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

STANDING COMMITTEE ON ENVIRONMENT AND PLANNING

REFERENCES COMMITTEE

Subcommittee

Inquiry into environmental design and public health

Melbourne — 7 September 2011

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Professor E. de Leeuw.

The CHAIR — Thank you for making the time to be with us this morning. There are a couple of formalities that I need to raise with you. This hearing is covered by parliamentary privilege, so you are covered by parliamentary privilege in terms of any comments that you make this morning, but of course once you have left here those comments are not covered by parliamentary privilege. You will receive a transcript of your contribution in about a week's time. If there are any issues you want to raise, could you please do so with Keir Delaney, the committee secretary.

I ask you to state your name, the organisation that you represent and your address. Once you have done that, could you commence your presentation and allow sufficient time for us to have genuine interaction with you on the issues that you put before us.

Overheads shown.

Prof. de LEEUW — My name is Evelyne de Leeuw. I am a professor of community health systems and policy at Deakin University. I have made two submissions to this committee. One is on behalf of the university and the other is on behalf of myself in my capacity as a longstanding member of the evaluation group of the Healthy Cities program with the World Health Organisation in Europe. Deakin University cannot take responsibility for the views that I have from that history and perspective. That is why I have made two submissions. My presentation will mix it up of course. You cannot really separate those views if you are speaking as one person.

I would like to talk about environments for, with and in health. You know about the environments for health framework from municipal public health planning, but there is much more than environments for health. There are also environments in health and environments with health. I hope my presentation will enlighten you a little bit; otherwise you will have an opportunity to ask the questions you need to ask.

I have a couple of messages. First of all it is clear that the environment impacts on the social, physical and mental health of people in very profound ways. Those impacts are not simple. It is not that you can say that living in a high-rise building will have these consequences. Some people love living in high-rise buildings and thrive there. Others do not. There is a lot of complexity in those things, but those things are very profound. In this session we do not really want to doubt the evidence per se that the environment impacts on health. As I say here, we do not want more problems. The epidemiology is out there. We want more solutions. That is exactly what my research has been over the years. I research health policy, which aims to look for solutions to problems and evaluate solutions.

I have been in Victoria for seven years now and in that time I have been doing research here, particularly around the environments for health framework and municipal public health planning. Looking at Victoria, we seem to meet those parameters to manage the problem really well. There is the municipal public health planning legislation. There is the Environments for Health program. There are a lot of agencies that are involved in this area, not just groups like VicUrban and government agencies, but also think tanks. There is the Victoria Eco-Innovation Lab in the city, but Monash University, Deakin University and La Trobe University all look at urbanisation and health in some way or another, and environments and health more particularly. So I am sure I am not the only one giving you these messages.

We could manage these really well and be the shining light for the world, but parts of Victoria seem to fail in doing this well. Again, there is varied ability across the state. You see in parts of Melbourne that the management of environments and health issues is done really well. On the other hand if you look at Norlane in Corio, Geelong, for instance, which is where I live, in spite of massive investment over the years it does not seem to manage this really well. There are all sorts of issues that drive that problem and the failure to actually do something about it.

Let me quickly look at the evidence and solutions that have been provided, which is the Healthy Cities project. Healthy Cities has been my, you could call it, pet project since 1986. I have been involved since the very start. In 1986 Trevor Hancock and Leonard Duhl for the World Health Organisation wrote up what a healthy city should strive to provide to its people. I brought in a copy of their book *Promoting Health in the Urban Context*. Interestingly over the years what we have realised is that these parameters, these 11 qualities of a healthy city, are not unique to big, large mega cities and urban environments. They are equally valid for smaller towns. In my submission I mentioned the smallest healthy city in the world which has a couple hundred of people — the

island of geese, or Isle-aux-Grues, in Quebec. They thrive as much pursuing these qualities as Shanghai, for instance, which is also a healthy city. Size does not really matter.

If you look at environments in terms of health and creating a better place to live for people, these are the 11 qualities a city should pursue. They have not come up as a fantasy of Hancock and Duhl. This is the result of a very solid systematic review of the evidence. There are tens of thousands of cities around the world that do these things.

Just to give an impression, Hong Kong in fact has joined this network that wants to pursue these 11 qualities. There is an interesting group in WHO — a collaborating centre in Kobe, Japan, that has an assessment tool called the Urban HEART measure; I am happy to share it with you. It gives all sorts of tools and parameters to actually look at environments for health, including social, physical and mental parameters. In very much the same way as here in Victoria we do environments for health. It is called public health planning. In that sense we are very much connected to the rest of the world.

One of the things I would like to talk about, because I think it is the biggest challenge maybe for Victoria, is urban sprawl. Although there are issues around environments for health in rural and regional situations in Victoria — I am associated with the National Centre for Farmer Health, and we look at regionality and rurality — I thought we should focus on urban sprawl. There is a book, if you are really interested and want to have an intellectual challenge, called *Urban Sprawl and Public Health — Designing, Planning and Building for Sustainable Community Living*. It has all the evidence on different parameters that say cities are very good for your health, but cities can also be very bad for your health.

When you look at urbanisation there are all sorts of push and pull factors — that is, why people want to come into the city and why people are pushed to the edges of cities into suburbia. It is good for people to come to cities because you have access to services, work and education. It grows social capital. People think they can find partners more easily in cities. There are all sorts of reasons people want to move into cities. But then the downside, or the doubt where urbanisation may be an issue, is transportation — getting through cities and getting into cities.

In terms of food security, we know that there are neighbourhoods, even here in Melbourne, where people have a hard time getting access to nutritious foods. My students last year looked at different neighbourhoods in Geelong. They did an account of fast food outlets in Belmont and Highton, which are upmarket neighbourhoods of Geelong — there are no fast food outlets there. Whereas in Norlane in Corio, which is in the lower end of the socioeconomic spectrum, there are seven fast food outlets. That means something. I am not necessarily saying fast food outlets provide bad food; it is people's choice. But the evidence shows, for instance, that community gardening — community gardens and community kitchens — create more health for people than fast food outlets. People have a hard time making those choices. That is maybe the point that I am going to make here.

Not good in urbanisation in Victoria and Australia in general are issues around walkability, which has its impact on obesity. Air, water, security, safety, access to water; issues of safety — people believe that in urban sprawl environments it is less secure to walk around, to move about. People tend to take their cars because they think it is insecure or unsafe to get out onto the street, which is exacerbated of course by media coverage of hooning in residential neighbourhoods, people driving their cars too fast, garbage and waste piling up and being dumped in illegal places because it is not being removed by councils. Often issues around perceptions of unsafety are boosted by media coverage of selected issues. There are — and I am sure you have heard about that — mental health issues in urban environments.

In the area of climate change and climate change adaptation and mitigation, in urban environments we see heat islands that create preventable deaths now on very hot summer days, and that is really an issue. My colleague Mardie Townsend at Deakin has been investigating climate change issues and their impact on health, so I am not going to go into that.

Ultimately though it is interesting. I started with push and pull factors for urbanisation. People want to come to cities because it seems to be good, and then it is not so good. There is a tension between individual want and need and population benefits. People want to work, people want to come to the city because they want the entertainment, they want partners. They may even want bad things like drugs, which you cannot get when you live in Swan Hill perhaps. So individuals have their own things that they want and pursue, but as a collective

they do not think about issues such as climate change, such as mental health, heat islands, public transportation. I think there is a critical role for government to look at these population level issues. There is a role to be taken for government to secure safe environments for health, proper environments for health, environments that are supportive for health. It has to do with governance and how we arrange the system, how we make the rules as a Parliament, as a society, for running our business.

I told you that I looked at the environments for health framework. We did an evaluation, but I also want to talk to Melbourne 2030, which is the strategic vision for the development of Melbourne. As you know, I think that Melbourne 2030 completely failed. It had a vision for the future of Melbourne, and the moment that the series of reports was published it was already outdated. Things went off the rails, literally in some cases, due to all sorts of challenges. Environments for health may fail. The reasons that I see from a political perspective, and there are all sorts of other reasons, but I think for environments for health and municipal public health planning framework, there is insufficient planning legitimacy. People do not feel that these things need to be planned for or feel that they can be planned for only superficially. There is no resource allocation for good planning for environments and health.

There is insufficient leadership in our evaluation of environments for health. We rarely saw true leadership for this sort of issue where environments impact on health. There are very limited planning horizons, and you will recognise that in Parliament you are elected for a certain period and then you cannot really anticipate that you will continue to be here. At the local level it is even worse. Planning horizons are only three years, so a municipal public health plan often becomes accepted by council and then the term of council ends already and then it needs to start to be approved again. That means there are inadequate support systems at the local and state level to do this well.

One of things we found is that the environments for health framework in fact provides or the government or the department of health thought that it would provide guidance for councils on how to do this. One of the things we found was that giving guidance once does not work. You have to keep giving guidance all the time. You have to keep supporting people in doing this. Capacity building really should not be just a one-off, a brochure or a book or something that has been given; it should be continuous.

Accountability — monitoring, keeping track of things and reporting about compliance is not the same as governance. We seem to be making a mistake here that measuring stuff in writing it up is the same as doing proper governance, and I think in the area of environments for health governance systems could be improved. I am not saying that that is only a government or public sector responsibility. That should be, in a civil society, a joint responsibility.

There is a bit of a developer dominance in the compromising issues around Melbourne 2030. Developers just do things without any restraint, without being checked and balanced by public intervention. Maybe all of this really boils down to the resources that we can make available to a dedicated perspective on environments for health. It is not just money; I am just mentioning here also time — the time to do this. In our environments for health evaluation we found that the local officers that are supposed to do municipal public health planning feel that they have very little time to do this and often do it on a Friday afternoon when everything else has been done. They feel that there is insufficient training to do this; there is insufficient support, and in a way it is interesting that local governments say, 'If you want us to do integral whole-of-government health planning, we would look at state government for role modelling, so integral whole-of-government planning should be modelled after what the state does, because if they cannot do it, why should you expect that we should do it?'. Again, that might be an issue of perception. Local governments are asked to do something that is not properly modelled by the state government.

Mr SCHEFFER — I just wanted to start with your observation about Melbourne 2030. I accept the point that you said you thought it was a failure in the end, but was it a conceptual failure or an implementation failure?

Prof. De LEEUW — An implementation failure. This is interesting. Right now my mind is in implementation issues; I want to do more research around implementation. One of the big issues that you see in implementation is that you need to start thinking about implementation before you even start planning the whole exercise. You cannot assume that when you have a policy it will implement itself. It is an implementation

failure, but that can be attributed to conceptual issues and the fact that implementation has not been considered in the conceptual phase.

Mr SCHEFFER — We have talked about this a little bit with other witnesses, and I think it is fair to say that the spread of evidence we have got would suggest that the kind of model, conceptually, that Melbourne 2030 promoted is pretty right.

Prof. De LEEUW — It was excellent. The message and the vision were good.

Mr SCHEFFER — Okay, so having ticked that off we are not dwelling on that. You say there needs to be an integration as we go forward in implementation. What were the sorts of elements that were not done? One that has been mentioned is, for example, transport and that that was not properly integrated into it, and also budgeting factors. Could you just expand on that a bit?

Prof. De LEEUW — I would have thought, in implementation failure, that there was not enough statutory power to govern implementation. I do not think the government adequately stuck with the message consistently. Again, that is an issue. Elections come up and people tend to forget these things so you need to stay on the ball with these things. I do not think the government consistently stayed on the ball and sent the same message. It is a statutory power issue; there is not enough opportunity to control the process through legislation, communication or facility. Sometimes you see that government does not need to do everything by itself. If you set the right parameters for planning and say, 'These greenfields developments are out of order, you can't go there', all of a sudden grasslands that are valuable are turned into greenfield building sites. That is an issue, and government should be more strict in enforcing the things that they set out to do, I think.

These days we do not see the role of government as a very hierarchical, top–down control role. This is about network governance, and you need to recognise that this is a network where all sorts of partners play their role, including the developers. You cannot say that the developers destroy or compromise division. They are part of a network and the network, as a whole, comprises division. In implementation where we failed was in managing that network appropriately.

Mr SCHEFFER — You mentioned the issue of the role of governance and you linked that to effective leadership, and then you talked about planning legitimacy. You have also talked about this election cycle, which can be very disruptive. Those factors are common, I would say, to all the Western democracies. Leaving aside China, which is a different model and other places you mentioned, where, for example, in Europe or North America is that balance best achieved that we could look at? They seem to be imponderables.

Prof. De LEEUW — Yes, there are a number of cases where it is best achieved. At the state level it is best achieved in Quebec, I would think, in Canada. At a country level right now, interestingly, it is very effective in Turkey. There is a large network of Healthy Cities that are very effective in Turkey. That is interesting. I have just recruited a PhD student who is looking into Islamic governance for urban development. You would not think that Turkey, which is a secular state but also an Islamic state, would espouse these values of Western democracy as we would think they should be. Still, it works. One of the largest networks of effective Healthy Cities is in Iran. How and why, we do not know. We are yet to understand how it works.

The commonality of successful Healthy Cities that have a strategic vision and that move beyond that elective cycle is to get the people on board and to not just make it dependent on the formal institutional actors — government, developers and services. I mentioned community gardens. If you have a network of community gardens where communities feel active and engaged with environments for health, it seems to sustain division in the perspective.

Interestingly in Quebec the mobilising concept was not health. I should mention that we had a European meeting of Healthy Cities last June. This is the 25th year that the movement is going, and it is going from strength to strength, which is interesting because you see wave movements — some countries drop out. The Netherlands, where I come from, has completely dropped out of the Healthy Cities movement. They do not feel the need to pursue these things anymore because maybe they have accomplished their mission, but other countries rise and rise.

It was odd that this happened at a World Health Organisation meeting, but it was observed that health in itself is a troublesome concept. When you say 'health' a lot of institutional actors hear 'medicine' or

'health care'. When you talk about 'environments for health' they hear 'department of health'. You hear references such as, 'around the corner from here the department of health needs to do this', whereas health is much more than the things that the department of health controls; it is a whole-of-government issue. When you say 'health' and hear 'medicine', you cannot do the things that environments for health tries to pursue. There was a long discussion about whether you should replace health with another notion such as wellbeing, quality of life or just life. Look at Melbourne: it is the most liveable city in the world. It does not say the most healthy city in the world; it is the most liveable city in the world. In many respects I think that is true — it is a very pleasant city to live in — but of course there are aspects that are not so healthy.

What has moved the people of Quebec to continuously support Healthy Cities as a brand name is not health, but it has been sustainability and environmental issues. That is what got the people on board, and that is what has organised them and kept them moving in a very sustainable way, because they believe that the ecological balance of sustainability and the environment impacts much more on their health, wellbeing and quality of life than does health care or whatever sort of health intervention. The lesson you learn is that you need to try to engage with what mobilises and activates people and communities.

Mr TEE — In some ways, if you look at the evidence we have received and at the terms of reference, it is very much about implementation failure, in the sense that we know we have got an obesity epidemic and that communities that are designed in a healthy way so that there is access to parks and access to public transport within walking distance make a huge difference. Yet we have failed, and that is the implementation failure. Then it is about accepting those two bits and asking how do you deliver implementation success. Partly that is about the evidence, and I am wondering whether places like Turkey, Quebec or the Healthy Cities have been evaluated so that we can see whether some of those lifestyle factors, like the amount of exercise, have turned around in those communities. Is that research out there and accessible, and what does it say?

Prof. De LEEUW — It is good that you mention this. This has been my role over the last 25 years in the European region of the World Health Organisation. The region of which Australia is a part is called WPRO, the Western Pacific Regional Office, and developments have been different here. In Europe we have been working on this generation of evidence for 25 years now. The evidence is out there, and I have been working to coordinate the publication of that evidence. Two years ago we published a special issue of the international peer-reviewed journal *Health Promotion International* where people looked at the evidence and demonstrated that, yes, it works, and they looked at the conditions under which it works and at which things work better than other things. There are some approaches that seem to be critical to the success of healthy cities, healthy environments, healthy communities or whatever you want to call them. One of those things for instance is the creation of strong partnerships, of those networks that I talked about. This is not just within local government and the partners you find there, but more interestingly it is those partnerships that exist between local governments.

A group of Italian researchers did some fascinating research that showed how the more city councils communicate with their colleagues from other city councils, the more they are inspired to do things differently and better. Of course this was European research and the context may be very different in Europe where the Danes travel to Slovenia and get inspired and the Slovenians travel to Bulgaria and get inspired. But the Italian group did show that this was independent of cultural context; contact with others and seeing what others do actually makes a difference.

Another thing is that if guided well — not implemented well — it makes a difference to health and social impact assessments, which are a procedure to look at the health and social impacts of large infrastructural works, for instance, or of policy decisions. These are capable of delivering very strongly contextualised evidence on the impact of such decisions on community health, and this then guides appropriate policy decisions. That is a tool that works really well. Again we are fortunate to be in Australia. Two groups in Australia have significantly contributed to the body of knowledge in health and social impact assessments. There is a group here at Deakin University, but I think the best group in Australia to do health impact assessments is at the University of New South Wales. I know that they are nationally active. They do really good work and provide tools and instruments to generate locally relevant and responsive evidence in very quick ways. There is that special issue of *Health Promotion International*, and this year the *Journal of Urban Health* will publish a whole set of papers. That is an American publication, and I believe it will be out in October. I have a book contract to write up the evidence for Healthy Cities, and that should be out, I hope, in early 2013. That may be a bit late for the committee though. The evidence is there.

The CHAIR — Can I just interrupt? We are really struggling with time, and I am also conscious of the fact that Andrew has two questions, too. If we could shorten the answers, that would be most helpful.

Prof. DE LEEUW — Yes.

Mr TEE — Just focusing on the translation aspect or the implementation aspect, one of the requirements of local councils is that they provide municipal health plans. They do that, and then the plan is put away in a drawer and no-one looks at it. I am wondering, because you talked about local councils and their relationships with each other, whether it would be helpful if those municipal health plans were audited and reviewed so we could have a sense of whether or not they have been implemented, but more importantly or as importantly whether we ought to then have a look at what is best practice so that other councils can learn from those experiences. Is that the sort of initiative that you think might help drive that implementation?

Prof. DE LEEUW — I would instantly agree. You could think of a website with case studies. You could organise site visits. You could organise annual conferences where they meet where it is not the academic stuff that matters but what you feel proud about and what works.

Mr TEE — The other aspect, or the other idea, that has emerged through some of the evidence and witnesses, is around the fact that we have an Urban Renewal Authority Victoria that will be designed to generate the urban renewal and we have a Growth Areas Authority out in the growth areas. A view has been expressed to the committee that they are too dominated by planners and on their decision-making boards there ought to be a broader contribution in terms of skills, particularly focusing on health. Would that help the implementation model that has been missing?

Prof. DE LEEUW — Exactly. Just very quickly, we have a master of planning at Deakin, and we observed exactly that — that planners tend to be spatial planners, the design planners. But the Planning Institute of Australia, PIA, is very active in integral planning, so we are offering a master of planning that is created by three faculties: arts and education, science and technology, and health. It has social design and health planning, and we integrate those things, because that is what Australia, Victoria and the world needs. That is what we think, and PIA agrees with that.

Mr TEE — Thank you. I think they are going to be a witness for us.

Mr ELSBURY — My two questions are quite divergent, but in any case you were saying earlier on that for some people high-rise, high-density living is fantastic — they thrive on it — but for others it creates problems. Do you know of any studies that have shown what the effects of a high-density lifestyle are on people, either mentally or physically?

Prof. DE LEEUW — There are such studies. I am not intimately familiar with them. The problem with epidemiology is that it looks at aggregates and then tries to identify groups within those aggregates. At an aggregate level urban living is healthier than rural living. It does not mean that dense urban living is healthier than general urban living. People who want to live in high-rises feel better in high-rises. People who are put in high-rises and would prefer to live somewhere else are clearly less healthy in those environments.

Mr ELSBURY — The next question is going back to the experience in Turkey with regard to their Healthy Cities. Are we talking about new developments when we talk about their urban sprawl or are we talking more about the ancient cities where people were not able to hop in a chariot and go down the road? It was a little bit more complex than that back then; you had to have a walkable city. Or is it a cultural factor that is carrying over the idea of being able to just walk down the road to be able to get services?

Prof. DE LEEUW — No, it is a great diversity of cities. It is absolutely fascinating, and, as I said, we are only starting to understand what is going on. Some of the cities that are members of the network are very ancient cities: Izmir, Istanbul and Bursa, which is on the other side of the Bosphorus strait. There is a great degree of walkability and closeness in the ancient centres, but they experience urban sprawl as well. And then Ankara, the capital of Turkey, is a healthy city, and that is a relatively new city. It is only a century old. It has a small old core, but it is largely a new city, and they have an opportunity to do proper urban planning, whereas others do not. One of the things we did in Europe which may have inspired the Turkish people is that there is a series of books on healthy urban planning, which is the design aspect of planning. There is a team that did that, and you may want to have a look at this book.

Again, the evidence is there. You know how to do this well. The question is: how do you get from the idea and the evidence to actually doing it? For Melbourne, for instance — and the message in this book is very consistent — it would be much more healthful to do more dense urban planning in the inner city rather than having the urban sprawl out. It would be cost effective. You do not have to put in more public transport and you do not have to build roads if you have more dense or high-density planning in the inner city. It would have all sorts of benefits. The evidence is there. The question is why we do not do that more. I gave some of the reasons why we do not do that.

The CHAIR — Thank you very much. We have gone over time. We truly appreciate your contribution today and also of course your highlighting a number of key resource documents that we will need to consider. Thank you again.

Prof. DE LEEUW — It was a pleasure having this opportunity.

Witness withdrew.