University of
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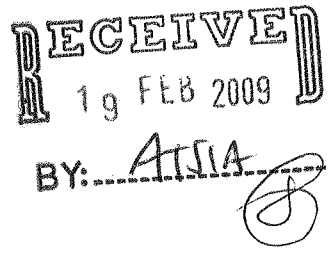
Dr Anna Dacre
Committee Secretary
Standing Committee on Aboriginal and Torres Strait Islander Affairs
Parliament of Australia
House of Representatives



Attn: Susan Cardell, Inquiry Secretary
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Dear Dr Dacre

Re: Inquiry into community stores in remote Indigenous communities

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It is well established that people living in remote Indigenous communities in Australia have poor quality diets, and that this is a major contributor to the early onset and very high prevalence of diet-related conditions and chronic diseases including obesity, diabetes, heart disease and kidney failure.

I have been conducting research into nutrition-related chronic diseases in Indigenous Australians for the past 30 years. My earliest studies conducted in the Kimberley between 1977 and 1982 demonstrated the very powerful therapeutic benefit of temporary reversion to the traditional hunter-gatherer lifestyle. In only six weeks of 'living off the land', middle aged people with diabetes and heart disease showed striking improvements in all of the metabolic abnormalities of diabetes, and a marked reduction in the major risk factors for cardiovascular disease. This was a clear demonstration of the rapid impact that diet and lifestyle can have on health. What we are witnessing in many remote communities today is the reverse of that study: the strikingly adverse impact of poor diet and lifestyle on health indicators. And little seems to have changed over the past 30 years.

In the meantime we have looked at the food supply in a number of remote communities and identified consistent patterns: very high intakes of refined carbohydrates, processed foods, fatty meats and very low intakes of fresh vegetables, fruits and lean meats. These patterns have changed little over more than 20 years of measurement. However, in the 1980's and 1990's we demonstrated that the quality of the food supply in community stores could be improved – and this translated into reduction in risk markers for heart disease in people in the community. However, good as those these changes were, they did not reach the levels recommended for good health.

What is needed to achieve a good quality food supply in remote communities?

Dr Julie Brimblecombe, Menzies School of Health Research in Darwin, recently completed a PhD under my supervision which included an examination of the many factors which contribute to poor quality diets in these remote communities. One of her most important findings is that, consistent with low income people in developed countries world-wide, people in remote Indigenous communities maximize energy (calories) per $. In our food system, highly processed, energy-dense foods rich in refined carbohydrate and fat (and often salt) and low in fibre **cost much less per calorie** than the healthy, nutrient-rich foods we promote such as fresh fruit, vegetables, lean meat and fish. When budgets are constrained, quality is compromised before quantity as consumers maximize calories. This has been described in the international literature as "the economics of food choice".

A very commonly held view is that poor quality diets in remote communities are due to conservative food preferences developed in earlier times of rations ("flour, sugar, tea"). We have observed consistently, over many years and in communities all over remote Australia, that Indigenous people in these communities love high quality food: particularly fresh fruit, lean meat and fish. They are keen to taste new dishes. The challenge is to develop mechanisms which facilitate healthy eating.

Below I summarise the types of programs/interventions which could be implemented;

1. Income subsidies to be spent on healthy food. This type of program has been implemented in the US in the WIC program (Women, Infants and Children) where vouchers can only be used to redeem specific food items. It has been shown to be very cost-effective in terms of less use of the health care system.
    a. The reality is that most people in remote communities are on low incomes, mostly dependant on welfare payments
2. Freight subsidies so that fresh foods could be priced at capital city levels.
    a. It is very important that quality is not compromised: canned fruit and vegetables are not nutritionally comparable to fresh (despite some out-dated nutrition rhetoric)
    b. Frozen fruit and vegetables: it cannot be assumed that people have a functioning refrigerator
3. Improved in-store equipment and infrastructure: refrigerated display cabinets (for fruit, vegetables and other healthy foods – **not soft drinks**), adequate cool rooms for storage of perishable items.
    a. I'd ban soft drinks if I could!
    b. Support and incentives for communities making these kinds of decisions (eg banning soft drinks, limiting times when confectionary and fast foods can be sold)
4. Training and continuing education and support for store managers. Store managers have a huge impact on the quality of food in remote stores.
    a. High costs in some stores are due to very inefficient employment and management practices.
    b. Maybe there could be an accreditation system – however, I do recognize the difficulty in attracting high quality people to these positions.
5. Healthy takeaway meals. The reality in many communities is that takeaway food is an important part of the diet for many reasons (no cooking utensils or operating kitchen, for example). Our experience is that when healthy meals are produced they are very popular.
    a. Training for personnel working in the takeaways
    b. Simple recipes for very palatable dishes
    c. Appropriate catering equipment and food storage infrastructure
6. A monitoring and evaluation system – now possible due to electronic data on sales being readily available. Outback Stores is currently trialing a monitoring tool developed by the Remote Indigenous Stores and Takeaways project (RIST)
    a. Stores that achieve good outcomes gain a tangible reward (probably financial)
    b. Stores that are under performing should have real incentive to improve.

Remote Indigenous communities have one really major advantage over poor communities in urban settings: they have the potential to control what is sold in their stores. They should be empowered to do so. Currently healthy initiatives such as banning soft drinks can be blocked by their major suppliers.

Key references

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I would be very happy to elaborate on any of the points made in this submission.

Yours sincerely

Professor Kerin O'Dea AO