# 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 — 14 September 2011

Members

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| Mr A. Elsbury | Mrs I. Peulich |
| Mrs J. Kronberg | Mr J. Scheffer |
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Deputy Chair: Mrs I. Peulich

Staff

Secretary: Mr K. Delaney

Witnesses

Mr C. Sindall, acting director, prevention and population health,

Dr J. Carnie, chief health officer, and

Mr G. Gillespie, manager, environmental health, Department of Health.

**The CHAIR** — We will go straight into the hearing. I am obliged to say to you that all evidence taken at this hearing is protected under parliamentary privilege, as you would be aware, and is further subject to the provisions of the Legislative Council standing orders, so you are protected against action for what you say here tonight, but if you go outside and repeat the same thing, those comments may not be protected under this privilege. As you are aware Hansard will be reporting tonight's hearing. You will be provided with proof versions of the transcript in the next week or so, and we request that you check those proof versions and then directly liaise with Keir Delaney in terms of resolving any issues.

What we have asked for tonight is a presentation of around about 5 to 10 minutes, and hopefully that will maximise our time so that we can ask questions of you and get a genuine dialogue happening. Perhaps you could just start with formally stating your name, the organisation you represent and the address.

**Mr GILLESPIE** — Graeme Gillespie, the environment health manager at the Department of Health, 50 Lonsdale Street, Melbourne.

**Dr CARNIE** — I am Dr John Carnie, chief health officer in the Department of Health at 50 Lonsdale Street, Melbourne.

**Mr SINDALL** — I am Colin Sindall. I am the acting director of prevention and population health, Department of Health, at 50 Lonsdale Street, Melbourne.

**Dr CARNIE** — Colin will start with the presentation, and then I will continue from there.

**Overheads shown.**

**Mr SINDALL** — I first of all give apologies for Professor Brook, who met with you previously and who was going to attend tonight. He is attending the International Society for Quality in Health Care in Hong Kong on behalf of the department, so he sends his apologies.

Just before I start I will make a couple of preliminary remarks. We have provided some information to the committee, and I hope what has been provided to date has been satisfactory. The department is very happy to continue to provide information, so if there are any issues that we cannot address tonight, we will certainly provide follow-up information for you.

I would like to start off by making some preliminary and background remarks and then just briefly cover the legislative context of the health and wellbeing plan that was recently released and its relevance to the inquiry, spend a little bit of time on municipal public health and wellbeing planning and then hand over to Dr Carnie and Mr Gillespie in relation to some of the health protection and environmental health issues that are also key to the work we do in this area. I would also like to say by way of introduction that we are not tonight going to cover any of the evidence base. We can take questions on that, but we are conscious that you have had some very rich presentations and a lot of detailed evidence, so we are not going to revisit that tonight.

My first slide — and the second slide that follows it — is really just to convey the international momentum we are seeing around the issues that you are dealing with. World Health Day last year very much focused on urban planning, urban design and public health. As you can see the director-general of WHO talked about the benefits of urban living, but also some of the downsides. Of course the WHO is particularly concerned about urbanisation in developing countries and newly developing economies, but there are obviously issues also that are of concern to us. Similarly, the assistant director-general for non-communicable diseases commented on the benefits of taking an approach across some of these key sorts of disciplinary areas.

Similarly in relation to the concerns about ageing societies all around the world and coupled with increasing urbanisation, WHO has also developed an approach to age-friendly cities. So we are seeing that sort of momentum around the world, without going into more detail but just to start off with those points.

We have presented previously some of the issues from our point of view in terms of some of the behavioural risk factors that we see are causing problems now and will be into the future, and we have provided the Victorian population health survey report, which gives you a lot more detail on that. Once again in the interests of time I will not dwell on it. What I would like to briefly comment on is just a little piece of work that we have done to give you some selected municipalities. You have probably seen and we may have previously provided

you with information on the breakdown of particular risk factors and conditions across municipalities. What we have not done previously is to look at that in relationship to how people report about their communities, their environments and their perceptions of whether they live in a pleasant place, whether it has open space, whether it is walkable and so on.

Although this is purely associational data — we are not saying there is a causal relationship — if you look at the pink bars, you can see the extent to which people report that they live in and inhabit a pleasant environment that is nice to be in, nice to walk in and so on, against some of the other factors. You probably will not be able to immediately read the black and the green text, but that is the proportion of people who have not met the physical activity guidelines, PAGL, and have not met the fruit and vegetable guidelines. These municipalities pretty much go from low-socioeconomic status to a higher socioeconomic status, and you can see something of a gradient across a number of those different factors. We just thought we would highlight that.

This has probably been said to you many times, but of course the risk factor trends are leading to concerns about the growth in chronic disease. These are some fairly linear projections based upon Victorian data. I will not dwell on it. The other analyses suggest we are going to see a greater impact even than is depicted here. I just wanted to mention that as we go through, because obviously how these risk factors play out in terms of chronic disease, combined with an ageing population and population growth, all combine to drive up the health budget. I am sure you are well aware of that. This is just to say that although health does not really control the levers of environmental design to the extent that our environment shapes our behaviours, risks and ultimately disease patterns, health deals with the downstream consequences, if you like, and some of the costs are captured there in some of the trends.

In terms of the legislative context, we will talk a little bit about the Public Health and Wellbeing Act 2008. There are a number of other acts that obviously are in our sphere of interest and concern. VicHealth, which has done quite a lot of work in relationship to healthy environments, is funded under the Tobacco Act 1987, an act which we administer, and some of the tobacco regulations obviously play out in terms of some design issues. In the interests of time I will not go through all the detail of the other acts. I am conscious even in talking to this that the Local Government Act also has importance here.

I would like to mention that the Public Health and Wellbeing Act, which we will talk about in a little bit more detail, requires that municipal public health and wellbeing — local government public health and wellbeing — are consistent with municipal strategic statements prepared under the Planning and Environment Act, and in that sense we see some relationship and alignment between the acts.

You may have already seen this figure. The council plan, the municipal public health plan and the municipal strategic statement all form part of the whole-of-council planning activities. In many cases there may be a separate community plan or community planning process, but the relationship between the municipal public health plan and the land use plan is something that is important. I also refer to the fact that under the act councils can apply to include their public health planning process within their overall council plan. I will refer to that in just a moment.

I probably do not need to go through too much in terms of the guiding principles; I do not know if John wants to comment. I was not here when the plan was being developed but he may wish to comment on those principles.

**Mrs PEULICH** — Could you explain the implications of the precautionary principle on the previous slide — within the Public Health and Wellbeing Act?

**Dr CARNIE** — What it is meant to imply is that we take into account all of the evidence existing at any time. We decide whatever actions we want to take in terms of protecting public health; we do not wait till we have every last bit of evidence. We act according to the evidence we have at the time but based on the precautionary principle in terms of protecting the health of the public.

**Mr SINDALL** — The act requires that a state public health and wellbeing plan be prepared every four years. It also requires councils to prepare public health and wellbeing plans within 12 months after the general election of each council, and the councils must have regard to the state public health and wellbeing plan. The state public

health and wellbeing plan was released by the minister on 1 September, which is the date specified in the act, and we have provided copies of that for you, something we were not able to do prior to that date.

The act sets out a number of functions of councils and defines very clearly the role that is expected of councils under the act and their contribution to health and wellbeing. As I said, the Victorian health and wellbeing plan was released on 1 September. It is a companion document to the health priorities framework. It identifies five priority areas for action over the next four years, strengthening what we call in the prevention system supporting priority settings in which we would like to see improvements and action. Those settings are communities, workplaces, schools and early childhood settings and health services. All that detail is in the plan. There is also the importance of continuing our investment and efforts in health protection at the same time as doing these other things. There are a number of measures in terms of keeping the Victorian population well and strengthening what we are doing in preventive health care in screening and other areas.

The plan identifies that although there are some specific community programs for all communities across Victoria, the primary strategic planning mechanism is the municipal public health and wellbeing plan. The plan also says that it is intended to build on the environments for health framework to support the next wave of municipal public health and wellbeing planning, to build on other experiences such as the Positive Ageing project, and to look for other opportunities to strengthen health and wellbeing planning and health and wellbeing objectives and outcomes in relation to other strategies — municipal, metropolitan and so on.

With respect to the cycle of public health and wellbeing planning, the next public health and wellbeing process will commence after the local government elections next year. I believe that that has been brought forward a little bit but I am not sure — —

**The CHAIR** — October.

**Mr SINDALL** — It is October. Then there will be 12 months to develop the plan. The public health plan is due in 2013, and then the cycle continues.

Over the last decade or so the department has been taking a number of steps to support the municipal public health planning process, including the environments for health framework and a number of other support measures. Our relationship with local government is also in terms of the work of the environmental health officers in local government who deal with a range of the sorts of issues that I have spelt out. Dr Carnie or Mr Gillespie will probably talk a little bit more about that in a moment.

We have worked closely with the MAV, with councils and through our regional offices with local government. We are strengthening our ability to build the evidence base and evaluation that can support activities in local councils; for example, by increasing the survey sample size of the Victorian population health survey to enable disaggregation by local government area. We have also established a new centre called CEIPS, which is the Centre of Excellence in Intervention and Prevention Science. It has been created as an independent organisation to provide evaluation and research support for community action on public health and wellbeing. There are a number of other measures in terms of the frameworks and tools we have provided and some workforce development programs. Examples of the resources and guides that have been prepared are available on the website.

I might leave it at that; that is probably a little longer than we were intending to go for. I will hand over to Dr Carnie to talk a little bit about some of the protection.

**Dr CARNIE** — Very briefly, there are a number of things that we do in association with councils in relation to protecting people and promoting good public health. These are just a few examples. We have a training and capacity-building function with local government environmental health officers, who are really the people on the ground who are working to protect public health.

There are specific examples of things that we have developed in the last couple of years. The heatwave plan is one that we have a particular interest in. We developed that in response to a number of things that have happened in the last few years. We are certainly very interested in water strategies in terms of planning. Obviously, as Colin has said, some of the things we want to encourage are green spaces and so on, but to do that you need supplies of water, and with the droughts that happen from time to time we are very interested in the issue of alternative water supplies while still protecting public health.

One of our functions is assessing works approvals under the Environment Protection Act. That is something they have to send us — works approvals — for us to have a look at in terms of health assessments. We continue to have challenges in terms of the environment and public health when it comes to things like industrial sites and the sorts of health issues that arise in association with those. We certainly have strong input into providing advice on the health risks related to things like that and water quality and land contamination. I might leave it there to give you more time to really get into the sorts of areas you want us to expand on.

**Mrs PEULICH** — Thank you very much for the presentation. Today the Auditor-General also tabled a report which looks at local government and the direction it needs to go in in order to integrate more of its key areas of activity, strategic priorities and so forth. Clearly that is consistent with what you have suggested — that is, that it ought be incorporated into the overall plan. I note that one of your roles is to support the development of leadership by councillors. Could I suggest that it is not just leadership; I would bet my bottom dollar that there would be at least 50 per cent if not more councillors who have never read the legislation under which they operate. To be optimistic in the assessment, the level of PD of councillors is extremely patchy. That really is an area that I think needs to be beefed up. Are you able to comment on any plans that you have or any suggestions that the committee could adopt or consider?

**Dr CARNIE** — I think that if a council is using the municipal public health planning process in the way that it was intended, it would really be a process of getting input from all of the councillors as well as council staff in the development of these municipal public health plans, and in doing that, also providing input. I think it would be an invaluable opportunity to have councillors educated about these sorts of issues that are important in terms of protecting public health.

**Mrs PEULICH** — I am not sure that it is the issues that are all that important. Obviously that is their representative role, but it is really about their roles and responsibilities and understanding where they start and where they end and how they dovetail into other agencies and so on. You could take that on board in your work with the MAV. I do not believe the MAV has done enough in that area.

**Mr GILLESPIE** — This is not really linked to educating councillors on their responsibilities, but we are doing some work at the moment on trying to get the valuable skills and competencies that the environmental health workforce possesses more recognised —

**Mrs PEULICH** — Your paid staff.

**Mr GILLESPIE** — by the council management and councillors.

**Mrs PEULICH** — But I have seen these plans often, and they really just hang out there; they are not really integrated. While it is convenient for council officers to operate in a vacuum where councillors may not be fully au fait as to what their responsibilities are, I think they would provide greater direction and scrutiny if indeed that level of PD was developed, in particular on their election, in conjunction with the MAV and maybe with the department.

More specifically, you are interested in water strategies. I represent an area which has a lot of water issues. The fragmentation of responsibility for water across a number of agencies presents a lot of problems. More specifically, there is a movement towards the establishment of wetlands as a method of treating water and run-off; however, the problem with that is that mosquitoes are rearing their big, fat ugly heads.

**Dr CARNIE** — Yes.

**Mrs PEULICH** — I understand there is an extension of the mosquito breeding season. I have a few areas where they are presenting significant problems. Not only that, we locate bike paths adjacent to the wetlands, and that makes sense in many ways, but the two are a little problematic. Are you able to comment on whether that is becoming an issue? I know the people in Seaford cannot even go out and enjoy their backyards, and the schoolkids complain about the mozzies.

**Dr CARNIE** — Absolutely. This has been an issue for a long time — that is, trying to balance the things that we would like to see in the environment: wetlands, bicycle paths and so on. Clearly those are things that we like to see. But then on the other hand in terms of health protection there are mosquito-borne diseases in certain years. It is quite variable. Last year was a really bad year. Last summer we saw lots of cases of Ross River virus

and Barmah Forest virus and so on. It is a balancing act. There are many wetland areas where the department or council officers cannot go in in order to spray extensively and so on. There are vast areas of forest land, for example, that are inaccessible. It is a balance. What we try to do is to ensure that councils — particularly in areas where these diseases are endemic, including in some of the areas around the Murray and so on, and in areas where a lot of people congregate — make sure that mosquito breeding sites are addressed and stagnation of water is reduced as far as possible. But, yes, it is a balancing act and there is no right or wrong answer in relation to that. We do have to encourage nice environments, but we sometimes have to live with mosquitoes. We do a lot in terms of educating the public on how to avoid mosquito-borne diseases.

**Mrs PEULICH** — But if you live adjacent to that, it is a problem.

**Dr CARNIE** — It is very difficult.

**Mrs PEULICH** — I understand they treat them by dropping some sort of pellets onto the surface of a body of water. I have had certain information presented to me that that needs to be reviewed and that the guidelines for the control of mosquitoes are long overdue for review. Are you able to comment on that?

**Dr CARNIE** — These things are addressed at a national level. There is a national committee that looks into all of these arbovirus diseases — mosquito-borne diseases. There are larvicidal methods of control as well as adulticidal methods of control. When there is a lot of disease around, as there was last year, we tend to focus more on adulticiding because then you can knock down the adults. You are trying to reduce the immediate transmission of infection. But the larvicidal methods are more long-term control methods.

**The CHAIR** — The committee has heard calls for the health impact assessments to be mandatory for certain types of developments. I was wondering what the department would say in terms of health impact assessments. Do you think it would lead to better development proposals?

**Dr CARNIE** — To my mind any development proposal really should consider what the effects are, whether it is done as a formal health assessment or not. Clearly these are areas that we consider ourselves in terms of what impact various changes in the environment have on health, so it would be something that we would encourage. People should always look at what effect any kinds of development or any kinds of changes have on health. Do you want to expand on that in terms of health impacts per se?

**Mr SINDALL** — Graeme may wish to comment on this, but health impact assessment can obviously be quite technically demanding to get right. While we may absolutely want to look at the potential health effects, benefits and others, of development, formal health impact assessment is not something that one goes into lightly.

**Mr GILLESPIE** — Yes, I think it needs to be pretty well planned and resourced. It would require a trained resource. It also needs to be in the context of a full health impact assessment across all of the determinants of health, rather than the more traditional hazard impact assessment.

**The CHAIR** — But it is surely possible that we can try to get developers to be more accountable in their development proposals?

**Mr GILLESPIE** — Yes, I am really fully supportive of that.

**Mr ELSBURY** — I have two questions, which are on either end of the presentation that you have just given. With regard to the *Urban Health Matters* document that we saw on the projected slide, does it go into density issues and, if so, did it mention a preferred density of dwellings?

**Mr SINDALL** — No, not into that sort of detail. Those international WHO documents are fairly high level sorts of documents.

**Mr ELSBURY** — You mentioned health concerns of industrial sites. Are we talking inadequacies in buffer zones or a need for improvements in technology?

**Dr CARNIE** — I think both. What we have to deal with is usually people who are living in areas where there has been a long-established site, whether it be a landfill or some other sort of industrial site, and development has happened around it. People then start asking us to look into whether there are any health

effects from whatever it is — whether it is a landfill, an industrial site, a factory or anything else. We have to try to establish the duration people have lived around this thing, and then look at what evidence we have in terms of any potential health effects and so on. We invariably get drawn into those kinds of discussions right around the state.

**Ms PENNICUIK** — I would like to follow up on that particular issue, because it is sort of what you were raising about health impact assessments. You were talking about technicality and how it might be quite difficult. It occurs to me that in the case you are describing, Dr Carnie, where there is an existing industrial site and development starts encroaching, that is probably when it would be a good time to have a health impact assessment, rather than you having to, as you say, deal with the problem. Perhaps that is an area on which we could make a recommendation that in the future developments that are nearby any sorts of industrial sites do have health impact assessments.

**Dr CARNIE** — Yes.

**Ms PENNICUIK** — With regard to the World Health Organisation, I was looking at the Public Health and Wellbeing Act 2008 and its definition of public health, which says:

> … includes the absence of disease, illness, injury, disability or premature death and the collective state of public health and wellbeing …

I do not have the World Health Organisation definition in front of me, but I know it is a lot broader than that, and it talks about social determinants of health et cetera. Does the department work beyond the definitions that are in the act and more towards those of the World Health Organisation, and is that informed by the Australian government as well?

**Dr CARNIE** — I think we do. The addition of the word 'wellbeing' was an attempt to do that; to go beyond what used to be the traditional idea of health. The earlier health act that we had was from 1953. With this new act we wanted to introduce the concept of wellbeing and to go beyond the absence of disease. It is something that we actively consider. All of the things that Colin is involved with in terms of physical activity, health promoting behaviour and all of that goes well beyond the traditional concepts of health and more into the wellbeing side of things.

**Ms PENNICUIK** — So you are not constrained?

**Dr CARNIE** — Not at all.

**Mr SINDALL** — Especially now wellbeing is built into that, absolutely.

**Mr TEE** — It has been a very interesting area for us to consider. We have had a fair few submissions and very rich submissions. What has been surprising has been the consistency in the submissions we have had on the clear link between obesity and the design of our communities and the fact that this we do not have in our communities a capacity to walk to shops, attractive open space and public transport. Almost every submission has focused on that. I suppose the challenge for the committee is how do we take that knowledge to the next level? How do we drill down and make recommendations that push that knowledge out into the community so that more people are living within walking distance of open space? I suppose a number of areas have been recommended, and I want to run through some of those to get your views on some or all or any. I suppose the first category is around deficiencies in the planning legislation and the lack of a health objective and the lack of an alignment with health or a recognition of health, which is something you find obviously in your legislation but also in the transport legislation.

**Dr CARNIE** — Yes.

**Mr SINDALL** — Yes.

**Mr TEE** — And somehow there is a deficiency there. Equally, from that level I drill down to the next levels of planning regulation and the absence of it either as an objective or as something that you consider in delivering planning outcomes. Then, drilling down further, you talk about the municipal plans, but again every council has got one but no-one evaluates them, no-one compares them, there is no monitoring, there is no best practice and there is no learning from them. That was the other bit.

I suppose a third kind of category is how we engage with the developers and require them to consider health as part of the delivery of those communities. Partly, obviously, it is through objectives in the legislation and planning scheme amendments. We are in the fortunate position of the government now reviewing its planning policies so there is a capacity for us to recommend that it puts those sorts of considerations into the planning scheme. I suppose there is that further category of how do we engage with developers and require them to put that in place? I want to get a sense of whether you think that is where the debate is up to, and what are your views in terms of the issues that the submissions have flagged for me?

**Mr SINDALL** — Certainly in terms of alignment of legislation, in terms of including health objectives directly or indirectly, however it might be done, we would welcome that obviously. It is something we hear quite a lot, that this act or that act perhaps does not permit the sorts of things that may advance these issues. Certainly that would be welcome I think from our point of view. I would certainly take on board some of the issues you have raised about municipal public health and wellbeing plans. But I should say perhaps for the record that our regional offices do take quite a serious interest in the municipal public health and wellbeing plans, and although practice is perhaps variable across the regions, there are various mechanisms for sharing information, for reviewing and for perhaps bringing councils together where appropriate. We have certainly funded in the past a public health planning best practice program through the regions which gathered case studies and so on.

I think what is becoming clear, however, is that as we move to the end of this cycle and move into the new cycle of health and wellbeing plans — now we have got the state plan and now quite a number of other really important issues are crystallising — we in fact do need to do a lot more in that area. We have started, in conjunction with one of our regions, to develop some tools to support councils in reviewing. The act does require that municipal public health and wellbeing plans are reviewed annually, and we are developing some tools to assist councils to do that. I would certainly take on board that there is a lot more to be done, and we need to really know what is being achieved through that process and where it may be necessary to adjust or take stock of what is being achieved so that we can ensure that we are really getting the outcomes that we need.

**Mr TEE** — I do not want to cut you off, but on the municipal plans, for the record I was not being critical of the role that you or your people or indeed the councils are doing. I suppose the challenge and the opportunity for us as a committee is to find ways to recommend how you take it to the next level. Rather than saying, 'We have done a terrible job', it is about saying you have got to a particular stage and what is the next stage in the evolution or the development.

**Mr SINDALL** — Yes, we would agree, I think.

**Mr SCHEFFER** — Coming to the operational level of some of the matters that Brian was raising, referring to the Victorian Public Health and Wellbeing Plan 2011–15 and looking at section 2.3 on health status and trends, on page 20 you list some emerging issues. For example, you talk about alcohol and related harms, then you go on to fresh food and then on to various other things. If we look at something like alcohol-related harms, we know — and we have had witnesses talk to us — from the evidence that is emerging that the saturation of packaged liquor outlets in particular areas has a direct correlation to people using alcohol harmfully. We know and we have had witnesses talk to us about the nexus between land use planning and fresh food availability. Then if you look at obesity, you have mentioned obesity — —

**Mr SINDALL** — Yes.

**Mr SCHEFFER** — So you know about the planning issues there. If I could throw another one in that we have discussed with witnesses — that is, the issue of the next wave of asbestos-related diseases that are being predicted through home renovations. Each of those manifests a clear nexus between the planning space and the health outcome space. Given that they are issues that you yourself have drawn up in this document, how do you go about dealing with those — given that breadth that Brian has alluded to as a future issue but I am alluding to as a here-and-now issue that needs to be dealt with? I am not trying to make light of your expression before, but I could not help noticing that you said the department takes 'a serious interest in' — and I absolutely respect that you would — but we are really searching for something a bit more than that, are we not?

**Mr SINDALL** — As I said, with many of the levers that can affect those things, we are trying to change and improve those behaviours, those risks and the opportunity to improve health in the areas that you refer to, but I

think this is why the World Health Organisation and others so strongly stress that the way we approach health in the modern era is an intersectoral, cross-sectoral approach where we have to get some alignment ideally across a number of spheres of policy and concern that, as I said, health has a limited capacity to influence. We can obviously, in terms of our work through local government — —

**Mr SCHEFFER** — Sorry to interrupt. I really appreciate that, and I understand that, but my question was: you, now, today, having those issues identified in this document that just came out — they are not my issues, they are your issues — with pencil sharpened tomorrow morning, how do you do it given that there is not at the moment an objective in the environment and planning act that requires you to do it? How do you do it in a context of taking an interest?

**Mr SINDALL** — Perhaps I can answer that in a couple of ways, and then I might ask whether my colleagues would like to comment. Firstly, the Department of Health uses the sorts of levers it has at its disposal to try to influence some of those behaviours.

**Mr SCHEFFER** — Which are?

**Mr SINDALL** — Not necessarily through planning controls or actions but, for example, through social marketing, through information and communication campaigns, through programs in workplaces, through advice given to people about drinking, smoking or whatever, through community health services. There are a number of things that we can do. We then need to work with partners, including local government, including other departments and so on in terms of addressing some of those structural environmental factors that also influence those behaviours.

**Mr SCHEFFER** — But we know — sorry to interrupt you again; I will stop in a minute — like in alcohol, that education is the least effective way of changing behaviours. We know is that the best way to change them is the price mechanism and then we know probably the second is density of outlets. That is what we know. The evidence tells us we have to have less outlets. That is a planning issue. Councils come and tell us — their legal officers tell us — do not even try it, because you will get rolled at VCAT. This is the nub of the problem we have, and while we have different departments taking an interest it will not click over into practical action that will help people's health. That is the problem that I see.

**Mr SINDALL** — Yes. I do not disagree in any sense.

**Mr TEE** — That is really the work of the committee, in a sense, is it not? In summary, it is how we bridge the gap, because you can only influence behaviour to a very limited degree with your campaigns, without the planning tools to drive that change in the way in which we design our communities.

**Mr SINDALL** — If you think, for example, about tobacco — perhaps starting more with education — over time society has come to appreciate exactly what you say. We have increased prices, we have banned smoking in public places, we have removed advertising et cetera, and there has been some societal consensus that that is how we need to tackle the problem of smoking. With some other issues I think we are possibly not quite at that consensus. In other areas we probably have a pretty good idea of what needs to be done but there maybe a little way to go before we can get there. Our approach to any of these issues is very much a sort of multilevel one, doing what we can, as we can, but we very much welcome the issues that this committee is looking at perhaps to help advance that agenda.

**Mr ONDARCHIE** — Good answer. I want to touch on some of the public health programs the department takes the lead on — for example, let us take something like childhood obesity, one of the fastest growing issues for this nation. Given that things like childhood obesity cut across other departments — the department of education, DHS, DPCD and councils, amongst others — who takes the lead on those sorts of messages? Given that I represent one of the most multicultural areas of Melbourne, how do we go about getting those sorts of messages through the different cultures and groups that are around?

**Mr SINDALL** — I think it is probably true to say that the department takes the lead, but working very closely with other departments and other agencies. We have a very strong relationship with the education department, for example, and you may have seen that there have been a number of statements that ministers have made in recent times in relationship to some of the things we are going to be doing in schools and also in communities. We would hope that by working with education to develop approaches to health promotion in the

school environment, by working with local councils around the issues that need to be addressed, the schools, the communities, the local authorities and so on can translate those messages into context-specific information that can meet the needs of different types of communities. We do very much see it as our responsibility to lead on those issues.

I think we have a very good working relationship with many of the other areas, such as education and early childhood. Of course you may be aware that the plan was developed in part under the guidance of a committee chaired by our secretary — that is, the Prevention and Population Health Advisory Board — and that brings together the deputy secretaries of many of the other relevant portfolios as well as organisations such as the Heart Foundation, the cancer council, VicHealth and the MAV.

**Dr CARNIE** — If I could add to that, some of the work we are involved in is also at the national level — for example, through the National Health and Medical Research Council. We were heavily involved in the development of the alcohol guidelines. We are currently involved in developing healthy eating guidelines — nutrition guidelines — which will be coming out within the next few months. We do a lot of work at the national level as well in terms of influencing public health policy.

**Ms PENNICUIK** — I will just follow on from the campaigns issue that we were talking about with Johan. If we are talking about tobacco and alcohol — not so much alcohol in itself, but in terms of, say, drink driving — those campaigns worked, as you mentioned, because there was education, but there was also legislation banning tobacco advertising. There was breath testing on the road, and it was enforced, so there was a perception that if you did something, you would get caught. I think that is the problem in terms of all the things we are trying to tackle here — alcohol-related harm, obesity et cetera. There are public health campaigns happening, but there is no legislation backing them up in terms of what Johan was saying. I just wonder whether you make any recommendations to government or other departments about how those sorts of campaigns could work better together — for example, with obesity in terms of advertising fast food in children's viewing time et cetera. That is an example.

**Dr CARNIE** — Obviously these are very contentious issues in terms of tackling some of the obesity issues. As Colin has said, we put a lot of effort into social marketing campaigns and so on, and as you say, sometimes legislative approaches are required, but when it comes to food those become extremely difficult. For example, when you look at the concept of food advertising for children that is such a contentious issue, and people very often disagree about whether the advertising community, if you like, has a great influence on children's choice of various foods. Some public health people think very strongly that it does, and yet there are people in the community who think that it does not. It is a very contentious issue.

For example, there is a lot of legislation in the food area about packaging and labelling and all the rest of it, and clearly food safety is something that we obviously put a lot of effort into in terms of health protection, but when it comes to the general things that are available in a supermarket for parents and children to buy, thinking of legislation or legislative approaches to prevent childhood obesity becomes a very difficult arena.

**Ms PENNICUIK** — I understand it is, but I think the problem with it is that if we just carry on with social marketing campaigns without any sort of legislative backing behind them, we will continue to have the outcome that we have. It is just what we are exploring here in this committee.

Can I go to one of the slides that you had there, Mr Sindall, which had a column graph? It is that one. In a previous life I did a lot of work on stress, depression et cetera, so I am not surprised to see that column graph at the end. The other one interests me — the one about arthritis. They are all interesting, but those stand out as the two chronic diseases on your graph there, and I just wondered if you have any comments on that. I went straight to depression and anxiety, and then I went, 'What is that one? Arthritis'. It is much higher than heart disease, diabetes et cetera.

**Mr TEE** — But it is also coming back. It is coming down, and the others are going up.

**Ms PENNICUIK** — Yes, but I would not say by a lot.

**Mr TEE** — No, I am just saying that it is interesting. The others are going up by a lot.

**Mr ELSBURY** — You can have heart disease and not find out about it until it is far too late. It is the same with stroke.

**Ms PENNICUIK** — I just think it is interesting, because it is a debilitating condition.

**Mr ELSBURY** — It is sort of a 'bang', whereas arthritis is not going to — —

**Ms PENNICUIK** — What are your comments on that?

**Dr CARNIE** — Clearly arthritis is a function also of the ageing population. Most of us are going to have some sort of arthritis as we age.

**Ms PENNICUIK** — That is mainly osteoarthritis rather than rheumatoid arthritis?

**Dr CARNIE** — Absolutely. It is mainly osteoarthritis. Rheumatoid arthritis tends to be a very small segment. That can happen at any age, as you know, but osteoarthritis, certainly as the population ages, becomes very common.

**Ms PENNICUIK** — So it is a challenge to keeping people mobile?

**Dr CARNIE** — Absolutely, and this is where the built environment is really important in terms of keeping people mobile and having access to things like swimming pools, walking tracks, cycling tracks and so on.

**Mr TEE** — And even houses designed so that you can be frail when you are older.

**Ms PENNICUIK** — So they can get around, turn the taps on and off and open the jars.

**Mr TEE** — We have had a fair bit of evidence on that as well.

**Dr CARNIE** — Yes.

**Mr SINDALL** — You have probably heard that expression about co-benefits — that taking certain actions can have benefits across a number of different areas. There will be some evidence to suggest that an environment that is conducive to walking and is therefore perhaps protective in terms of some musculoskeletal problems would also be one in terms of the right-hand side of the slide. If people are meeting each other in the street and walking and so on, that can contribute to addressing mild depression and moderate depression — a sense of social connectedness. You have heard all of this evidence, for sure.

**Ms PENNICUIK** — Yes, we have.

**Mr SINDALL** — In fact almost every condition there could benefit in some way from more activity and more connectedness in communities.

**Mrs PEULICH** — I have three questions, if I may. First of all, you said you have got the healthy eating guide coming out soon. Perhaps reflecting on that and other work you have done, what effort is made to actually communicate those messages on sites and so forth to multicultural communities, and in particular those from emerging communities who perhaps may not have had the opportunity of buying and preparing food — some of them have very few skills, having lived, say, in refugee camps for years on end?

**Dr CARNIE** — With National Health and Medical Research Council guidelines these days, in the development process the developers have to come up with an implementation plan. On the NHMRC, which I am on, there is a consumer representative who always asks questions about how this is going to be made available to the general public, so issues like translations are actively considered at the time guidelines are being developed.

**Mrs PEULICH** — At the same time.

**Dr CARNIE** — Yes.

**Mrs PEULICH** — Secondly, if I may, I raise the planning challenges and some of the problems of interface between public housing tenants and the general community, because in many instances public housing estates

seem to have an overrepresentation of people with mental health problems, drug and alcohol and other substance issues — social disadvantage is probably the least of those. There has been a movement towards the clustering of those people into high seven, eight or nine-storey housing, commonly referred to as social housing. So there is a clustering of people who may suffer from mental health issues, social disadvantage or alcohol or drug abuse. They live within smaller dwellings in close proximity to one another, often with very limited, if any, green space. Is this direction consistent with your knowledge of what sort of built environment people who suffer mental health issues or alcohol and drug abuse need in terms of their recovery and functional living?

**Mr SINDALL** — It is not an area I really feel confident to comment on, but I do not know if John would.

**Dr CARNIE** — Not really, no. My impression was we were getting away from some of those high-density environments —

**Mr SCHEFFER** — Exactly.

**Dr CARNIE** — and we were moving more toward independent living away from the high-rise kind. That is my impression, but as Colin said, I have not had a lot to do with that area so I cannot really comment on it. We can find out what the real situation is in that area and get back to you, but my impression was we were going away from that.

**Mrs PEULICH** — There were the federally funded social housing projects. I know of the ones in my electorate, and many of them would have tenants derived from those particular demographics.

**Dr CARNIE** — The point you raise, however, is important, whether it is the Office of Housing or whatever. The importance of green spaces, the importance of things like allowing people access to green spaces and allowing people places where they can walk and ride — that is important across the board.

**Mr ONDARCHIE** — Gentlemen, there is some suggestion that a number of the presentations at our major public hospitals' emergency departments are people who could have been better served by going straight to their general practitioner. Is that a fact? Is that true? And what sort of percentage are we talking about?

**Dr CARNIE** — I do not know percentages, but I do not think that is universally true. In fact people who present to public hospitals by and large tend to be people who actually need to be in a public hospital. Now there is also an issue on weekends that there are people who would like to see a general practitioner on a weekend but there are many areas in Melbourne where on a Sunday, for example, it is very difficult to find a general practice that is actually open. So whenever acute illness occurs on the weekend sometimes people are forced to go to a hospital if they are ill enough to warrant immediate attention. Again, I do not have percentages, but my impression is that emergency departments tend to be by and large dealing with people who actually need to be there.

**Ms PENNICUIK** — Could I go back to the slides again? It is the one that had the five key areas that you were looking at. I do not want to spend too much more time but I just wondered if you could briefly just go through what each of those means — what would be the key activities? And I just want to take the opportunity to say thanks very much for coming here tonight and it has been very interesting. I would like a little bit more on your work.

**Mr SINDALL** — I would be happy to explain it. Obviously the detail is in the document but I did not put the detail up on the slides in order not to double up.

**Ms PENNICUIK** — It is not so much what is in the documents, it is why they are there as opposed to anything else et cetera.

**Mr SINDALL** — The first one is not necessarily something you would see in a lot of these sort of plans, although increasingly there is an understanding of how important it is. Really what 'strengthen the prevention system' refers to is the fact that historically in many cases the prevention effort, the health promotion effort, has been fairly diffuse with many small projects, none of which together have necessarily achieved the sort of outcomes that we would like to see. There are some areas such as tobacco control where there has been a really long-term, intensive, comprehensive, multilevel approach, but we have not seen that in a number of areas.

Two or three years ago the World Health Organisation did some work on a sort of systems approach to building health-care systems, and some of that thinking about what the building blocks of an effective, sustainable approach are have been translated to a prevention public health context. So one of the things that we are saying there is that that first priority is: let us look at the elements of the effort that we are making across these issues.

Let us look at all of the areas that are often not necessarily neglected or dealt with in an ad hoc way — for example, the workforce. Let us make sure we have the workforce to do the job. Let us make sure we have the governance arrangements and the coordination mechanisms so that we use resources most effectively. Let us look at financing and resourcing and how we are allocating our resources. Is it based on the best evidence, the cost effectiveness and so on? Let us look at how we approach partnerships. It is about those structural elements? If you get them all working together in alignment, you hopefully get better outcomes than if you have lots of small-scale projects. That is the first one.

The second one is priority settings. Once again, while in the past our activities across different settings have been not terribly well organised or connected in some respects — I am talking generally, internationally as well as in Australia — we are taking a really focused approach on particular settings. The settings that we have identified as priorities just for the next four years — that is not to say there are not other settings — are local communities, because that is where people live and interact and so on; workplaces, because obviously where you work and whether you are sedentary and how you get to work and so on is an important factor in health; schools and early childhood settings, because that is where habits are formed and shaped in early life; and health services is the fourth of those priority settings.

There are two elements in the plan about health services. One is the final one, and that is strengthening preventive health care, and that is doing better in terms of our screening programs, our early intervention and our counselling and education for people who are at high risk of disease. But the other element in terms of health services as settings is — and you may be familiar with the concept — health-promoting hospitals, where the hospital does not just provide beds and treatment and so on, but in terms of its staff, patient education and a whole range of things, it takes a more comprehensive approach to health. That is the next one.

The health protection side things, as I mentioned, is much more John and Graeme's area. As we address new concerns we must not forget that we have to keep in place all of the things that we have developed over time to protect us from the mosquito-borne diseases or water-borne diseases and so on. Keeping people well is really the category in which we put all of the sorts of behaviours and risks that are modifiable and where we know that we can gain some improvements if we address them. That ranges from physical activity to sexual health to alcohol et cetera.

As I said, strengthening preventive health care is done through our screening programs and our early intervention programs. In terms of the prevention system, one of the building blocks that I failed to mention but is absolutely a key part of what we are trying to do is ensuring that all of those different dimensions are underpinned by a constant building and review of the evidence evaluation et cetera. Information, evidence, evaluation, intelligence around all of that is what we are aspiring to so that we really know whether we are making progress.

**The CHAIR** — I am going to draw the hearing to a close now. Thank you very much not just for your presentation, which was excellent, but also for your in-depth answers to a range of questions that were put to you by the committee. I really do appreciate it, so thank you.

**Mr GILLESPIE** — I have some small kits on some of our protection issues, if you want me to leave them for members.

**The CHAIR** — Yes, absolutely. Thank you.

**Mr GILLESPIE** — The other one — it is the only one I have — comes from my previous life in another country. It is a health impact assessment tool. If the committee is interested in that, I might be able to arrange with the committee secretariat to try to get some copies over from New Zealand.

**Mrs PEULICH** — Can you just outline what that is about?

**Mr GILLESPIE** — This is a guide to a health impact assessment. It is a tool for carrying out a health impact assessment. It looks at all of the determinants with a particular focus on making sure that any policies or plans do not increase inequality, because that is one of the more significant — —

**Mrs PEULICH** — Did you say there were multiple copies of that?

**Mr GILLESPIE** — No, this is the only copy I brought with me.

**The CHAIR** — But you might be able to organise some?

**Mr GILLESPIE** — I can look into that.

**The CHAIR** — If you could liaise with Keir, that would be great. Thank you again.

**Committee adjourned.**