C O R R E C T E D V E R S I O N

STANDING COMMITTEE ON ENVIRONMENT AND PLANNING

REFERENCES COMMITTEE

Inquiry into environmental design and public health

Melbourne — 4 August 2011

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Dr M. Beavis.

The CHAIR — Thank you for coming today and also for providing a submission. I need to go through some basic technicalities with you. The first is to do with parliamentary privilege. You are probably aware that you are covered by parliamentary privilege. However, if you make comments outside of this hearing, you may not be. This hearing is also being recorded. You will receive a copy of the transcript in the next week or so, and you will be able to verify that as an accurate record. We envisage that you will be able to present for, say, 5 to 10 minutes, and then we would like the opportunity to ask a range of questions and to test out a number of propositions. To begin with, for the record could you introduce yourself by stating your name, an organisation that you may or may not be representing and your address.

Dr BEAVIS — My name is Margaret Beavis. I am here on behalf of myself. My background is that I am a doctor working in general practice. I am a senior examiner with the Royal Australian College of General Practitioners. I teach medical students at the University of Melbourne. I am currently doing a masters of public health, and my area of interest is population health and urban planning, which is why I put the submission in.

I thought I would start with a story rather than with a whole lot of statistics. I want to tell you about this new pill that has come along. It is a terrific pill. It reduces heart attacks and strokes.

Mrs PEULICH — Is it called nature?

Dr BEAVIS — I wish! It prevents obesity and being overweight. It prevents and treats diabetes. It reduces cancers of the bowel, breast and uterus.

Mr ONDARCHIE — Could you write me a script for that?

Dr BEAVIS — I can, easily. There is more. It treats blood pressure and high cholesterol and prevents kidney disease.

Mrs PEULICH — Is it called exercise?

Mr ONDARCHIE — You have ruined the punchline!

Dr BEAVIS — It is called exercise. It improves mood and job satisfaction. It reduces absenteeism. It is interesting that there is a huge body of evidence saying that it is just as good as taking an antidepressant. It reduces the risk of premature death by 25 per cent. Why is the entire population not taking this pill? VicHealth put out some data saying that 70 per cent of Australians are inactive, so only 30 per cent of people are actually getting their half an hour five times a week. There you are, Craig: your prescription is half an hour five times a week.

Mr ONDARCHIE — Terrific. Is it funded by the federal government?

Dr BEAVIS — No, actually this has to be funded by you, but that is another story. Urban planning makes a huge difference. In terms of thinking about prevention, prevention is something that is a long-term picture. It is the most efficient and the cheapest way to improve health outcomes. A really good example is tobacco. For every $1 we have spent since 1971 we have got $50 back, but it has taken 40 years for us to work that out. Tobacco is also a good example because it is multisectoral. It is not just your doctor sitting there saying, 'Stop smoking'; it is not just an ad on the telly saying, 'Stop smoking'; it is people saying, 'You can't smoke at work, you can't smoke in the restaurant and you can't smoke in the car with your kids'. That is why it has worked. We know that multisectoral interventions work much better than any single intervention.

There is a government and community approach because of environmental change, and recognition is needed that the benefits will be slow. We will probably all be dead by the time — —

Mr ONDARCHIE — Thanks!

Dr BEAVIS — I am serious. You are looking at 20-year time lines.

Ms PENNICUIK — It is because you did not take the pill.

Dr BEAVIS — Where is your 30 minutes? Moving on from there, I thought it would be interesting financially to do a little bit of a comparison, because prevention, particularly in building infrastructure, is not

necessarily cheap. Just for comparison — and as I said, I am a GP, so I have chosen my own particular bugbear — there are three statin drugs that are in the top 10 drugs prescribed nationally. Every year these drugs cost us $1.1 billion nationally. For a point of comparison, the Victorian health budget is $13 billion, so this is a huge amount of money. That is just the drug costs; it does not include GP or specialist visits, it does not include hospitalisation and it does not include medications for other conditions or the general misery that the illness around this conveys.

Having given you my little spiel, I will move on very briefly to the terms of reference and just quickly run through my two bobs' worth on them. The first one is: where is the evidence about the environmental contribution to health and wellbeing? Public transport is really crucial to increasing exercise at a population level, and there have been a number of good studies around this. In Brisbane in 2004 they surveyed 11 000 respondents, and those who were using public transport averaged 28 minutes of daily exercise. Incidentally they are getting all of those health benefits. Recently in Melbourne — it came out early last year — they surveyed 42 800 respondents. That was really impressive in that public transport users averaged 41 minutes a day, whereas car drivers only got 8 minutes a day.

This slide shows a map that came out. The current densities are too low. If you look at the train lines, which are the black lines, and you look at the densities, you can see the inner suburbs where there are lots of destinations, there is lots of transport and people are getting exercise. When you look at the outer suburbs where things are much more spread out, there are fewer destinations and suburbs are less walkable, the health issues are there.

The next term of reference is about opportunities. The first opportunity that is facing you is increasing density. New developments need at least 30 dwellings per hectare. Mixed land use is important to give people destinations to walk to: walkable design features. I expect other people — urban planners — will have talked to you about grid layout. A grid layout is really important. All these dead-end streets make it very hard to walk from point A to point B. Footpaths and cycle paths are important and, ideally, speed limits in side streets. Little residential streets should be 30 kilometres an hour, which makes them much more pedestrian friendly and much more cycle friendly, particularly for kids riding to school and things like that.

The other issue is public transport. What tends to happen is that a suburb gets built, and then people buy their cars and get into their habits. They add a bit of public transport, and then it is not viable — surprise, surprise! Public transport needs to be at least known from the outset.

The second opportunity is increased destinations: what urban features are associated with increased transport-related walking, because that is what we are really after? We are really after incidental exercise that people will do just to do stuff instead of having to think of it as going to the gym. There is a very nice study that was done in Sydney where they analysed what features were useful. Within 400 metres people will walk more if they have got a bus stop, a milk bar, a newsagent or a postbox. They will walk 1500 metres for schools, train stations and shopping centres. This was additive: for every feature that was added — a 400-metre feature added 12 minutes a fortnight; a 1500-metre feature added 11 minutes a fortnight.

The third opportunity is increased public transport. It is terrific that there is a public transport authority, but it really needs to be up there with VicRoads in terms of really good long-term planning. VicRoads has done a terrific job. There are 2000 engineers. They build roads; we have terrific roads. But public transport has suffered from not having a good strategic viewpoint. It needs capacity building, and it needs good funding. The third opportunity is encouraging inner and middle suburban brownfield and transport node developments where there is existing infrastructure and mixed use. I do not know the costs of this — I am not an urban planner, as I said — but it seems to me that if the stuff is already there, you save an awful lot of money.

The second-last slide shows recommendations. I think public health really needs to be a major objective of the new environment and planning act. It is really important that it is integrated, both into the planning and into the planning tools, and that those planning tools at state and local level integrate with each other so that when you have got local planners facing a development they are not then undermined by the state having different planning rules. It is also important that people start to understand that health is why you want this increased density. It does not need high-rise development; medium-rise and single dwellings are the way to go. We need health impact assessments. The advantage of health impact assessments is that developers will start to design for health. They will realise there are a set of parameters that they need to design within, and they will realise that

this is a priority at government level. It is really important to recognise the adverse effects of urban sprawl on health.

To conclude, I think the health impact of urban planning, low-density, car-dependent suburbs will result in increased illness and increased unrecognised costs to the community. To increase physical activity we need public transport, we need medium-density, we need mixed use and we need active transport design both for walking and cycling. Thank you.

Mr ELSBURY — Thank you very much for that presentation. It was quite enlightening; I enjoyed it quite a bit, except I was a bit miffed that that pill does not actually exist and I am going to have to get out and do some work.

Dr BEAVIS — I wish.

Mr ELSBURY — I want to pick up on one of the points you made in your presentation about the grid layout versus the current cul-de-sac arrangements. Having lived in both environments at different stages of my life, I have found that a grid pattern with the encouragement of flow-through traffic actually inhibits kids from being able to get out into the street to play — to race around on their bikes and such — whereas in the court I live in currently we definitely have much more of a community feel. The kids are always out there, either hitting a ball with a bat or on their bikes or scooters or whatever. Basically anyone who lives in the court understands that you do not do 50 down the court; you do about 20 because the kids are going to be there. Do you not think the emphasis on a flow-through of traffic would also impede that sort of activity amongst children?

Dr BEAVIS — I think that is a good point. I think I am probably trying to get incidental exercise in terms of transport and exercise related. I think that with children playing is a big issue. I suppose that is why the 30 kilometre speed limit in streets would be important, because I would hope that with 30-kilometres-an-hour speed limits kids would be able to play also in the grid streets. I agree with you that cul-de-sacs have that advantage. It is just that when they have done the research looking at cul-de-sacs they have found that they do inhibit walking for transport.

Mr ELSBURY — I do know of areas where two cul-de-sacs have been connected with a footpath, so it is still an incidental.

Dr BEAVIS — That would be a good design; that would be the best of both worlds.

Mr ELSBURY — I have one other question which my colleagues have already heard today but which I will throw at you as well. Are you aware of any studies into the impact of population density on mental health? You mention that we need to increase population density to 30 dwellings per hectare. If we create concrete canyons, we are going to end up with people who are not going to react well to that change in lifestyle, especially as in Australia we all have this idea culturally of the three-bedroom house with a small patch of grass out the back that you have to throw the lawnmower around every so often.

Dr BEAVIS — It is not an area that I can quote studies in. My gut feeling, just briefly, would be that social isolation is a huge factor in mental illness, that car-dependent suburbs have a huge problem with social isolation and that getting people out into the streets tends to mean that there is more interaction with your neighbours, and from first principles I would say that that may be more protective in terms of mental health issues. I am not talking high density, but medium density in fact might be better mental health-wise, but I cannot quote you any studies.

Mrs PEULICH — It does bring people into conflict with one another — and I know because I represent an area where there is a very high level of mental health issues and drug and other substance abuse — if they are living too close to one another. I have people who break down in my office. It makes their lives a misery when they have difficult-to-manage neighbours who have mental health issues, personality disorders or psychiatric illness and so on, when they are congregated.

Dr BEAVIS — I think high-density living is difficult. I think people living in high-rise and high density is difficult. In terms of the mental health issues in the outer suburbs, I think if you were doing a comparison of mental health issues in the inner suburbs versus the outer suburbs — which I have no data on — there would be

significant problems with mental health issues from social isolation in the outer suburbs, different sorts of problems. I think there are probably problems in both.

Mr SCHEFFER — Thank you for your presentation. Could we have a copy of it?

Dr BEAVIS — Yes. I did not want to give away the pill story, but I have given it.

Mr SCHEFFER — In your submission you say that the annual direct health-care cost caused by physical inactivity is around $377 million a year nationally. I just want to ask you where you got that from, given that the cost to the community, to Australia, of harmful alcohol consumption is around $8 billion, family violence is around $8 billion and you have there that obesity in Australia is $58 billion and diabetes is unspecified. I understand that that is the whole picture, the $58 billion, but in terms of the quantum $377 million would be under $20 a day per head of 20 million population. That does not seem like a lot.

Dr BEAVIS — That figure came from VicHealth, I think. I have read an awful lot of journal articles and so I am guessing, but that sounds like a VicHealth figure. That is physical inactivity; that is not the diseases that are related to it.

Mr SCHEFFER — So what does it take into account, if it is not diseases that would arise from inactivity?

Dr BEAVIS — That is a good question. I just know that the diseases that are subsequent to physical inactivity are worth a whole lot more. I cannot actually answer that question, but things like heart disease, things like cancers and things like diabetes are all huge financials. That is a good question. I do not know; I am sorry.

Ms PENNICUIK — Take it on notice.

Dr BEAVIS — Yes, I will get back to you.

The CHAIR — First of all, I was very interested in the cholesterol fact. That is an amazing statistic.

Dr BEAVIS — It is a terrifying statistic.

The CHAIR — In some ways you think that the message has to get through to us in our age group before we retire, otherwise we are really not going to have a retirement that we enjoy. My question is to do with the recommendation about the objective in the act. There needs to be something put in there. What in particular would you think is an appropriate objective to put into the act?

Dr BEAVIS — That health needs to be made a priority when planning decisions are made; that the long-term and short-term health impacts need to be taken into account when planning is done.

The CHAIR — Are you saying that you would recommend that the health impact statements or studies be mandatory?

Dr BEAVIS — Yes. There are some very good tools and there are about seven cities. Carolyn Whitzman gave a very good talk at the forum leading into this. I can also send you that tool, if you like. There is a very good questionnaire, which asks: is there public transport — it is basically a checklist of about eight items. I can circulate that to the committee if you would like it. It is a checklist for developers to ask: does this exist, does this exist, does this exist? And they can answer yes or no. If they fill in the right boxes, they do not need to do a health impact assessment because they have fulfilled the criteria already. If they do not fulfil those criteria, then a more detailed analysis needs to be done.

The reason I think that is important is that if the developers understand the framework that they are designing for, they will design it. If they know that they need to have a density of 30 dwellings per hectare, if they know that there needs to be public transport — that is integrating with the state — and if they know that various things need to be available, then they will design them appropriately.

Mr ONDARCHIE — Doctor, thank you for your presentation. I do not know why you are nervous; I am nervous now that I have seen it. I am just wondering what the GP profession can do as a collective to drive home some government changes in the legislation? You are an individual who is self-driven; we thank you for

that today. I am wondering what the general practitioner community can do as a fraternity in terms of driving home the legislation?

Dr BEAVIS — Did you have anything specific in mind?

Mr ONDARCHIE — You talked about making sure that factors around public health are almost mandated in planning and environmental design. Is that something that the GP profession could do?

Dr BEAVIS — I wish. General practice is, unfortunately, very time driven. I am lucky; I spend 15 minutes with each patient. Some patients get 10 minutes, some patients get 6 minutes.

Mr ONDARCHIE — Five-minute consults.

Dr BEAVIS — I am very lucky that where I work I can choose my appointments. Be that as it may, your focus is on the patient and what they come to you with. To start to give them a discussion about the pros and cons of the urban planning world is not appropriate in a general practice setting.

In terms of public health, improving public health literacy would be fantastic — getting the public to understand that better. It is like telling you that 30 minutes per day, five days a week, is something that would do all these things for your health — if we could get the general population to understand that, that would be a wonderful thing. Once they understand that, they can then understand why having a house in the outer suburbs with three or four cars and jumping in the car for everything is not good for you. I cannot remember the exact figure, but I think about 30 per cent of car trips are under 3 kilometres.

Mr ELSBURY — Just from personal experience my wife walks my daughter to kindergarten, and as she is leaving the kindergarten she gets asked if she needs a lift because she is walking. She says, 'This is my exercise. I am going out to walk on purpose; it is not that I need a car'.

Dr BEAVIS — That is right, and it is changing culturally. We have to try to shift that culture back. But at the general practice level I think there is plenty to fill a consultation without doing a little rant about — —

Mr ONDARCHIE — I meant more as a college.

Dr BEAVIS — As a college? I have no endorsement from the college, but I would be very surprised if the college did not endorse what I was saying. I am sure they could make statements and things like that, but in terms of how effective that would be at a population level I am not sure that many people would be paying much attention.

Mr ELSBURY — Do not worry about the college. You have parliamentary privilege at the moment, so it is all relative.

Mrs PEULICH — I went back to work when my son was 6 weeks old. I was driving between different destinations, picking up my child from child care, dropping him off, doing the shopping and so on. This is a great concept. I think that in terms of the numbers in the general population you can obviously make improvements, but when it comes to those types of demographics — the working mothers, the working families and those who do not have a job that starts at a particular time and ends at a particular time at a single destination — how can all of what you say apply to them?

Dr BEAVIS — It does not. You need a car. To do that, you have to have a car. This is not about saying that people should not have cars; this is about making healthy choices easier. It is about saying, 'Okay, there is a choice'. Your husband might have been able to walk to the station and catch a train if there was a good train station in walking distance. This is about reducing the 70 per cent down to 65 per cent and then hopefully down to 60 per cent, but there are certain situations where a car, especially in Melbourne, is what you need. In relation to those households that need to run three cars — for instance, those in the outer suburbs — the RACV said that the Commodore, which I think is the most popular car, costs about $12 000 a year to run. If you put that on your mortgage, it means that those houses are no longer affordable. The cost of running those extra vehicles is huge so that if you can cut one car out of the household, then those households will be healthier, they can move closer to the city — —

Mrs PEULICH — It is much more expensive for them to drive a motor car, absolutely.

Dr BEAVIS — Yes. But if you are a mother in that situation, you have to have a car.

Mrs PEULICH — Can you think of anything that can be done in terms of our terms of reference for those particular groups of people — that demographic — to improve their health and wellbeing?

Dr BEAVIS — In terms of urban planning? More open parkland so kids can play. And I really like the idea of cul-de-sacs joined at the end. That is a terrific compromise; that is very nice. Not that I am an urban planner, but that appeals to me.

The CHAIR — Is there anything else you want to say to us at this point in time?

Dr BEAVIS — No, I would just like to thank you. I am delighted that you are having this conversation. I think it is a big step forward. Well done on thinking about this as an issue.

Mrs PEULICH — You are not a Beach Road cyclist by any chance?

Dr BEAVIS — I actually ride not on Beach Road but on the beach cycle path. It was interesting to hear you talk about it, because most of the really fast cyclists do go on the road rather than on the cycle path. I use the cycle path as a commuter, and it is a terrific facility that I really enjoy and get an enormous level of satisfaction from. Just a little medical aside, there is good evidence and there are good studies that say that bike helmets work and you would be crazy to get rid of them.

The CHAIR — Thank you, Margaret. All the best.

Witness withdrew.