier? We have discussed advertising at certain times to children on TV. There has been a range of things such as looking at simpler labels and larger type on labels. We have heard a whole range of different things. You are working on the ground to try to get this information across, so what would you like to see happening in the future? You have spoken about cheaper food and fresh vegetables being available. You have already touched on some of those things, but I would be interested to know if there are other things.

Ms Gilmore—I would like to see, starting from the day care preschool right up to the high school kids, the government introduce some type of program so that you know that the kids are getting the correct amount of calcium and the correct amount of fruit from the start.

Ms RISHWORTH—From the school?

Ms Gilmore—Not from school; from the start. If kids are in day care, start it then.

Ms RISHWORTH—But provided by the child care or the school, not by the families. Is that what you are suggesting?

Ms Gilmore—Yes, that is what I am saying. One of the other things is that we have to look at calcium. We cannot forget about that. It is alright to talk about fruit and vegies, but we have to

remember calcium because a lot of our kids do not get enough milk. We have to be realistic—some families cannot afford to do that. If the government could put in the appropriate programs in, it would be great.

Because these are small communities, the school canteens often run at a loss so they are forced to provide what we would consider to be not necessarily healthy choices. The government needs to support the smaller schools with smaller canteens and preschools that do not have options to buy in bulk in the city by supplementing them somehow so that they can provide the healthy options.

We all know that if we do not introduce sugar to a baby, they are never going to get the taste for it. That is why I am saying we need to start early as opposed to starting at high school. That is why I say across the board, that is what I would like to see.

Ms Duncan—This might be a bit unrealistic, but I often talk to our dental consultant about being able to just ban Coke and all sugar drinks completely from Walgett. It would just make such a difference, it would be fantastic. You do see kids with bottles of Coke or even little two-year-olds struggling to carry a big 2-litre bottle of Coke.

ACTING CHAIR—Coke in bottles?

Ms Duncan—Yes. Then they go and have their dental clearance at the age of four because they have just got black stumps, which then of course leads to things like heart disease, diabetes and everything else down the track.

Ms RISHWORTH—Of course.

Ms Duncan—The cycle continues, which we are trying to break.

ACTING CHAIR—Mr Coulton, do you have a final question?

Mr COULTON—One of the issues I have been trying to assist by getting funding for in Dubbo is for young mums. As I go around the traps, I am told that you have to start, as you said, from minus nine months—pretty much at conception.

Mrs Corby —Basically, yes.

Mr COULTON—Quite often, by the time a child gets to school, the patterns for life are set.

Ms Duncan—Yes.

Mr COULTON—And the initial damage is already done to their health. The Riverside Church has been trying for some time to get a project whereby they encourage young teenage mums or mums in their early twenties to come along. There is a playground for the kids with a kitchen that is similar to what they have at home. It is not a commercial kitchen, but just a little stove and stuff, and there is a food bank there. While they are there, they teach the mums about cooking different meals and monitor the kids. It takes on a social aspect as well. It just does not fit any category that attracts funding. Are you doing something along those lines?

Ms Gilmore—Not like that. Ours has gone into the schools, but what you are talking about would be something that WAMS would be looking at through one of their kitchen facilities. We would look at having something very similar to that, except we would be targeting the whole population but breaking it into separate groups and having the groups coming in. We would run it with young mums and a playgroup at the same time as they are doing their little bit in the kitchen. We had not thought about how we would supplement the food, but we are looking at running at least some type of cooking, budgeting and lifestyle stuff.

Mr COULTON—One of the things we saw in Melbourne that stirred all our imaginations was the Stephanie Alexander program whereby the school has a vegetable garden and a kitchen. The kids grow the vegetables at the school and prepare them. Not only that, but they sit around under the supervision of volunteers and teachers and consume that meal, learn about sitting at a table and having a conversation or discussing issues. The government has just introduced that.

ACTING CHAIR—I was just going to say that there are grants available for that.

Mr COULTON—I have written to Walgett primary school and urged them to apply. Obviously, there are only a limited number of grants, but something like facility tied in with the community would, I think, would be very good—particularly tied in with the garden that you are planning. That would have potential. The standard thing I am always told is to get the kids before they go to school.

Ms Duncan—And they educate their families.

Mr COULTON—Yes.

Mrs Corby —Our facility at Euragai is a community centre.

Mr COULTON—A primary school, yes.

ACTING CHAIR—There is a primary school facility?

Mrs Corby —Within our facility at Euragai Goondi, we have that. Once we had the boundary fence and the garden, there was a kitchen there where you could transfer the skills from planning to growing to preparing and to eating.

Mr COULTON—Yes. It is very important.

ACTING CHAIR—My final question—I am allowed to ask only one—is actually two questions. To what extent do you think the cost of food is a barrier to healthy eating in the community that you represent? What initiatives do you think could be taken at the federal level to help to address obesity and associated problems in your community?

Ms Duncan—As we said earlier, obviously it is cheaper to feed your family with some chicken and chips from the takeaway store than it is to buy some meat and some fresh vegies and perhaps make a stir fry, or something like that. Our nutritionist is currently looking into where the food comes from and the trucks that deliver it.

ACTING CHAIR—That is what I was getting to, more than the chips and gravy.

Ms Duncan—She has looked into all that. As I said, she works at Bila Muuji Upper Sector at the Bourke-Brewarrina Orana Haven, which is the drug and alcohol rehabilitation centre. She has been looking into all that to see if there are ways we could possibly source supplies from somewhere else, especially to supplement schools and things like that for their programs for fruit and vegies instead of the food that is sold at the canteen. She is also looking at sourcing funding to help out.

ACTING CHAIR—And the initiatives? Are there any initiatives you would like to see?

Mr Fernando—Probably last year you saw all the fruit growers basically chucking out their fruit. There was an opportunity to buy very cheap Australian-grown fruit that was produced virtually in our own backyard. It was just a matter of having someone buy it from the farmers and deliver it to the areas where it is most needed. We need transport to pick it up. That is rural and remote, not so much in the city areas. That is out in areas like Walgett and Dubbo. When I saw on TV that all that fruit was just going to be dumped into yard and even the cows would not eat it, I thought it was a total waste when we have people out here who are buying oranges and stuff that are slightly overpriced, which is only because the transport costs so much to get it up there. At a certain time of the year when there is an abundance of fruit that is going to waste, there should be a program to enable that fruit to be bought by the government and given out to the communities.

Mrs Corby —I think it was down at Mildura where they were throwing out the oranges because they were getting the pulp from South America.

Mr Fernando—That is right, yes.

Mrs Corby —What a terrible waste.

ACTING CHAIR—Thank you very much for attending the committee hearing. Your evidence is very much appreciated. You will be sent a copy of the draft *Hansard* record within the next couple of weeks. Have a look at it and if you have any corrections, just send them back to the committee. If there is any additional information that you would like to add at a later date, please feel free to do so. Thank you very much. Could a committee member move that the submission be accepted?

Mr COULTON—I will, Madam Chair.

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

That this committee accepts the submission into evidence of the Walgett Aboriginal Medical Service.

Mr COULTON—Having done so, I also thank the witnesses for coming down. One of the issues associated with living in a more remote area is, as you know, that you have to travel to attend these hearings. On my visit to Walgett, I was absolutely blown away by the professional and far-reaching effectiveness of your organisation as well as the motivation of your staff. Thank

you for taking time out of what I know is a very busy schedule to come here today. This committee very greatly appreciates your efforts.

Mrs Corby —Thank you.

[2.44 pm]

HARRIS, Professor Bruce, Program Coordinator and Counsellor, School of Rural Health, National Rural Health Alliance

HEATHCOTE, Mrs Sophie, Board Member, National Rural Health Alliance

LAWLER, Ms Louise, Affiliate Member, National Rural Health Alliance

PHILLIPS, Mr Andrew, Policy Adviser, National Rural Health Alliance

ACTING CHAIR—I call representatives of the National Rural Health Alliance to the table and welcome them to the hearing. Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the Commonwealth parliament. Giving false or misleading evidence is a serious matter and may be regarded as contempt of parliament. Knowing that that is not going to happen, I thank you very much for your excellent submission and invite you to make a brief introductory statement before members of the committee ask questions.

Mr Phillips—I have prepared a statement.

ACTING CHAIR—That is wonderful.

Mr Phillips—Would you like a copy to follow as I read it?

ACTING CHAIR—I think we would rather listen to you.

Mr Phillips—Very good. First of all, I would like to say that we are not obesity experts, but we have an interest and concern for the health of people living in rural and remote areas throughout Australia. People in rural and remote areas have, on average, poorer health, worse risk factors—for example, smoking and being overweight—and lower levels of access to health services than do people in major cities. With regard to obesity, I am sure you are familiar with the numbers that are floating around at the moment. There is a dramatic increase over time, the costs are quite substantial in terms reduced productivity and medical costs as well as personal costs, and you should be aware that people in regional areas of Australia are 15 to 40 per cent more likely to be obese than are people in major cities. It is something that we regard as a serious and substantial issue in rural and remote areas.

The other issue is that Aboriginal people are about 50 per cent more likely to be obese. As they are a major constituent of rural and remote areas, we have concerns about that also. We commend to you the alliance's submission to the inquiry. The alliance believes that the new Australian Health Care Agreements, or the National Health Care Agreement, if that is what it is to be called, could be used as a framework for agreement between the Commonwealth, states and territories of a set of incentives for health promotion and primary healthcare programs that are targeted at reducing the overweight and obesity incidence. We take quite an interest in prevention and health promotion as a means of tackling obesity.

With obesity, prevention is manageable and critical for both the individuals and their families as well as for the public purse. As with health generally, the alliance believes that a holistic approach is important. Measures to prevent and manage the obesity epidemic will need to embrace public health initiatives and involve whole-of-population work.

The Commonwealth and state governments should immediately prepare to increase expenditure over the coming years on illness-rated obesity—for example, diabetes, heart disease, renal disease and so on. They and local governments should also prepare for reduced per capita productivity, particularly in regional areas where the prevalence of obesity is substantially greater than in major cities and where per capita government expenditure on health is already lower. This reduced productivity will stem from higher rates of absenteeism and lower workforce participation, principally due to an increase in obesity-related chronic disease. The burden for all parties may be reduced by taking preventative action now. Simplistically, action should aim to increase the options for active life, reduce options for sedentary life, increase access to healthy food and decrease access to unhealthy food. It is simple, but it is much simpler to say than it is to do.

Obesity should be attacked in at least three distinct populations so as to mitigate future damage to health and health expenditure. These populations are babies and toddlers, schoolchildren and adults. The highest priority should be given to Aboriginal and Torres Strait islander children. Addressing obesity in adults can head off the rapidly increasing health consequences of current and expanding obesity; otherwise our children will have to put up with the consequences of our carbon economy and also foot the medical bills for our obesity. In addition to having lower access to health services, people in rural and remote areas have, on average, lower educational status and lower incomes—generally about 80 per cent of those of people in major cities.

Children are substantially less likely to still be in high school when they are 17, and they are much less likely to go on to university. For a start, generally they cannot live at home while they are studying. Housing costs are about 80 per cent what they are in major cities, but other items such as food and petrol are more expensive than they are in major cities. There is constraint both ways because of lower incomes. I mention these because obesity is linked to, amongst other things, lower socioeconomic status. All the work that governments do to encourage rural development, sustainability, enhanced income and education for those in rural and remote areas will, in the medium term, help to combat obesity. For example, not only would the provision of broadband Internet access in rural and remote areas reduce city-regional inequality, facilitate the provision of health services and bolster the sustainability of many rural and remote communities; it would also encourage the development of business opportunities and careers outside major cities, which would have an impact on socioeconomic status.

Ironically, people in rural and remote areas tend to have poorer access to fresh fruit and vegetables, particularly in smaller and remote communities where access to fresh fruit and vegetables can be very limited, and typically it is of inferior quality and higher price. Coupled with restricted access to refrigeration and secure food storage, for example, in some Indigenous communities, that means that fresh fruit and vegetables might not be a ready option and there is a greater reliance on preserved and processed, refined or fast foods. It is also worth mentioning that people living outside major cities are more likely to experience food insecurity as a result of not having enough than are people living in major cities.

The availability of junk or highly refined food that is high in sugars, fats and salt should be discouraged, for example, through tax, legislation, restrictions on advertising and so on in a similar way to tobacco. Nutritional labelling should be clearer. Recently I read something about traffic light food labels, which seemed interesting.

ACTING CHAIR—Do you like the idea of traffic light food labelling?

Mr Phillips—I do. I should mention also that although the statement that I am reading to you is my summary of the alliance's submission, or my highlighting of it, I believe it is representative of what is in there. However, there may be some dissenting views.

ACTING CHAIR—I am interested to hear them once you have finished.

Mr Phillips—I think that is important so that people can easily make informed choices. On the other hand, the consumption of healthy food should be encouraged through a range of incentives or initiatives, for example, enhanced availability, tax breaks, legislation, advertising, and so on. Policy relating to healthy and unhealthy options is useful only if people have access and the means to take advantage. For example, apples cannot be eaten where they are not available. People in rural and remote areas have lower levels of access to health services, including GPs and dieticians, than people in the major cities. Time taken with clinicians accessing remote populations consumes time spent doing clinical work. They have to drive there first and then do their work.

Efforts to increase the supply of health workers outside major cities would have multiple benefits. Whatever action is taken to fight obesity, it must be focused specially to help Indigenous people who are particularly at risk on multiple fronts. Sustained health promotion has the ability to change social norms that are important in encouraging activity and discouraging poor health. The environment in which people live has an important influence on their health behaviour. For example, urban design can have a strong influence on residents' opportunity to be physically active. Rural towns can be of assistance to our community through walking and pushbike riding. However, it is far too easy to drive and it may be safer and more comfortable to do so on a hot day.

New urban developments tend not to have footpaths—I am thinking of large places, for example, Dubbo—and rural streets can be very cyclist unfriendly. Public transport is frequently restricted, or more usually not available. Corner shops tend to be absent in new developments, which requires residents to drive to distant shopping centres for milk and bread, et cetera. In some towns streets can be unsafe at night because of social or law and order problems or they are too hot during the day due to a lack of tree shade. Construction, maintenance and promotion of swimming pools, cycleways, footpaths, tree planting, sporting facilities and so on may be very good investments.

We are all aware of the increase in sedentary occupations and sedentary behaviour in children. We advocate any changes that the government could think of that would reduce that tendency. With schools we are particularly interested in physical activity and nutrition. For example, an emphasis must be placed on food policy and activities that encourage or mandate healthy eating at school.

In conclusion, I would like to make the following points. High body mass, physical inactivity, high blood cholesterol and low fruit and vegetable intake are responsible, after tobacco and high blood pressure, for 22.4 per cent of the total burden disease in Australia. Addressing diet and exercise is likely to have substantial benefits, both for health and for the economy, over and above the benefits from reduced obesity.

If you tackle obesity you will probably also tackle these other issues, for example, physical inactivity, low fruit and vegetable intake and high blood cholesterol. You have an opportunity to make some substantial and beneficial changes. If you tackle obesity you are likely also to enjoy fringe benefits. Interestingly, a rapidly increasing prevalence of obesity and a decreasing prevalence of smoking will soon make high body mass responsible for a larger proportion of the burden of disease than any other single factor, including smoking.

People in rural and remote areas and especially Indigenous people are in the vanguard of this obesity epidemic. They already suffer higher rates of obesity and poor health, they have high rates of diabetes, arthritis, hypertension and so on, and generally they have higher rates of death. They have poorer access to health services, they tend to be poorer and have lower levels of education, they tend to have poorer access to portable healthy food, and their environment can encourage sedentary behaviour. Rural and remote areas can frequently be forgotten by governments, particularly if they are not in marginal seats.

People in rural and remote areas make substantial contributions to the national economy, especially to exports, and they grow our food. It is time to protect that capacity by ensuring sustainable and healthy rural communities in which people have access to basic good health—at least as good as the health of their brothers and sisters in the major cities. Thank you.

ACTING CHAIR—I will ask Mark Coulton to ask the first questions as he is the local member. Amanda will ask the next questions and I will finish up.

Mr COULTON—Professor Harris referred to a subject that is close to my heart. One of the issues relates to a lack of health professionals in regional areas and the fact that those that we have now, in particular GPs, are flat out keeping up with emergencies. They do not have time to undertake precautionary or preventative work. With your association with the school in this area you would be aware that medical students in regional areas have to be trained beyond university. Quite often they come here as students but we lose them through their internship and residency. If there were a way to keep younger doctors here I am sure it would increase your workforce and enable you to undertake preventative work.

Prof. Harris—That is a big question which requires a big answer. Thank you for asking it. The position I hold with the alliance began when I was working as a GP at Walgett, from whom you have just heard. We decided that doctors alone were not going to fix the problems of the country, so we went to Toowoomba and formed the National Rural Health Alliance in 1990—a 28-member organisation that you must admit has given some fulsome thought to this issue as time has gone by. The concerns that we have had go back over a period. As parliament knows, the investments of this government, the previous government and the one before that—back to Brian Howe—have been substantial in rural medicine as well as in rural health.

So far as this town is concerned in the area of rural school health, the Rural School of the University of Sydney is currently achieving that which 10 years ago was unimaginable, and that which perhaps 20 years ago could not have been announced—that is, it is delivering the University of Sydney's medical course in Dubbo. Our students currently do 12 months, that is, of a four-year course. They do 12 months of clinical work in this region, which includes the region surrounding Dubbo. So they will attend practices in places such as Walgett, Cobar, Lightning Ridge, and other places that are mentioned. For the purposes of a finer understanding they also meet the people in Dubbo base who come from those areas. They are familiar not just with the geography of the small towns; they are also familiar with the problems faced by people who live in them as they come into a major regional hospital.

Of those students that we have had in the past five years, every one of them has passed, which is a credit to the education capacity of the country. I can quote to you numbers of students who are in rural practice. For example, and hopefully for your enjoyment, our current obstetrics registrar at the base is a former student of our school. Our current paediatric registrar is a former student of the school. One of the trainees who is going into general practice in this town and has lined up a practice to take over from a current practitioner is a graduate of our school. Two of them have married locals, so other forces are at work apart from career. The school, which is new, is the result of many years of lobbying, not just by doctors but by a range of health providers and, of course, politicians and bureaucrats, who have supported the process of rural education.

It is early days yet. It would be a fairly mean person who tried to judge whether or not it was effective. It has brought student interest, teacher interest and equality of medical service to western New South Wales. There are 12 or 13 other rural schools doing the same elsewhere in Australia. You would be surprised if I thought ill of it; it is an excellent process and it will work in time. It will not work right now to get someone in Narromine by the weekend, but maybe next year.

Ms RISHWORTH—I would like to comment on a few things. I was interested in your comments about portions in restaurants. I am sure that is a bigger issue in rural and regional centres where you do not have a lot of choice in restaurants. Do you have any thoughts about what could be implemented to specify portions? Would you have guidelines or would you try to get all the restaurateurs on board? Do you have anything in mind to address that issue?

Ms Lawler—My pet hate with the whole of the restaurant industry is the idea of the children's diet, which invariably is rubbish. Somehow or other I think that gives the general population the idea that it is sanctioned child food, and that becomes a lesson that society learns.

Ms RISHWORTH—Absolutely.

ACTING CHAIR—You made a very good point.

Mr COULTON—I had never heard of it before but it is so true.

Ms RISHWORTH—Another issue that I found interesting was exercise. I do not know whether or not you have given much thought to this but we have heard a lot about exercise. As Mark said earlier, there is a good club culture in rural and regional areas. However, as you point

out in your submission, kids who are not necessarily active or good at sport might go down to the club to socialise but they do not go to play sport because they are not good. That all contributes to self-esteem. We have heard about implementing programs such as that in schools but I noticed a reference in your submission to implementing something at clubs that is not competitive. Could you elaborate on that?

Mr Phillips—Basically, there is a whole range of different sorts of sports. Sport does not include only football and cricket. If you have a small rural community often those might be the only things that are currently available. For the adult population we would encourage the development of other forms of sports, perhaps individualistic sports such as mountain climbing. For example, going to the dam to do water skiing would be excellent.

Mr COULTON—Pig chasing is a big sport out this way.

Mr Phillips—Pig chasing, yes.

ACTING CHAIR—They do that in utes.

Ms RISHWORTH—They need to get on their feet.

Ms Lawler—That is one of the problems, in particular, for Aboriginal children. The vast majority of them are very athletic. They play any kind of sport and they develop sports. However, at the age of about 14 or 15 girls in particular give that up. That is when we see long skinny kids becoming kegs all of a sudden, just before they get pregnant. After primary school the girls in particular get fat very quickly. That occurs in about the beginning of high school. That is due in part to a lack of sport. Sport is no longer compulsory in high school. Part of it relates to child sociology that cool girls do not run. The other part relates to most boys continuing to play football. Those that do not play football have obesity problems. We need to develop a sociological culture or belief that sport should continue right through to adulthood.

Ms RISHWORTH—Are there opportunities for leaders in the community to be doing that? How will that sort of change occur in the community?

Ms Lawler—I think it is occurring all over the place. People are very aware of it and they are doing what they can. This week a park with a playground centre was opened in a disadvantaged area in Dubbo, which will result in the introduction of rugby union and all that that can bring. I do not know whether that will extend to the smaller communities, but I suspect not.

Ms RISHWORTH—I am quite interested to hear everyone’s opinion on the issue of traffic light labelling. That concept will result in red light and green light labelling and bigger labels on the fronts of packages. I am interested to hear other people’s comments about that.

Prof. Harris—The last time I heard, mine was the face that screwed up.

Ms RISHWORTH—It was.

Prof. Harris—I think that is because I always found the quick fix a problem. I am very much in favour of clearer labelling, both for those who have difficulty reading and, perhaps

predictably, where it is on the label, the lid, or the bottom of the jar. There is not much point in well-trained scientific minds reading down the periodic table to see what is in something. That will not really add to anyone’s understanding. I think labelling that is meaningful is important. I find problematic whether or not a few red dots cover the relativity of how much fat, how much carbohydrate, or how much sugar is in anything.

The quick fix solution bothers me if we are immediately dubbing something as a red dot or a green dot and then we are trying to say, ‘Three green dots are better than two’, or whatever. I would rather look at labelling in general to see whether we in Australia can come up with something that answered the needs of those who seek to find out. I could live with traffic lights, provided the other things were done.

Ms RISHWORTH—The concept that has been put to the committee is that you would have to have it in a number of dimensions and you would then need an overall dimension. You would have it on salt, saturated fat, fat overall and sugar and then there would be an overall rating. That is the sort of concept that has been put to us.

Prof. Harris—Andrew and I were discussing this earlier. With the benefit of some years and looking back on what I might have first seen in practice, particularly with Indigenous people, we saw really severe malnutrition. We saw people who were iron or vitamin deficient. That is not really a feature of current practice. What we see now are people who are too well fed. It is a matter of getting the proportions and relativities right. Perhaps traffic lights would lead in that direction. It is important to ensure that the notion provides good food. It is more a question of choice and discretion as to how they are used.

Ms Lawler—From the high school perspective the children and families with whom I work have no idea how much of anything you should eat. Rather than having traffic lights on things I would like to a whole lot of ideas, or even pictures, of how much constitutes breakfast. At lunchtime we were saying that, if you were in America and you sat down for breakfast, the menu choice for eggs would start at three or more. Somehow or other that frightens me. In Australia it is still one or two, and it is one or two lumps of sugar.

The Aboriginal girl with whom I have morning tea every day probably has six teaspoons of sugar in her tea. She was just diagnosed as a gestational diabetic and she does not know why. I sit with her every day and watch what she eats. It is very clear to me how she ended up there, but she says, ‘The only sugar I use is in my tea.’ She does not include in her sugar intake hotdogs, sausage rolls or anything else that she eats. There is no sugar in those.

We really have to make it clear what is in the food that we eat. At one stage I saw pictures of teaspoons of sugar attached to food labels. There would be 10 teaspoons of sugar in a glass of Coca-Cola or whatever. I am with the Walgett girls; ban the soft drinks. Get rid of them altogether.

Mrs Heathcote—Louise said that it is good to have pictures, which is what we used to have for medicines. When you take medicine you have a teaspoon, a tablespoon, or whatever. I know it is a slightly different sized spoon, but people need to see something physical rather than a statement that there are 5 grams of fat in your meal. Nobody really knows what 5 grams of fat looks like until it is attached to them.

ACTING CHAIR—Mark, did you have question about the issues we are discussing now? I did not want you to wait if your question related to this issue.

Mr COULTON—No, it is more about behaviour.

ACTING CHAIR—I refer to Commonwealth health care agreements. You talked about using those to address obesity. Do you have any ideas about what you would like to see included in those agreements?

Mr Phillips—I would be interested to see an increased emphasis on prevention and health promotion. Thirty-two per cent of the burden disease is a consequence of 14 different risk factors. Tobacco smoking and being overweight are big factors. About 2 per cent of the health budget is spent on that sort of area. Obviously there are benefits from other areas of government. There is the old story of people falling off the bridge into the river and people jumping in downstream and grabbing them. However, if you went onto the bridge and you put up a barrier you would stop people from jumping in.

Much pressure is placed on clinicians to fix what is coming through the door. It is difficult for them. They might not be equipped to make legislative changes or to send out messages via the media about what should be done. Governments must increase expenditure on health promotion and prevention. Some of that might include legislative change, for example, the sort of legislative change that occurred with tobacco smoking. If we make it more difficult for people to smoke it makes it easier for them to give up.

ACTING CHAIR—Does everyone support the legislative change to address some of the issues that you have just raised, as that issue has been raised before?

Mr Phillips—Yes.

Prof. Harris—Earlier I did not clearly answer Mark's question about prevention. An absolute mantra, or statement of clear truth in rural practice, is that you are so busy with active and acute issues that you do not have time to sharpen the axe. There is no time to get out there and say, 'It would be better if.' Most practitioners would argue that they know enough. They simply do not have time, or their patients do not have access to them to sit down and deliberate what would be a healthy meal when three people are waiting to have their wounds mended. Doctors in the country—the same applies to palliative care and many other aspects—could do better. They are not ignorant of doing better; they just have to put in priority what it is they do.

ACTING CHAIR—That comes back to workforce issues, does it not?

Prof. Harris—It certainly does. It probably comes to a workforce discussion as to what is appropriate and for whom in relation to service delivery.

ACTING CHAIR—It is a difficult issue.

Ms Lawler—A lot of the time practitioners say, 'It is really simple. You have to burn off more than you put in and then you will lose weight'—end of story. If it were that simple we would all weigh 50 kilograms. That is part of the problem. At school I see kids who are totally addicted to

carbohydrates. We are way past choice, particularly when we are looking at children with dietary problems who have gone back to when they were force fed S-26. They are addicted to those foods. It will take a lot more than a bit of advice to change their eating habits, even if their mother starts cooking broccoli and chops instead of giving them a meat pie for dinner.

ACTING CHAIR—I put on the record of the committee that you stated in your submission that workforce issues are important in the delivery of services in regional and rural communities. We know how stressed and strained health service providers are, not only in medicine but also right across all allied health areas. They all contribute to addressing the obesity issue. Another issue I found interesting in your submission related to rural planning and designing for healthy living. What kind of design would you like to see in place for healthy living in rural communities?

Mr Phillips—Perhaps I could start?

Prof. Harris—You do not want to compare Canberra to Dubbo.

Mr Phillips—Canberra has a number of cycleways, which is gorgeous. However, that might be a good place to start.

Ms RISHWORTH—I grew up in a country town!

ACTING CHAIR—You will be going that way to Canberra every time, will you not?

Mr Phillips—I should indicate that I have lived in both Dubbo and Canberra. I used to live in Dubbo for quite a long time. I am familiar with the East Ridge area of Dubbo. I am sure Mark is familiar with that area. It is a great sprawling development, but there are no shops and the footpaths are very limited. If you need to go to the shop to get some milk, bread or whatever—I used to be constantly annoyed about this—you have to jump in the car, drive all the way down to the Myall Street shops, or something like that, get your stuff and drive back again. As I am now living in Canberra I just walk.

It takes about 10 minutes to walk to the local shopping centre, you get your stuff and you walk back. Sometimes you drive but, generally speaking, you would walk. A lot of people walk. That is one example. In a place like Dubbo, because of the way in which developments are going ahead, you might have an opportunity to design some of these areas so there is somewhere for people to walk. Because of the way in which the streets are organised you can walk up the street, down a laneway to another battleaxe or cul de sac, and then through to the shops.

Mr COULTON—It is nearly impossible to walk to the biggest shopping centre in Dubbo and get there alive. There is no pedestrian access.

Ms Lawler—There is no cycleway.

Mr COULTON—There is no pedestrian access. You need to be in a vehicle to get there.

Mr Phillips—At lunchtime we were talking about the United States. An American friend of mine recently came back from there. She said that she was astounded because a shopping

complex to which she went covered four blocks. You could not walk from one part of the complex to another. There was no way of crossing the road because it was so busy and there was no pedestrian crossing. You had to get in the car and drive to the other corner. This is a little reminiscent of that.

ACTING CHAIR—You are placing an emphasis on town planning?

Mr Phillips—Yes.

Prof. Harris—Yes.

ACTING CHAIR—What about a sense of community and the role that plays in addressing these issues?

Prof. Harris—There are so many issues that I am quite sure you have been blasted with data. One of the issues that we discussed earlier today was the valuable asset of the Dubbo markets. People in this town can go there to get fresh produce from those who produce it locally, and those who purchase it can make these judgments so that it will last longer in their freezer boxes than that which they would get from Coles or Woolworths.

ACTING CHAIR—How often are the Dubbo markets held?

Ms Lawler—Once a fortnight.

Prof. Harris—Fortnightly, so a purchase from there would last two weeks. The argument put forward by those who know, and I do not, is that your mandarins would be better than those you would get from Woolworths or Coles. That led me to return to a discussion that I had in Walgett, which has echoed around the country in rural and remote areas—that is, the shelf life of goods. People in Darwin have always said that they could get their cereal after the competitions. It was always close to expiry by the time they could buy it in the shops. People in Walgett were being presented with specials of custard tarts that had expired a week earlier. Fitzroy Crossing had nothing in date on the shelf.

Somewhere in the whole mire of legislation there must be a loophole by which retailers can purchase minimal expiry or cheaper stuff and flog it to communities, et cetera. I do not think it stayed on the shelf for the length of its expiry; I think it had been brought in at a cheaper price. That is where a community could do a little more Neighbourhood Watch and be conscious that what is being retailed is safe. Dubbo markets are a valuable asset for their fresh produce. In Walgett where people do not read, where they are not really discerning, and where they do not think they are empowered, they could start to search the shelves and ask, ‘Are we getting a fair deal or not?’

ACTING CHAIR—You referred earlier to socioeconomic factors. Those same factors kick in when you look at breastfeeding. That beginning of life process comes into play when we are looking at obesity and health. I loved the quote that you used at the beginning of your submission.

Mr COULTON—We have been conducting this inquiry for some time. Two of the things that have come up are that prevention is better than cure and the younger you get people the better. The only people who sat before us and guaranteed that they could cure obesity were the lap band surgeons.

Ms Lawler—It is highly likely if you gave them a child early enough.

Mr COULTON—Those were Christine’s views, so do not start too early. For the benefit of communities from out of town, Louise wears another hat. She works with kids from the wrong side of the track and she helps them get into education, employment and things like that. The program, which is called Get Real, is well recognised. My question to Louise is: We are talking about modifying behaviour and getting people to eat healthily but, in reality, are you able to modify kids’ behaviour?

Ms Lawler—You can, but you have to educate them about what they are doing wrong in the first place. If they are eating what their families are handing them and everybody around them is eating the same thing every day, like the little girl with whom I am working at the moment who has gestational diabetes, it not fair. It is not fair when a diagnosis comes for a 32-year-old in her third pregnancy that she has gestational diabetes. She is doing the same as everybody else, which is the problem. They do not believe that they are eating poor quality food because it is what is naturally available.

I noticed this week that the size of sausage rolls has trebled over the past few years. Believe it or not, I saw pies, sausage rolls and hotdogs listed in the school canteen as healthy food. They are listed in healthy canteens as foods that are able to be eaten. The sausage rolls are huge. Portions and attitudes are wrong, what constitutes a normal diet is wrong, and these kids do not know what is normal. It is an educational problem for them.

Mr COULTON—Sophie Heathcote is with us. Everyone knows that nurses are the backbone of medical practices. They carry the doctors and everyone else. As we are dealing with issues in remote areas I wondered whether she had anything to add.

Mrs Heathcote—Yes. I was interested to hear the contribution of Walgett AMS. Referring to events such as rugby league, if you go to the rugby league on Saturday morning you will often see milk being poured out of baby bottles and being replaced with coke. They were talking about starting at preschool which is fabulous, but most of our flavours are developed prior to the age of two. If your baby is fed on hot chips and fizzy drinks from the breast or the bottle that taste will continue for the rest of his or her life. Nurses in remote areas need to work to prevent this. That is occurring but the reverse is happening at rugby league games in Dubbo. It is sad to see children aged eight having their teeth removed. You cannot eat an apple if do not have any teeth. What would you live on?

Ms Lawler—It is all part of the sociology that that is a normal Australian diet. Boys play football, girls watch and you are all obese and dead by 35.

ACTING CHAIR—You made a really good point, Louise. Can we get a copy of what constitutes a healthy school canteen?

Ms Lawler—I imagine that the Department of Education would have that.

Mrs Heathcote—I cannot think of the name, but a group scrutinises what you have in your canteen. I cannot think of its name, but I know that there is such a group.

ACTING CHAIR—Could you find out?

Ms Lawler—A lot of these canteens are private operations. If you put in apples instead of sausage rolls the apples will not get eaten, the tuckshop will go broke and it will close down.

ACTING CHAIR—That is something that has interested me throughout this inquiry.

Mr COULTON—I wish to enunciate something that has not been said here. A lot of the towns that we talked about do not have fast food restaurants.

Ms Lawler—No, but they have service stations, and that is where the food is. Last week when I was in Bourke the service station there was the greatest fast food outlet I have ever seen. Everything in it was battered, including the chips. That was the only food that you could get.

Mr COULTON—My favourite is deep fried sausages. I promise that I do not eat them.

ACTING CHAIR—Thank you very much for your great submission and your good evidence. It seems as though Louise is extremely dedicated. You all are.

Ms Lawler—I am dedicated because I am on federal funding.

ACTING CHAIR—Thank you for your good presentation. The alliance does fabulous work.

[3.31 pm]

CANT, Mr Greg, Acting Principal, St Pius X Primary School

GABB, Mrs Myra, Teacher, St Pius X Primary School

ACTING CHAIR—Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the Commonwealth parliament. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. Would you like to make an introductory statement before we proceed to questions?

Mr Cant—Firstly, I would like to say thank you for this opportunity to speak. Basically, we have been invited due to a policy that we run at the school entitled, 'Fruit First Monday.' At the start of our recess we encouraged every child to eat a piece of fruit—fresh fruit, not a Rollup or anything processed, and no tinned fruit. That continued successfully for the whole of 2007. On most occasions 95 per cent of our students ate a piece of fresh fruit. In 2008 it was suggested to us by our parents and friends that that should change, with their support, to Monday through to Friday, in other words, every day.

As I said, that has been going now for almost two years, with the parents support. It has been fantastic. A high 90 per cent of people are doing that. We had some teething problems as some students basically refused to eat fruit. Toffee apples, Rollups and processed foods were considered to be a piece of fresh fruit. With the support of parents, communication through newsletters, and parents and friends meetings, that issue was addressed and it continues. Some students bring vegetables to school, for example, carrots, instead of fruit. We also encourage that. As this is fruit and veggie week, we have made a note of that. We heard you talking earlier about canteens. Our canteen is a silver level canteen. I do not know whether that has been assessed in the past few years.

ACTING CHAIR—So there are different levels?

Mr Cant—Yes.

Mrs Gabb—They are accreditation levels.

ACTING CHAIR—It could be a healthy canteen but it might be a low level healthy canteen as opposed to a high level healthy canteen?

Mr Cant—Yes, that is correct. Our canteen is at a relatively high level. If we were to assess it now we would be at the highest level, simply because of what we do not give out. We heard people talk earlier about the size of sausage rolls and things. Basically, we give out only party pies.

ACTING CHAIR—But you do sell pies and sausage rolls?

Mr Cant—We do not sell sausage rolls, we sell only small pies. Obviously we also sell fruit. Sometimes students say that their parents have not had a chance to go shopping, so we sell fruit, obviously at no profit. It is a non-profit canteen. Students can purchase fruit and we have a few novelty things. I do not know what it is called but we place an apple in a slicer, the apple is sliced up like a long worm, and the kids love that. They take an apple to school and they might pay 10¢ extra to get their apple sliced. It does not taste any different but they love it as it is a bit of a novelty.

They can also buy watermelon, which obviously is very popular with the kids. Fruit is available at the canteen. Their parents give them 50¢ and they can purchase fruit instead of bringing their own. In the canteen our fruit juices are size limited as there is a lot of sugar in fruit juice. We encourage them to bring their own drinks from home, mainly water.

ACTING CHAIR—Do you sell water at the canteen?

Mr Cant—We do, and dairy flavoured milk. Because our school is a smaller school, we struggle a lot of the time to get volunteers for our canteen, so we are talking about Wednesday through to Friday, or two days a week. Obviously that is a volunteer-based thing. We have a canteen manager but she is paid only eight hours a week, so it is more of a love job than anything else as she spends a lot more than eight hours a day, let alone the two days. It is volunteer work and we have support from the parents both there and in supplying the food.

Mr COULTON—What number of students do you have at the school?

Mr Cant—Slightly over 200—204 to be exact.

Mr COULTON—Would they be from a good cross-section of Dubbo society?

Mr Cant—I would say so. We are in the west. In the past there was some stigma associated with west Dubbo. But that no longer applies to areas of west Dubbo now—round the golf course and in other areas. I would say that we still have a good cross-section.

ACTING CHAIR—Do you have a high Indigenous population at the school?

Mr Cant—We do not. We are looking at only 20 per cent.

Mrs Gabb—But of the Catholic schools in Dubbo we are the highest.

Mr Cant—Yes.

Mr COULTON—After introducing this program have you noticed kids bringing more fruit on other days without being prompted?

Mr Cant—We run the program for five days but we also encourage it at recess. That is when it is compulsory. When we say it is compulsory we cannot say, ‘You are under detention for not bringing fruit.’ We still rely on the parents’ support, but they have been fantastic. Students might eat fruit at recess as well as lunch. Our school seems to be at the end of the bus line as a lot of schools have relocated now to east Dubbo, so the kids have afternoon tea while they are waiting

for the bus. In the afternoon we notice apple cores and other things that are left in the bus area. So the kids are having three serves of fruit a day, which is great from their point of view.

Mrs Gabb—When we first talked about introducing this program staff members argued amongst themselves and said that we could not make it policy; that we could not force the parents to send along certain foods. So we made it an unofficial policy. We found that we were supporting the parents. Parents are getting up in the morning and they are trying to put their kids' lunches together. From anecdotal feedback that we have received we have been told that the children say, 'We do not want any fruit', and the parents send along anything. Once we said that the kids had to have the fruit we were supporting the families. Parents now say, 'The teacher said that you have to have it, we say that you have to have it, so it is coming along.' That was the biggest change of mindset. We were supporting parents and they were supporting us.

Mr Cant—I think I mentioned earlier the change from one day to five days. That was not our initiative—that was the initiative of the parents and friends. They brought it up at a meeting and said, 'Why do you not do it for five days? If you guys do it we will do it.' We said, 'You are the ones who are packing the lunchboxes. We will go along with it.' It has gone from there and it is now second nature.

ACTING CHAIR—Do you support it with morning PE?

Mr Cant—Every day we do a morning PE program for 10 to 15 minutes and the kids get up a bit of sweat before class. We have found that our kids are active anyway. Today one of the kids apparently brought a can of Red Bull to school. He was asked to get out his lunchbox so that the teacher could check. I have noticed other classes doing this as well. The teacher checked to ensure that this Red Bull was there and she also did a fruit check. It is hard for duty teachers to check on 204 students to ensure that they are eating their fruit, so sometimes we check their lunchboxes in class. We say that we are looking for something else, but we are checking to see whether or not they have any fruit. We use other means.

Mr COULTON—This is probably a hard question to answer but I am interested in kid's behaviour as a result of food additives. Have you noticed different or moderated behaviour since they have been eating more fruit?

Mr Cant—That is a hard question to answer.

Mr COULTON—It is a bit out there.

Mr Cant—We are very lucky. Over the past few years we have not had many problems with major discipline issues.

We have not had many problems in the last few years with major discipline issues. In saying that, other schools might stand out where there are major discipline issues. But it has not fed out to us at all. I had one parent today come to me and say that they are getting such and such assessed for ADHD. I know that this child very rarely brings fruit. I have also found out that he will have a Vegemite sandwich for lunch and dinner. I have spoken to his mother about that on a number of occasions. Looking at his diet and his behaviour, maybe there is something there individually.

Ms RISHWORTH—This might be not be such a big issue, but we have heard about the expense of fruit and vegies, especially in rural and regional areas. Has the price of fruit and vegies for kids to bring along to school been an issue for parents?

Mr Cant—It has not been raised with me.

Mrs Gabb—I have not heard any parents mention it. Our biggest concern is just walking around when you are on duty and they have their lunchbox lids off. You look in there and see all the little packets. I think they are quite expensive. Families have probably realised that packaged foods—muesli bars and all the other little intricate things you can buy to fill up a lunchbox—are expensive. I think they realise that fruit really is not that expensive at all compared with all this convenience food that is in these mini packages. They are paying a fortune for the packaging. They have realised that and it has probably been an education on their part as well.

Ms RISHWORTH—Have you backed it up with any specific healthy eating programs within the school? We have seen different programs at different schools. Has there been anything else? You mentioned the PE program, but has there been anything else?

Mrs Gabb—It is part of our PDHPE program anyway. It is the standard syllabus approach. But we constantly reinforce it and praise the children for eating it. We say, "That is fantastic. You are eating fruit and getting healthy." We just sort of keep that rolling. It is just the syllabus anyway, and we teach from the syllabus the same as the state schools.

Mr Cant—I have noticed that supermarkets have apples cut up in little plastic bags. I would like to question the parents about why they bother, because I am sure it costs more. They do not have to worry about the plastic. There it is, the kids just eat it as it is and throw away the core. I do not know why they need to do that.

Mrs Gabb—Teaching them just to eat fruit for the sake of eating a piece of fruit was a little bit of an education process in itself. They would say, "Why can't we bring tinned fruit?" It is just a piece of fruit. It is such a convenient thing. If you are travelling you can walk into a shop and buy a banana, an apple or a mandarin. A punnet of strawberries is such healthy food and an easy thing to buy. It is just a matter of re-educating people, I think.

Ms RISHWORTH—We heard from a previous witness today that they have been on a pretty big re-education process of getting people to connect with fruit—the feel of it, the smell of it and the taste of it. That is a big part of their program. Your program is partly about that as well.

Mr Cant—We have been to Canberra. I met Mark there earlier this year. We do a program through the Electoral Commission. We do a mock vote about our favourite piece of fruit. You would be surprised what their favourite fruit is.

Ms RISHWORTH—And they debate the pros and cons of it.

Mr Cant—They are great. They obviously go through the whole voting thing. There are five pieces of fruit to choose from: strawberries, bananas or whatever. But apples always come out at the top. I would not be going anywhere near apples. But they are so convenient. All those things are so convenient, including the apple. It is probably the most common piece of fruit.

Ms RISHWORTH—Thank you; that was great.

ACTING CHAIR—That is great. It sounds like a really good program.

Mr Cant—Thank you very much. It is so simple.

ACTING CHAIR—It is interesting from the committee's perspective. As we have travelled around, in each place we find a program that seems to be really working well and something that could be put out there as a model for other schools and communities. Your program seems to fit into that category. Thank you.

Mr Cant—The support of the parents is the end. That is basic. If you do not get the support of the parents, it is not worth it.

ACTING CHAIR—So you involve the school and the parents and you end up having the successful outcome that you have had.

Mr Cant—Yes. Thank you very much.

Mr COULTON—Thank you. I look forward to going out there. I will make it for recess.

[3.47 pm]

MENDIS, Dr Kumara, Senior Lecturer, School of Rural Health, University of Sydney

ACTING CHAIR—Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the commonwealth parliament. Giving false or misleading evidence is a serious matter and will be regarded as a contempt of parliament. That ends the formal statement I need to make. If you would like to give a brief introductory statement before we proceed to questions, the committee would greatly appreciate that.

Dr Mendis—The front page of this morning's Daily Liberal newspaper states that McDonalds is going to open up another outlet in west Dubbo. Underneath it states the federal government is having an inquiry into obesity.

We were just about to publish a paper about a unique study we did in Dubbo towards the end of 2006. I want to present the findings. The study was designed to see how young adult males from 17 to 25 years of age would be tempted to change their behaviour by using mobile phone SMS messages. We have just completed phase one of the study. We gathered a lot of data about this unique cohort of people who do not come to the doctor very often. In fact, they are the lowest Medicare service attractors. It is a very dangerous group as far as health care risks go.

I am from Sri Lanka and I have been Australia for the last three years attached to the University of Sydney. It was hard for me to believe that rural people are more obese than metropolitan people. I just could not believe it. That is why we started this study.

Males are more obese than females. I could not believe that either. As a result, we wanted to get the social demographics of this cohort group as well as whether they were agreeable to this kind of study. In November, after getting a clearance from the university and advertising the study, we went to the two Dubbo shopping malls. We wanted to involve 17 to 25-year-old men or YAMS—young adult males. We said if you are 17 to 25, if you have a mobile phone and if your postcode is 2830—the Dubbo postcode—come to one of the two malls and we will give you $10 worth of mobile phone credits. You will have to fill in a questionnaire and be measured. That is all. The school approved the staff being in the mall for three weekends. We collected 145 questionnaires—about 7 per cent of this cohort in the Dubbo area.

The main thing I want to present to the committee is the latest figure that we have from the New South Wales Chief Medical Officer's report. The state has only 31 per cent of men in this category are obese or overweight. That information was gathered from telephone interviews. No-one has directly measured the 17 to 25 year olds in Australia. The AusDiab study, which is a world famous study, researched 25 onwards. We were the first ones to measure the 17 to 25 year olds and we got 39 per cent.

It could be argued that YAMS coming into malls are not representative of Dubbo 17 to 25-year-old males. But we think it is an under-representation. The really big ones do not come to malls. We had several people refusing—the really huge kids. They feel shy or too embarrassed to

give their measurements. We think the 39 per cent figure is an under-representation. The BMI figure, or the body mass index, was 39 per cent. According to the waist measurement, 24.1 per cent are at increased risk of metabolic complications. That is not a very good trend in rural areas.

I also practice in Narromine one day of the week as a GP. I am attached full time to the university as a senior lecturer. As the previous witnesses said, we just do not have the time. It is sometimes under 10 minutes a consultation and we do not have time for preventive medicine.

This age group does not come to a doctor or a hospital until they injure themselves, so we have to think of other measures. One of the best messaging systems is SMS on mobile phones. Everyone in this age group has a mobile phone. Australia is saturated with mobile phones. There was almost 97 per cent saturation last year. On average, YAMS receive 17 SMS messages each day. Unless you think like they think and get through to them, they will not come to the doctor. We have to get our messages to them by their methods.

We want to continue this SMS communication because they do not like face-to-face consultations. That is part of the problem; they will not come to the doctor. This may be a way of controlling their behaviour in the long term. This is not like drugs for obesity, which stop acting after two years. This would be a very good way to control their eating and exercise habits. In that way we will reduce obesity, which is a huge problem.

Recently researchers have said that the age of men with obesity has been decreasing. It is now at the 25 to 30 age group, and in five years it will be the 17 to 25 age group. It is the lowest group now, but it will be the highest in a few years. They are becoming more obese very early in life, especially young males. We will just focus our attention on them, because females get a lot of attention. They go to the doctor because they want the pill or for any other thing. These people just do not go. They end up in hospital when they are injured. We think this is another way of looking at the problem and proposing a solution.

ACTING CHAIR—This is fascinating research. Has any research been done into the use of mobile phones to collect this data outside this area? If anything has been done in the metropolitan area, have the two groups been compared?

Dr Mendis—Are you referring to the obesity problem?

ACTING CHAIR—Yes.

Dr Mendis—Not in obesity. In Australia we have quite a few studies. Reach Out is one of the best known studies. It is a nice study along these lines. They are helping mental health people, who, once again, do not like to go to the doctor. The NHS in the UK has opened up a huge section where anyone can just SMS or make a call to obtain health advice. They do not even have to come to the doctor. My daughter always texts me, even if I call her. It is the age. They will text only; they will not return calls. You have to speak to them on their own wavelength.

ACTING CHAIR—Once you get results from the survey, what is the next step to address obesity in the group that has been identified?

Dr Mendis—We had a problem that we did not foresee. This was just the start of community based research at the School of Rural Health. The school is about five years old now. I was really interested in community research—not only theoretical research papers. We have to go into the community. Then we had to ask for funding, because the second stage needed funding. We did not manage to get the funding. We had to apply in December for funding in January 2007. We have now analysed the data and we are hoping to apply for some grants based on that information.

We will be dividing this group into two. One group will be left alone without any SMS messages and the other group will have SMS support and advice. At three months, six months and one year we will weigh them and see whether there is any change.

ACTING CHAIR—If you produce a paper on this, can you send it to the secretariat? That would be greatly appreciated.

Dr Mendis—Yes. The Australian and New Zealand Journal of Public Health has just accepted it for publication. It may change a little bit.

ACTING CHAIR—Thank you.

Mr COULTON—Do you envisage people SMSing a doctor and telling him how they are feeling or sorting out a problem? Are you looking along those lines and communicating doctor to patient in that way? Were you indicating that that might be a possibility, or is it just part of the research?

Dr Mendis—It would be a possibility if I had a say. I would welcome that in practice if a patient does not want to see me. I may give a five-minute SMS consultation or a mobile phone consultation. It is better than them not coming at all. There are so many things we can do without seeing a patient face-to-face.

Mr COULTON—When you were interviewing these people, were you asking them about physical activity such as sport? Was sport a variable factor that was having an effect right the way through?

Dr Mendis—We did not see a correlation between those who spent less hours exercising a day and weight. We did not see anything like that. We compared average New South Wales eating and physical activity habits with the Dubbo cohort. In Dubbo, only 45 per cent did some exercise on five or more days per week, whereas in New South Wales the average was 72 per cent. In Dubbo, 24.1 per cent smoked as compared to the state average of 19 per cent. Again, this may not be a representative sample.

Mr COULTON—What about the amount of alcohol that that age group consumes? That age group would consume a large amount of alcohol. What about the relationship between alcohol consumption and being overweight?

Dr Mendis—There was still no correlation. But the Dubbo cohort drink less. In Dubbo, 16 per cent of the cohort drank four or more drinks, whereas the New South Wales figure was 42 per cent.

Mr COULTON—That is amazing.

Dr Mendis—Yes.

Ms RISHWORTH—When you divide the two cohorts, are you going to have issues with some people not being motivated because it is quite random? Is the idea of the SMS to motivate people?

Dr Mendis—Yes. It is to motivate them so that they change their behaviour.

Ms RISHWORTH—What type of SMSs do you think you might send out?

Dr Mendis—That is an area for the psychologists. We have to work with a psychologist in that area and get it exactly right. This is not about doctors addressing patients in a normal consultation. We will lose the whole cohort if we do that. We are hoping to get the young people in this group to advise us how to send the appropriate messages.

Ms RISHWORTH—Are the messages going to be about exercise, eating or a combination?

Dr Mendis—It will be a combination—physical activity, health habits, and smoking especially.

ACTING CHAIR—That is probably it. Thank you very much for appearing before the committee. It is very interesting. Good luck with your research, and keep us in mind. We would be interested in your final results. Thank you.

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

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

Committee adjourned at 4.04 pm