PUBLIC

THE JOINT SELECT COMMITTEE ON PREVENTATIVE HEALTH CARE MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART, ON WEDNESDAY, 6 MAY 2015.

Dr SEANA GALL, MENZIES RESEARCH INSTITUTE, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Forrest) - Welcome. Everything you say is recorded by *Hansard* and will become part of the public record. You are protected by Parliamentary privilege while you are before the committee but not if you spoke to the media afterwards.

Dr GALL - The Menzies Institute for Medical Research is part of the University of Tasmania and we do research across a wide range of areas, but preventative health care is one of things that we are very passionate about. We think it necessary to reduce the burden of disease in Tasmania. We commend the efforts of the committee in taking on board the public's opinions regarding preventative healthcare and social determinants of health more broadly.

I am an epidemiologist and I work primarily in cardiovascular disease, and through that I am acutely aware of the need for equitable and evidence-based preventative healthcare. For example, in cardiovascular disease we know that upwards of 70 per cent of it is due to known modifiable risk factors, like smoking and blood pressure, that can be managed relatively easily with things we know that work.

We believe that a focus on prevention within the healthcare system is really important, but it requires the community and healthcare providers and the government to place value on maintaining health across the life course and that investment is needed to do that. We also know, as outlined in the submission, that investments in preventative healthcare are known to have real benefits in terms of health in the short and long term but also benefits in terms of the economic productivity of the country and the broader social wellbeing of people.

Tasmania has a higher burden of social disadvantage than a lot of other areas of Australia and certainly of more major cities, so addressing the social determinants of health is really important. It is one of those things that does not require only engagement of the health sector of the government but also lots of other areas of government like planning, infrastructure and education, which are all important.

One of the things that we put in our submission was about taking a whole-of-government approach to that and acknowledging that there are a wide variety of things that need to be done to decrease social disadvantage in Tasmania. That will have flow-on affects to health outcomes for Tasmania.

The final thing we talked about in our submission was that we are a research institute and that we strongly encourage the Government and people involved in policy development and implementation to acknowledge the role of research and evaluation in this process. This really requires good quality data on the health and wellbeing of Tasmanians. One of the things that we would encourage is the ongoing support of things like the Tasmanian

Population Health Survey that is conducted by the Department of Health and Human Services. Two of those have been conducted so far and we encourage that to be ongoing to see the levels of health in the population and also be able evaluate how different measures that have been taken are having an impact on the health and the health behaviours of Tasmanians.

The other thing that is quite important is ensuring adequate numbers of Tasmanians are in national surveys done by the Australian Bureau of Statistics, like the Australian Health Survey or the National Survey of Health and Wellbeing. It has sometimes happened but not always, so that can mean there is not enough people for us in Tasmania to be able to look at regional differences, or differences by different socio-economic groups, because there is simply not enough people do that with any confidence in the statistics you get.

That is pretty much all I have to say about our submission. We are happy to take any questions anyone has.

CHAIR - Thanks, Seana. We appreciate that you have addressed the terms of reference which makes it really good. It helps us in preparing a meaningful report.

I would like to pick up on a couple of areas that you have identified, one under term of reference one, towards the end of your submission, where you talk about encouraging the Government to refer to the considerable body of work carried out by the Minister for Health and Wellbeing Advisory Council and I am wondering if you have had any feedback from the Government in relation to that?

Dr GALL - I am not aware of what happened with that after it was put together - I am trying to think when it was released - and issues with the change of government.

CHAIR - February 2013.

Dr GALL - Yes. So a lot of it has been put on the backburner, as it were. But a lot of the people who worked on that report still advocate the things within there that we talked about, whole of Government approaches, and so on.

CHAIR - Following on from that part in your submission, you particularly support the notion of an intersectorial action on health - the so-called 'health in all policies' approach which tackles the association and determinants of health. How do you see it working? I have an image in my head of how it works but how do you see it and how does the Menzies Institute see it?

Dr GALL - As was claimed in the Thriving Tasmania report it requires buy-in from all the different departments and an overarching body that would help that to happen. I think that is one of the things, in terms of the implementation, that is a challenge. There are various places in the world that have tried to do it in more detail. In Scandinavia, certain countries take this approach and when we first started talking about this - quite a long time ago, about 2009-2010 - and we had been meeting with people from various government departments like education and the like, trying to get people to understand the concept of health in all policies.

That is where we were at that point but the Thriving Tasmania report does outline what they would have recommended in terms of the development of a body that would provide that overarching framework across the different sectors of government. There is a lot of documentation available, and reports, to guide that process.

CHAIR - As far as they are not an agency - we have had different views on this, whether Health should be the lead agency or whether it should be DPAC. How do you see it working?

Dr GALL - The view from the people I was involved in that we were originally talking about that it would be better if it didn't sit within Health, that it was removed from that because that makes other people see that it is the responsibility of the Health department to run this, whereas it is probably more advantageous to have buy-in from everybody across the departments. But how that would work in real terms, I guess I am not the right person to comment on it.

But that was my understanding of it. You would get more buy-in from other departments if it wasn't led through Health. If it was through the Department of Premier and Cabinet, or the like, it would be better because otherwise everyone else will still view it as a Health thing not a whole of government approach.

Mrs TAYLOR - Following on from that, how do you see this working because one of the difficulties is often when you have that overarching body, it becomes such a cumbersome animal in itself. Do you see it as policy or do you see it as directive to other departments, information gathering, or research?

Dr GALL - The Ministerial Health and Wellbeing Advisory Council came out with those discussions about how would you do this, how would you put it together, and they came up with various recommendations. One of the ways that they thought about it was that you have communities that you would focus on to try and implement this sort of approach across the different sectors and through that - there is a nice diagram here of a cycle of how it would work - and it would be integrated within the community across the different sectors. That way you would develop the evidence-base of how you would do it as you go along.

CHAIR - It would also need to include local government.

Dr GALL - Yes, of course. Local government is the other part of that. A lot of other bodies involved in service delivery are also important in this model.

Mrs TAYLOR - Sometimes we have that type of body and it is almost an entity in itself.

Dr GALL - Yes.

Mrs TAYLOR - Unless you get results from it, unless you have outputs. It is so big because it involves everybody. It is hard to keep that tight; by its nature it has to. You talked about Scandinavian countries - do you have an example of where this has worked?

Dr GALL - South Australia worked towards doing some of this quite a few years ago and they had someone embedded with their government who was trying to help develop it. I

cannot recall where they got to with that. It is an idea that has been around for quite a while but as you pointed out there are challenges in how you implement it. From our perspective the first goal is getting everybody on board, that this is something you should think about doing.

Ms O'CONNOR - Dr Gall, I am interested in your whole submission, it is really good. You talk about the decline in funding of the total health budget from 2.6 per cent of the budget to 1.7 per cent within three years. Is that a consequence of the cessation of the National Partnership Agreement on Preventative Health and a combination with the state health budget cuts?

Dr GALL - I am not sure what contributed exactly to that decline, from what was taken out of the documents. It is probably a combination of those.

Ms O'CONNOR - Okay. There is a suggestion in here that we move towards other revenue-raising measures, like a state-based tax on tobacco. Have you heard of other jurisdictions where they have done that, and is it something that the Menzies Centre is lobbying government to consider?

Dr GALL - Victoria has done it and Western Australia, in terms of that is how they fund VicHealth and Healthway in Western Australia, which are prevention bodies within those jurisdictions. There is precedence for it. It is not something that to date the Menzies Centre has lobbied for but we would consider it as a way to implement this kind of thing. It is one thing to say things need to be done but you need to have a way of funding them.

Ms O'CONNOR - Isn't the other challenge convincing Treasury that an investment in preventative health now, which may not be measurably effective for a couple of terms of the government at least? Have you heard of any place that has successfully been able to change the way state treasuries think about investment in preventative health, because that has been quite a persistent tension in this space?

Dr GALL - We acknowledge that. That is one of the big issues for the community as well. The money has to come from somewhere and a lot of it is being spent on acute care and nobody wants to take money out of acute services that people need, to fund into things that they see as, 'What are the health outcomes here?'.

One of the examples I give is that people think it is going to take a long time for the investment to show returns. In tobacco control, for example, where the government put a considerable amount of money into evidence-based programs and from a range of data sources we have it looks like that has worked with smoking levels going down. That was only within a five-year period. So it is possible to see those things happen in a reasonably short space of time. We acknowledge that is one of the issues. It is about the way that the community understand these things and it is one of the things that the Menzies is interested in, in helping to bring the community along with the need for investment in these types of programs.

Our research shows that even in young people, these types of health behaviours are having an impact on them and that changes can very quickly result in health improvements at an individual level. At a whole population level, it could be hard to

measure but individuals will receive improvements in their health if they change their health behaviours quickly.

Some of the evidence we brought in from other reports was that the initial cost is very high but the amount of money actually being saved far exceeds that in terms of prevention of acute care costs and productivity. It is probably partly about the crafting of those messages and the way they are sold to Treasury.

Mr VALENTINE - With regard to funding for research and the money being spent on the population health surveys, those population health surveys are very important to you, aren't they? Do you see those as essential not to be cut in terms of putting other money into research?

Dr GALL - It is important for the state to understand that we are spending a lot of money on health care, health services and health policies, and without this population monitoring you really have no idea whether it is making any difference. From an accountability point of view, the Government should be interested in having data. They will be able to find evidence that what they are doing is making a difference. For example, with the tobacco control investment, we can see that smoking has gone down, and that is great. Without collecting that data it would never be known.

It is also important, with the proposed redesign of the health system, to understand where the burden of disease is, what types of conditions people are suffering from, how they are distributed - they are all important parts of the picture.

Mrs TAYLOR - I would like to ask a question about evaluation as opposed to research. You mentioned the importance of both research and evaluation. How much of the Menzies Research Institute program would be devoted to evaluation, why is that important and what does it actually do? It would probably help in future funding, I suppose.

Dr GALL - Evaluation is probably slightly different to doing research in the objectives of what you are trying to do, and the Menzies institute has had ongoing links with the Department of Health and Human Services in terms of evaluating some of the programs they are involved in. One of the big things we have done in the past five or so years is called Partnering Healthy@Work, where we helped the state Government evaluate a health and wellbeing program for State Service employees which was implemented. It has been great to have the Menzies institute working with people throughout the Government. The type of evidence that is gathering is very important for Tasmania and the Government but has also been important worldwide in terms of what it is showing about whether these programs are worthwhile investing in, and so on.

It is probably a smaller part of what we do at the Menzies institute in terms of evaluation but it is one of the areas where, as various people work with different people within the Government, we assist them in developing evaluation plans and programs, and how they might go about doing that type of thing. Certainly other experts at the university, other schools and faculties, also have expertise in evaluation.

Mrs TAYLOR - My question is related to the fact that it is a matter of convincing government, or whoever, that these preventative health programs are very important.

You cannot do that unless, as you say, you can promote it by saying 'these are actually the results'.

Dr GALL - Through the various things I have been involved in, the DHHS at least, does seem to be devoting some of the funds for policies towards evaluating the policies when the National Partnership Agreement on Preventative Health was in place. Part of that program was evaluating how it was working and what was being done, and so on. Obviously Partnering Healthy@Work was very much about evaluating that investment. That has been an important part of it. It should be right at the very top and planned before these things are done rather than after the fact. Often the problem people have is that they do something and then they say, 'How can we figure out whether it worked?' You really need to plan for these things at the very outset to be able to figure out what you think is going to change, how you are going to measure it, and so on.

CHAIR - That is one of the key points. We might stay on the path a little while.

Seana, what confidence do you have in the quality and reliability of the data? You have to have decent baseline data to start with. Do we have that and if we haven't, how do we go about that? If you do not know what you are starting with, it is really hard to measure outcomes from there. Outcome measures need points of time, I guess. An intervention in pregnancy may be reduce the rate of premature birth. It is hard to miss that the baby was not born prematurely but how do you actually measure that and then demonstrate the savings? It is money not spent as opposed to savings.

Dr GALL - Yes, that is right. The recent advancement in this area that is really important to those types of questions is the Tasmanian Data Linkage Unit which I mentioned, which is based within the Menzies institute. It is a little bit like big data which gets everyone a little scared. It is about taking various information sources that are available to answer those types of questions at a population level about health service delivery and outcomes.

It is a very cost-effective way of doing this type of research because you are using already available information about different healthcare services that are provided and the types of outcomes that you can measure from that type of administrative data. It obviously has its limitations because it is based on administrative data. That is certainly a very big advancement in this area in Tasmania within the past 12 months but it has taken a long time to get that going. There are various data custodians, as they are called, that hold onto the various data sets that the Data Linkage Unit can bring together to answer these types of questions. That is why there is a lot of ground work with lots of different parts of government and people who hold on to various parts of data.

Of the other types of information we have, the Tasmanian Population Health Survey is a telephone based survey that gathers information on various health risk factors and outcomes.

Mr JAENSCH - Landlines only?

Dr GALL - Yes, it was a landline-only survey, which is one of the -

CHAIR - You don't get many young people that way.

Dr GALL - Yes, and there are some that questions about who you miss out by doing it that way. It is cheaper to do it that way. It is not to say that it is not valid; it is valid, it may have some limitations, one of the things that we are worried about when we do research is: who are the people we have in this survey and how might they differ to everybody else? By gathering enough information on those other things like where people live, their socioeconomic status and so on, we can at least make some inferences about how likely we think this represents everybody. Obviously you are missing some people. They can include mobile services but it costs a little bit more.

It is important that once you are using, for example, a particular set of questions, that at least a subset of those are continually used across time so that you are comparing apples with apples across surveys, even if some of the questions change as what we are interested in changes as well.

CHAIR - In this whole area of data, which I think is really important, how important are electronic health records to this? I am not just talking about scanning PDF files and sticking them somewhere. I am talking about true electronic records where there is live entry and live access. How important is the sharing of that data across health professionals, whether it is the Launceston Hospital, Royal Hobart Hospital and the GP out at Beaconsfield or somewhere?

Dr GALL - That is certainly part of it. If it were fully digitised that would make it simpler to do a lot of these things. I guess because Tasmania is quite small, people can do a lot of it anyway, from a research point of view, but also from the view of being able to share the information more easily, electronic based records would make that a lot easier. There are barriers to people, including the people who own the information; we want to share that information.

CHAIR - As far as the ownership of the data, and I may be wrong about this, I understand that the GP owns your GP record but you can ask for that to give to another GP or whoever, but who actually owns the data?

Dr GALL - I am not quite sure of that either, it is not my area of expertise. I assume it would work in that way.

Mrs TAYLOR - My question was going to be before this but it is related to this. How much do we use modern technology like you do in research across the whole field? When you are talking about how to survey people these days, it is actually easier to survey them and you get greater response from certain sections of the population at least, if not all of us, just by a text question. How stuck are we in not using these?

Dr GALL - It depends what you are doing. In studies we do within the institute we use a variety of different ways of gathering information. One of the studies I work on is called Childhood Determinants of Adult Health. It is an Australia-wide study that has followed people since 1985 and they are now between about 35 and 45 years of age and, to connect to what you are saying, we thought everyone would want to do an online questionnaire. No-one wanted to do it - about 20 per cent of people did the online survey. We had to either call people and physically ask them the questions or send out very large paper based things. It surprised us and they were slightly younger then so the people were between 25 to 35 when we did that. We were really surprised.

Mrs TAYLOR - That doesn't surprise me because none of us likes the long stuff that comes with all of that. A text question of just one question, I would always answer quickly.

CHAIR - I would wonder if it was legitimate if it was just one text question.

Dr GALL - What we find with the types of studies we work on is that people have a relationship with us and the research we are doing.

Mrs TAYLOR - Yes, if you knew where it was coming from and you would say, 'We're going to send you 20 questions out in the next 20 days. Here is question one.'.

Dr GALL - Even when we were in that situation and we sent people a very brief online survey, they still tended not to complete it and we had to call them and say, 'Can you complete it now while I'm talking to you and it will only take five minutes.'. That is how we managed to do it.

Mrs TAYLOR - Okay.

Dr GALL - It varies, depending on the setting. People tend to think, 'Oh, it's in my inbox, I'll do it later'.

Mr VALENTINE - They are all too busy.

Dr GALL - They forget about it, so once we get people on the phone we know they are there and they can complete it.

Ms O'CONNOR - Dr Gall, the conversation about preventative health in Tasmania has been happening for quite a long time and yet we have these persistent, chronic disease issues and really hard to reach cohorts of the population. work. It might fall slightly out of your space, but what is the best practice, preventative health communication mode? How do you reach really hard to get at populations who might be dispersed by rural or regional geographics, or dispersed by socioeconomics. How do you engage with those more at-risk communities in an effective way?

Dr GALL - The way that the research is generally conducted, as in specific conditions and specific risk factors, different things are shown to work in different ways. With more disadvantaged communities, peer-based models seem to work better. I am familiar with in terms of tobacco control through things like the Tasmanian Aboriginal Centre and that sort of model, where they take it on as a whole organisation and it begins with peer-modelling of smoking cessation, for example, by the people who work at the organisation and then it filters through. That community and peer-based approach seems to work in that kind of setting for tobacco and that is also the case for other conditions.

Physical activity is one of the areas that some of my colleagues work in. Verity Cleland, one of my colleagues, did a review looking at interventions for physical activity and socioeconomically disadvantaged women, quite specifically.

One of the things that worked there were walking groups like the Heart Foundation Run where you get a group of people together and it seems to be about that peer environment

where that kind of thing works. People tend to do things in their own little area so bringing together what works can be more challenging.

Ms O'CONNOR - Thanks for that. I am also trying to explore with you the different kinds of engagement. You can have health prevention messages that some of us might view as hectoring or lecturing, and I hear what you say, because Glenorchy On The Go is a fantastic example of a place-based approach to preventative health but what is the best practice in communication even about preventative health messages.

Dr GALL - That is one of the things we probably do not know everything about at the moment and one of those questions about how do we do this, and there are arguments about whether these target approaches really work at all. In the tobacco theory that I work in, there is some evidence that targeted programs in particular areas do no better than widespread campaigns aimed at everybody. That debate goes on.

There are issues in certain sections of the community in terms of literacy and numeracy and their ability to even understand the messages that are being conveyed. That is one of the areas that probably has to be looked at.

Across various avenues, it is agreed that just giving people pamphlets of information doesn't work. You have to do much more than that. Tied to the whole of government approach, is it is not just at the individual, you have to do all these other things around people to make it possible for them to change their behaviour in a healthy way.

Ms O'CONNOR - And by their own choice.

Dr GALL - Yes. A lot of the messages can be very stigmatising for people in these situations. Drawing on the tobacco thing, which is what I know a lot about, the more we make smoke-free areas, and so on, there are groups in society that become more and more marginalised by their smoking behaviour, and that is something that needs to be considered and how to topple that.

CHAIR - Talking about whether the smaller programs work, I was at a forum in Fiji last week, looking at domestic violence and violence against women, and the new government there has established a zero tolerance to violence program within communities. They have small villages, and we visited one chosen by the government - so they are probably doing okay. One of the things the village had agreed to - the men and women together - was the zero tolerance to violence, and some training about managing anger and disputes between couples.

They also decided to cease all use of kava and tobacco for two months. I said, 'How's that going?'. As well as zero tolerance to violence that is a pretty big ask in one year. It was toward the end of the two months, and these men, particularly, are very heavy smokers, and they just stopped. You could smell cigarettes if someone was smoking in the village but they said no women had been sent to hospital and no men had been sent to prison, which is the only measure you can measure in a short space. It was interesting that was community led and driven. I will be interested to see how that works over the longer time.

Dr GALL - In the Thriving Tasmania report, and using the community level thing, is what they were talking about, that partly you need to engage the community to understand what they think, want and need. That is half the battle, finding what the issues are that need to be solved in the community and then working with them to develop interventions across the different parts of the community that need to tackle those problems. Then built into that, the evaluation of what you are doing, and understanding what you might measure to figure out whether it has worked in the end.

Mr JAENSCH - I refer to the first point you addressed. We are very familiar with the language and the idea of social determinants of health and the various housing, status relationships, social inclusion, literacy, education, access to - those suite of things. As I go through the literature and various submissions, we are saying social determinants of health as almost like one word, which everyone nods and agrees at. It explains that there is this raft of factors that tend to travel with poor health and somehow create each other.

On one hand, the social determinants of health story is one of a clustering of statistics. What research have you been involved in, or aware of, that goes into detailing the relationships between those statistics that travel together? The reason for asking this is that after establishing there are social determinants of health and they are causative factors, and that government needs to respond, we then look at governments. It is already investing in housing, literacy and education, planning and the built environment, and a whole bunch of other things. If we are going to have a response, we need to be able to identify what it is about housing - I know that that might apply differently in different places but if we are going to start to even incrementally modify the housing budget and policies towards creating healthier environments, what do we know about what we need to do to housing to make it better? Are we across that or do we just know the statistical relationships?

Dr GALL - Housing and planning is not my area of expertise unlike, for example, in education where I have done work in understanding the relationships of why low levels of education are associated with poorer health behaviours[?!] in children and adults and so on. It is very complex with something like education but it is linked to lower literacy and lower numeracy, which means you have a limit and less understanding of the risks and so on associated with your behaviours. It is also the groups you are selected into by being of lower socioeconomic status and the social norms theory is that you are surrounded by people with these other unhealthy behaviours, for example, so you are more likely to model them and take them on.

As for what do you do to improve these things or make things better, one of the areas that we have done work in is looking at the role of: if you happen to get more education than your parents have, what impact does that have on your health outcomes and health behaviours as an adult?

Certainly we have found that people who attain higher levels of education than their parents go on to have better health behaviours and better health outcomes than people who have about the same level as their parents.

Mr JAENSCH - It is a statistical thing again, isn't it?

Dr GALL - When you say that, what do you mean?

Mr JAENSCH - What I am interested in is - and it is through the journey of this inquiry and whatever becomes of the information it provides - beyond having a better understanding of the social determinants of poor health outcomes, how do we start to write the story about the enablers of better health, and what would you do in each of these areas to influence or foster an improved health outcome that we are not doing now? Or in what priority order, or what weighting do we give certain aspects? That is what I am looking for.

Dr GALL - Obviously it is so vast that it would be very difficult to do. For example, a very simple thing that we often talk about and we work on with people in the Faculty of Education is that education would be transformative for people in so many ways, and so ensuring that as many people complete as much education as they possibly can will be very important for reasons that we probably do not really understand.

For example, a very surprising research outcome from developing countries shows that if you put young women into schooling for even a few months and they go on to have children very shortly after that, the children of the ones who have even only been at school for less than a year have better health outcomes than those who had never been to school. There are so many things we do not know about being in a community of people, being around people, understanding the way you go somewhere and you do something and you are expected to achieve these various things - that all has immeasurable influences on people. Therefore the specifics in every different aspect of the social determinants of health will be very different.

Mr JAENSCH - That is the sort of insight that I would like to explore as we go through this as we are hearing from many people. In a minute there are going to be a bunch of people here who will tell us that if everyone rode bikes we would be fine. There is someone else who runs Heart Foundation walking groups who is pretty sure that if everyone was part of a walking group the evidence shows that we would be fine. With education, one of the things you have mentioned is that there are a whole lot of things we do not understand yet that seem to be working. It seems to be a solution as complex and mystical as the problem appears to be, and that is starting to match up quite well. If we are going to do something, we need to be able to get through the enormity of social determinants and the inevitability of all those things and try to grasp some action out of that. It is a big challenge. I guess the ultimate thing is that across all these different areas, there is an evidence base of what works in physical activity and smoking and so on. It is important to make sure the investments that are being made are being made in things that are evidence based. Often the decisions made on policy are not made based on evidence. They are based on other things; we understand, from a pragmatic point of view, that people make decisions in government for many reasons, not just because you know it is going to work.

Dr GALL - If you look in the scientific literature, people spend years bringing together all this evidence and saying this is your best buy and this is known to be cost-effective; if you invested in this, this would work. But there are also hundreds and thousands of examples of nobody actually using that information because you have to do all these other things to get it implemented.

Mr JAENSCH - It might be that you are getting the Education budget to pay for something which will turn up as a saving in the Health budget in 10 years' time.

Dr GALL - Yes, and that is one of the challenges of this 'health in all policies' thing, but in many ways it also has its advantages. You are getting outcomes from one area that you did not really count before as being a potential outcome - say, increasing the proportion of people who have finished school or attained different levels of literacy and numeracy can be linked to other health outcomes. That is a win for everybody.

CHAIR - And better health will often result in a better attendance at school, too. We are a bit over time, probably go to Bec.

Ms WHITE - Dr Gall, I wanted to ask something in relation to your specific area of knowledge about tobacco. Has the Menzies Research Institute done any work around e-cigarettes and the potential impact they have on somebody's health because e-cigarettes are not very well regulated? Also, the impact that might have on normalising smoking in groups of people amongst whom we have been trying very hard to denormalise smoking. Have you done any research on the impact of e-cigarettes?

Dr GALL - It is an area that people are just starting to get into. The Cancer Council have done a survey over the past couple of years looking at various smoking behaviours in the Tasmanian population. As part of that, they have collected information on e-cigarettes, which they are beginning to look at. Many people have heard of them but not many people have used them. I am trying to think if that information is on there website yet; it might not be but I imagine it would be in the future.

Ms O'CONNOR - Which website is that?

Dr GALL - The Cancer Council of Tasmania in their smoking and health survey. It is one of those areas that I think people just do not know yet and that people are starting to get into, and trying to understand how people are using these products and what they really mean for smoking. Many people in tobacco control are very worried about exactly what you mentioned, that these are going to denormalise it again. There are movements to try to include e-cigarettes in what we consider in the legislation as just cigarettes at the moment, which would then mean they cannot be used in smoke-free areas. That would help with that message that this is essentially a cigarette for all intents and purposes.

Ms O'CONNOR - Is it?

Dr GALL - That is right - this is one of the problems about it, trying to understand what it is and how people are using it and the contents of it.

CHAIR - It has nicotine in it; it does not have the carcinogens, I understand.

Dr GALL - Yes, but as you are saying, they are not regulated. Many people have no idea what is in them.

Ms WHITE - The Therapeutic Goods Administration has concerns about what is in them. Have you, in your field of expertise, started to look at this more deeply yet?

Dr GALL - As I said, the only involvement I have had to date is through this Cancer Council survey. That is one of the areas we are analysing at the moment to see what the status is in the Tasmanian population. From memory, it was less than 5 per cent of people who had used them as of last year, it was very low usage at the moment. It is an area of research that people are becoming a lot more interested in trying to understand if there is any safe and useful way that they can be used. Anecdotally amongst smokers, many people say it is very useful in helping them to quit but whether that is true or not, we do not know.

Mr VALENTINE - Isn't the big issue there that you can get different types of capsules, some have nicotine, some don't. So that is the normalisation statement.

Dr GALL - Yes.

Mr VALENTINE - Kids are encouraged to use the flavoured ones - no nicotine. It is that sort of thing?

Dr GALL - That's right. Then whether that transitions those people to, at some point, using cigarettes is what people are concerned about. The other thing that a lot of people are not aware of is that it is the tobacco companies that are trying to buy or own a lot of these companies that have manufactured e-cigarettes. Probably more promotion of that fact to help people understand.

Mr VALENTINE - Mind you, even if they don't have nicotine in them, they could be harmful anyway.

Dr GALL - That's right, there are all these other health effects. It still emits a vapour, people are inhaling it - not just you, other people around you and what effect does that have. It is an evolving research.

Mr VALENTINE - It is a very important area, I agree with you.

CHAIR - Dr Gall, unless you want to make any closing comments, thank you for your time and expertise in this area. It has been quite helpful.

Dr GALL - Thanks a lot.

THE WITNESS WITHDREW.

PUBLIC

Mr ALEXANDER BROWNLIE, PRESIDENT (TASMANIA DIVISION) AND **Mr ROBERT JOHN NOLAN**. MEMBER OF COMMITTEE (TASMANIA DIVISION) PLANNING INSTITUTE OF AUSTRALIA, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - This is a public hearing. It is being transcribed by *Hansard* and the transcription made publicly available on our website. You are protected by parliamentary privilege while you are before the committee. It does not extend once you are outside the committee, so if you speak to the media it does not extend to that. If you have anything you want to provide to the committee in confidence, you can make that request and the committee would consider that. Otherwise, it is all part of the public record and we will be reporting in due course. Do you have any questions at this stage?

Mr BROWNLIE - Not on the process, no.

CHAIR - Thank you. We have your submission, and also the submission that was provided by the Planning Institute for the last committee, which disbanded at the election and has been since reformed. Would you speak to your submission and the members will have questions following that. Would you give some background about who you are and then speak to your submission?

Mr BROWNLIE - I am Alex Brownlie, current president of the Planning Institute of Australia (Tasmania Division). I am a planning consultant and work with GHD, multi-disciplinary planners, engineers, architects and the like.

I have a few introductory comments to make. Rob, perhaps if you introduce yourself. Rob spoke to our previous submission a couple of years ago.

Mr NOLAN - I am Rob Nolan, town planner and life member of the Planning Institute of Australia (PIA) and member of the Tasmanian division of the Planning Institute and probably had a primary role in preparing this submission and the previous submission.

Mr BROWNLIE - Thanks Rob. As indicated, we stand by the previous submission made a couple of years ago and we have sought to elaborate a little further in this current submission.

By way of background, the Planning Institute is the national body representing the planning profession. Through communication, education and professional development, we seek to support professional planners as they go about their role in creating sustainable communities.

PIA Healthy Spaces and Places website, which is a manual and training for our national program, was developed as a unique association between the Australian Local Government Association, the National Heart Foundation of Australia and the Planning Institute. It is aimed primarily at the local government employees and it is about the link between health and planning. We see that as an important way forward.

PIA was also one of the key contributors to Healthy By Design which was produced by the Heart Foundation in 2009. It was one of the key bodies of work that were undertaken prior to the previous submission in 2013.

Given Rob spoke to the committee last time, I was going to ask Rob to continue in that vein and I will chime in as we go. As Rob has indicated, he was the primary author of the work that we have put in.

Mr NOLAN - Chair, if you are happy to work our way through the submission made?

CHAIR - Yes.

Mr NOLAN - Thank you for confirming the previous submission and also the evidence of the hearing in front of this committee. We do not seek to make any corrections to the earlier submission. Through our 2013 submission - I have a tick to add to that - we continue to adopt the evidence and opinions of health professionals about rising rates of chronic disease and the continuing factors of a sedentary living, ageing population, and the significant portion of the population of lower economic ranking, and poor health.

In effect, we would like to take the evidence that the various bodies with the empirical work that is done and apply that to the built environment. Therefore that evidence of the health professionals that hopefully you are hearing from, we adopt where that contends that the social determinants as opposed to individual responsibility and choice, are major factors contributing to poor population health.

In our submission we summarised the main points from the earlier submission and I will go through those as there is some advantage in doing that.

CHAIR - Yes.

Mr NOLAN - We say the built environment is a key determinant to longer term improved health outcomes. The built environment, that is where we do most things, where we live, we work, we learn and play, where we move, and it is the sum-total of those things that make up the built environment.

Healthier communities are central to the planning processes and a theme through this exercise is that planning should be more about strategic outcomes and whole of government processes rather than where people seemingly like to put planning in that basket of planning schemes, approvals, and tribunals and such like. There is a bigger environment for planning that we endorse.

The Resource Management and Planning system objectives for sustainable development emphasise that whole of government approach to planning and we can elaborate of that if need be.

We say there is an economic imperative to address the social determinants of health. If you are unhealthy you are not employable. Absenteeism is high and you lose the capacity to be a productive member of the community. Planning of cities and towns can address many aspects of the social determinants of health and contribute significantly to improve in the health of communities.

There are various catch-phrases that go with that like liveability, liveable communities, walkability, sustainable cities, healthy cities, healthy communities, walking more, riding

more - Roger? I think you mentioned that earlier - it might be part of our submission as well.

Mr JAENSCH - You are going to hear more.

Laughter.

Mr NOLAN - The health of communities and the corollary preventative health care should be the focus of governments at all levels, in that it supports the current government's push for having the healthiest population by 2025. It is a bold objective but gives something to target for. Courageous, but why not?

When it comes to health, it is not just hospital waiting lists. Is it true that waiting lists are a product of an unhealthy population because they are not sufficiently healthy to operate on?

CHAIR - There are two aspects to that which can equally influence it.

Mr NOLAN - The waiting list goes on - you are not healthy enough to operate on so you go to the back of the waiting list and so you never the solve the waiting list. The key point is we are trying to keep people out of hospital and out of acute care.

The social determinants of health must gain better traction than the Tasmanian planning system. I mentioned earlier the Resource Management and Planning system objectives - and they apply across 19 pieces of legislation relating to planning and resource management. It is a whole of government obligation.

Proposals for the use and development of land should carry an onus to demonstrate health and wellbeing benefits of the proposal. This seeks to find an alternative to just reading rule books - can we move to a desirable position where the onus is on the applicant or the person providing particular activity to demonstrate that health and well-being benefits from the proposal. Not one size fits all, not one regulation or standard cut is the ground, but this particular view is contrary to current administration of planning.

We hope the recommendations of this inquiry can be pivotal to addressing the social determinants of health. We put a strong view last time that policies for healthy communities should be embodied in the planning system through a state policy. This would seek to have health integrated into decision-making at all levels of land use planning, including the strategic and permanent assessment.

We say a state policy because a state policy is the only mechanism for the imprimatur of parliament, in terms of policy settings, activities and aspirational aspects of what we are trying to do. To push the case, a state policy does bind the crown and councils in terms of their own activities, not just what they require other people to do.

Turning to the 2015 submission, we focus on terms of reference 1 and 3. We try to get a guernsey under those two terms of references but we do not fill the full statement of those terms of reference. For instance, in terms of reference 1, we do not go into the capacity of health and community services to meet the needs of populations adversely affected. Similarly in terms of reference 3, we do not go into consideration of funding models. But

if our submissions fall short of terms of reference 1 and 3, hopefully it can be captured under terms of reference 6 - any other matter incidental thereto.

It is a big picture we are trying to paint and it would be a shame if we are confined to those matters that are about funding models et cetera.

Term of reference 1: we reiterate that the built environment contributes to inequities in Tasmanian communities and is a major factor in improving the social determinants of health. When you see the sins of the past, where we have put people of low incomes in isolated settlements, maybe it is not so much the problem of where they are but that they are isolated. In the Tasmanian context, unlike other places because of our very slow growth, the bits in between have not been filled, which was always the intention. If you look at Rocherlea or some others, the roads never really connected up, nor did the footpaths or anything else. That is where a lot of issues come to a focus.

We also submit that health and the built environment affect both physical and mental health. Sterile, impersonal environments can have negative effects on mental health. It is interesting that the current work on the affordable housing strategy is looking for measures to not only increase access to houses but also improve the liveability requirements for successful housing.

A built environment that focuses on preventative health would enhance the capacity for health and community services to meet the needs for populations adversely affected by social deferments of health. We cannot avoid being in the area of repair and retrofit and improving the public spaces we have, to concentrate on making local communities more liveable, and streets that are walkable. There a lots of areas where they are not walkable. Footpaths are not provided, or where they are provided they are inadequate and not continuous. Parents are reluctant to let their kids ride to school.

Why don't we have traffic jams during school holidays? The new school at Port Sorrell is a good example. There has been good take-up of kids riding as opposed to being delivered. What in the built environment there encourages that?

Ms FORREST - It's flat.

Mr NOLAN - Yes, but there must be off-site infrastructure, something about the paths to the school, whether on roads or footpaths, and it is safe and the parents are happy for their kids to ride.

It is also about improving access to facilities and services, particularly out of hours. When you move to a point where you cannot rely on someone else to drive you or drive yourself then you are vulnerable. Reducing barriers to walking includes things like poor lighting, amenities for walking long distances - providing rests and toilets - poor pavements. If you are able-bodied you might have trouble walking safely in some areas. If you are not able-bodied, in a wheelchair or on sticks or using a frame, you are in big trouble.

They are examples of more immediate things that could be addressed. We are after a longer term change of focus from where we are now to making health and wellbeing the focus of activities by government, because there are a whole lot of means to ends but we

see this as probably the ultimate end if you have a healthy population. Part of the journey is being more active and providing facilities to facilitate and encourage people to be active.

If things were working well and everything we were doing was appropriate we would not need this government inquiry committee so there is something wrong and we know that.

If you are going to have built environment for a focus on health outcomes, we can look at the walking and cycling routes that are well planned and are appropriate for use. Streets with directed, convenient access to services, local destinations within walking distances of homes. That starts to build up the picture of increasing densities of urban areas. Access to open space for recreation and leisure. Some parks work better than others, particularly about distribution and how they are developed and the family make-up of the particular community and the ability of that park to operate over time.

Convenient public transport stops, local neighbourhoods offering social inclusion. They are the sorts of parameters around the terms of reference one, that we would like to put to the committee.

In terms of terms of reference two, structural and economic reforms through the lens of health and the built environment can facilitate the prevention or reduction of these sorts of ill-health and poor wellbeing. I mentioned earlier that if you are not healthy you are probably not very employable which is very much about how the economy can be stitched together.

Civically, policies addressing the built environment and health to encourage and facilitate physical activity would change many of the conditions conducive to chronic disease and I would like to see some of that emerging evidence of the co-benefits from an active, friendly, built environment and those co-benefits are physical health, social inclusion, safety and injury prevention and environmental sustainability.

In the 2013 submission we advocated for a state policy under the State Policies and Projects Act 1993 to bring about the changes to health and wellbeing through the built environment. This 2015 submission takes that and looks at some of the rhetoric and strategic settings under a state policy.

Part 4, or paragraph 4, of our 2015 submission we talk about the integration of land use and transport and here we seek to have the built environment arranged so that active travel, walking, cycling and public transport functions effectively. The operative words are 'functions effectively'. It is facilitating as well as encouraging, so that brings in that area of access to healthy food and there are significant areas emerging in Tasmania that does not have access to healthy food.

Access to workplaces and the fact that a considerable proportion of the population is transport dependant or, more to the point, travel disenfranchised which results in social exclusion. Our earlier paper referred to some 50 per cent of the population is transport disenfranchised, in that for those who rely on others for transport, mostly parents and other members of the family, buses, because they are too young or too old or they have lost their licence or cannot afford it and all those reasons for relying on others. The whole host of stuff around land use and transport that is available but still not fully

developed. Part 5 seek mechanisms, including appropriate pricings, to facilitate consolidation of urban settlements, providing for or allowing whatever is required, to encourage mixed residential development. A compatible mixed use, particularly so more immediate needs are in closer proximity to where you live and exposing not so much planning for infrastructure provision.

In the literature there is reference to obesity promoting low density car-dependant development. We seem to be in some ways encouraging it as opposed to not encouraging it. Most of our lower density subdivisions could be described as obesity promoting, low density and car-dependent.

CHAIR - There must be an acronym for that.

Mr NOLAN - We have to work on that. There is the view that if you are out in the country you are going to be healthy because the air is fresh and you are very active, clearing the scrub and mowing the grass. It seems the greater truth is that because the only way to get access is to drive, you drive from when you leave the house to when you arrive at your destination, and you spend most of the weekend taxiing your kids around, it loses some of its gloss.

Interestingly, in Australia it seems to be that better health outcomes, on the measures, are from the bigger cities rather than the regional areas. That is how those price signals can start to change where and how development takes place. In part 6 we get down to more detail of land subdivision and how the design of streets can reduce or increase in equities. We seem to view subdivision as something which is routine, ordinary and quite bland, and that all seems to be as a result of how we do it and don't perhaps give sufficient time to what that street means.

A street, once it is in is probably there for all time. We still have Roman roads in some places so it is hard to change once it is there. Cul-de-sacs that do not allow connectivity across overheads and require a long move around to get anywhere, those sorts of things are very hard to change. It is hard to put pedestrian links in later when we avoid doing them now.

For instance, I draw attention to the Local Government Association of some 20 councils subscribed to some Tasmanian subdivision guidelines which are essentially engineering based which have a high degree of responsibility for the boring subdivisions that we have that provide for streets that do little in terms of pedestrians or walkability or safe cycling. Also in part 6 we talk about the Local Government (Building and Miscellaneous Provisions) Act 1993, which was a bit of a leftover from the suite of legislation in 1993. That is legislation that does not have much left in it but it does have a provision for public open space, and public open space there is based on subdivision of land. It is based on 'take at once'. It does not apply to the intensification of land and one would assume that a requirement for public open space increases the level of intensification. There is not the ability to take any form of public open space or what we call cash in lieu of public open space to provide it elsewhere for strata development - and we are limited to 5 per cent.

Without suggesting what it should be, it is probably useful to see that in South Australia, for instance, they talk about 12.5 per cent of land, and for smaller subdivisions and strata

developments and so on, that goes into a planning and development fund. I do not know but I suspect that our urban areas - Launceston's, Hobart's, Burnie's and Devonport's - do suffer because there is no real regional fund for doing those things that make up a much more liveable community.

Part 6 at 6.3 talks about contemporary guidelines for the built environment. One thing that is clearly evident is that there is considerable material on how to do it and how to do it better from everywhere. Some of that may need to be tested for being contemporary and tested for local conditions as required.

The trouble is that a lot of these examples are good examples for where they come from and they are not usually amenable to being reduced to some sort of planning scheme standard. Clearly not one size fits all.

That is probably where we get to in our primary submission, apart from where we draw some conclusions.

Mr BROWNLIE - Just to add, while it sounds like doom and gloom, there has been progress. Through the planning reform process we have been going through for the last four or five years, and the push for preparation of regional plans, there is a recognition of many of these elements we have talked about and the need to think carefully about how to construct your schemes. Although I think we recognise many of the points that have been raised today, it is the implementation of those through the planning scheme. There are some good examples of councils moving forward. I am very familiar with Launceston. They have made great use of the Urban Mixed Use Zone supporting the CBD. The intent is to get a greater mix of uses, increase residential densities, bringing people back into the city and the vibrancy that that adds to the city. I guess over the next decade that will bear some fruit.

Rob talks about subdivisions. Increasingly we are seeing master planning occur before the surveyors come up with their subdivision plan. There is some thought about how you might plan an individual subdivision, how you look at the landscape, look at the road, footpath and cycle networks connecting with areas, and looking at what other uses might be encouraged in those subdivisions. I think we are seeing some things coming through. One recent example is of the Glenorchy City Council, the Hobart City Council and Department of State Growth looking at a pilot program identifying areas for high-density development on the Brooker Highway corridor. I think these are isolated examples of where we are starting to think about health outcomes and what we can do to bring vibrancy back to the city. We have to continue to build on those successes - hopefully they will be successes. I guess we recognise what needs to be done and it is really, how do we implement those changes?

CHAIR - Thanks for that. Is there anywhere, in your view, in the state policy approach - whether it was in another jurisdiction of Australia or another country - where they seemed to have got it right?

Ms O'CONNOR - What about Melbourne? What about some of the work that Rob Adams did?

Mr NOLAN - Central Melbourne is great. It comes in very high in the liveability stakes.

Ms O'CONNOR - Just central Melbourne?

Mr NOLAN - Central Melbourne, and Adelaide is great, what they have done there with the street cars. Internationally, I suppose all cities have their good points and bad points.

CHAIR - There is no shining example that you can look at?

Mr NOLAN - Not particularly. I think very few are saying about the state policy side, from where I see it, that there is a mechanism available to Tasmania that is not available elsewhere. We already have here now MPS objectives - reference to 'social, economic and cultural wellbeing' and 'for health and safety' - words like that. In other states are trying to get those sorts of words into their planning legislation.

I think under the previous Queensland government they tried to pool together a lot of state policies into a single state policy. Everyone does it differently, it seems.

CHAIR - Places like Copenhagen and Vienna often win awards for their smart city approach - which is not just about planning, it is about liveability of the city, if you want to use that word. Are you aware of any particular area that seems to have found a formula that works?

Mr BROWNLIE - I think one of the benefits of many of those cities are the densities that they already have. They already have people living in close proximity and therefore you have to think very carefully about the road connections, the cycling, the open space that you provide. We suffer the tyranny of low-density development and absolute reliance on cars.

With Melbourne there was a very conscious decision - 'We are going to increase the density in the city', and so through various means they went about building the blocks to make sure that happened and the result is a much more vibrant Melbourne than probably 10 years ago.

Ms O'CONNOR - Sorry to interrupt, but wasn't the planning also around transit orientation development and that was, for political reasons, was walked away from a bit but all the planning has been done about how to grow Melbourne sustainably.

Mr BROWNLIE - Yes, that is right.

Mr NOLAN - And we can. There is Copenhagen, there are some of the Dutch cities, there is Portland in Oregon, US and what they have done there, to name a few.

CHAIR - I have looked at some of these websites and see what they have done.

Mr VALENTINE - We have a lot of questions we could ask you but we have not enough time for that. I am interested to know what needs to be fixed in local government and state government collaboration to really address these issues. Is the legislation good enough? Does it give local government enough power to be effectively designing spaces to get good outcomes, or do developers simply have too much free range, in your opinion? It is important how much collaboration there is between state and local

government. This is a state government committee and yet, it seems to me, reading through your submission, that local government is where all the action really needs to be, and should there not be more collaboration? If there is something that needs to be fixed, what would it be?

Mr NOLAN - Yes, there needs to be more collaboration. Where we were before, and we reiterated it in this submission, was that the state can do a lot in terms of its own activities. The state policy is one mechanism for bringing that together and ensuring that as it applies to agencies those agencies would need to look through whatever their activities are, their budgets, and the budget submissions and so on, in accordance with that state policy.

The difficult has been is that the state policies we have, which are only three, the state did not take it as a state interest. It took it as essentially an impost on local government to sort it out. That is what we are trying to get away from. Each has its role and the implementation is probably best left with local government. Without collaborative arrangements and those aspirational things put in place, everyone seemed to operate in a vacuum and searching for good ideas, never getting the picture of where we want to take the state.

Mr VALENTINE - The levels of government all have their own areas of operation but do you think it is time that needs to change in order to get good outcomes so that you have state government consulting with local government in forming their policy, effectively. Is that something you see as requiring more attention?

Mr BROWNLIE - I think it is essential. We have acted in a policy vacuum but there needs to be much direction from the state in terms of a suite of state policies - this being one of them. It needs to set the framework within which local government then produces its regional plans and then its individual municipal plans. There needs to be better arrangements, better resourcing, from the state in terms of driving that process. At the moment, the commission and others are so caught up in getting these new suite of schemes through, that we do not have that direction we are after.

Mrs TAYLOR - Has the Planning Institute had input into the single statewide planning scheme? The things you are saying need to be translated into local government, having the capacity and the power to -

Mr BROWNLIE - We have been invited, and I will be sitting on a steering committee that has input into that.

CHAIR - You haven't yet?

Mr BROWNLIE - Not yet, no. We have not seen anything.

Mr NOLAN - There are members of the Planning Institute on the steering committee.

Mrs TAYLOR - There are?

Mr NOLAN - Yes, but not representing the Planning Institute.

Mrs TAYLOR - Right.

CHAIR - They are bringing their expertise but not as representative.

Mr NOLAN - That's true.

Mrs TAYLOR - Would they be bringing those same ideas, as you have said, to be built into that statewide planning scheme?

Mr NOLAN - The real issue there is that the statewide planning scheme is essentially a planning scheme and a book of rules.

Mrs TAYLOR - So it does not have the things that you have been recommending?

Mr NOLAN - And each planning scheme would probably have somewhere written in it that we would look for the health and wellbeing of communities. Yet, we see the result out there that we do see, and that is what we are talking about, the change of emphasis, but also looking to see that planning is not just the responsibility of local government and planning schemes to deliver that stuff on the ground, it is the responsibility of all levels of government in their own particular bailiwick but also trying to break down some of those silos.

Mrs TAYLOR - I had the experience in local government where the developers say, 'I don't have to do that because your scheme doesn't say 'you have to', it says, 'we'd like this'.

CHAIR - So a state policy.

Mrs TAYLOR - Yes.

Mr JAENSCH - Has someone said about drafting a state policy along these lines?

Mr NOLAN - I probably neglected to say, but I have been trying to avoid saying it, that I am employed by the Heart Foundation to do just that. It has been a work in progress for some period. As Alex opened by saying, there has been strong collaboration between the Heart Foundation nationally and all state divisions, so there is a lot of commonality there between the two. Through the Heart Foundation we have been seeking support and collaborating with others with what might look like a state policy we are at the moment calling 'Healthy Places and Spaces'.

Mr VALENTINE - Is that at a stage or format where your client - the Heart Foundation - might be prepared to share it with the committee?

Mr NOLAN - That would be a very good idea. The Heart Foundation is appearing as part of the health policies collaborative. This has been in preparation for some period and has previously had the support of the Premier's Physical Activity Council. It has developed a bit further than that in terms of the Heart Foundation's own acts for this. It need to be recognised. It is interesting that a charity should take on this work because it believes it is important. It is probably in an area where the government has not really taken the initiative.

Ms O'CONNOR - Are you aware of the work done by the State Architect, when we had that position, on the residential development strategy, which tried to imbed liveability principles into all future housing developments?

Mr NOLAN - Yes; when I was with the Tasmanian Planning Commission he was in the office next door.

Ms O'CONNOR - So often in public policy we reinvent the wheel and produce another report that says many of the same things that a previous report said. A lot of good work has been done of liveability, but translating it into planning schemes seems to be a sticking point. What is you view on whether we have a cultural issue in what we value in our environment? In New Zealand, even their really disadvantage suburbs are planned. They are aesthetically attractive places. How do we need to shift that culture, not only at a state level but also at a local level where we value urban aesthetics and green spaces? Is it a state policy?

Mr NOLAN - State policy is a mechanism. Most legislation is about regulation, what you can't do or don't want people to do. A state policy enables aspirations, promoting where we want to be. It binds people onto it, even though they may be more aspirational, which is not operational, not something you can take court action against, but it sets those principles. When through the Planning Commission I was looking a planning directive for residential development, the arguments were, that's all very good but where is the policy background - to increasing density, about open spaces, and improving accessibility. There are a number of ways of doing that. The most routine way is through a report that ends up sitting on the shelf because it does not have a mechanism for implementation. Or, it is a small 'p' policy which can be changed tomorrow. The beauty and difficulty of a state policy is that their approval goes through a rigorous process, but once in are very hard to change, and there is some longevity of those policies.

Ms O'CONNOR - In budget Estimates last year when the Planning minister was questioned about state policies - the same applies to the previous planning minister - there seems to be a move away from state policies by successive Tasmanian governments. We have not created or implemented a state policy for a very long time. I want to see this Heart Foundation work progressed to the point where it could be developed into a state policy, but how do you change the thinking of government, which has determined that state policies may be a thing of the past?

Mr NOLAN - I would like to think there is hope on the horizon because in the last couple of years state policies have come much more into public commentary. For instance, at the last state conference the Planning Institute held in August last year it was clearly on the table. Minister Gutwein has talked about state policies and we have not heard a minister talk about state policies for a long period.

Mr JAENSCH - Statewide planning principles.

Mr NOLAN - The Liberal Party went to -

Ms O'CONNOR - He has not committed to state policies.

Mr NOLAN - No, but he has talked about state policies. At the TCCI breakfast a little while ago he talked about state policies.

I think the problem is in many ways the bureaucracy but if we are ever going to get a state policy up, this is probably the year to do it because it is still the second year of the four-year term. It is a good time.

There are a lot of threads to develop out of what you just asked there. What needs to be clear is, the State Policies and Projects Act really tried to make planning a function of the state government, not the Land Planning Approvals Act, which is more about local government and all the others. The intent for the resource management and planning system was to fill that vacuum that existed pre-1993 and now post-1993 when that suite of legislation came in, to give a planning function to what the state does in terms of its own activities.

Ms O'CONNOR - And give direction to all levels of community.

Mr NOLAN - What we have done since, as you said, the ag-land policy was I think in [inaudible], the coastal policy was in -

Ms O'CONNOR - 1996.

Mr NOLAN - The good thing about it is, it is still there.

Ms O'CONNOR - Yes, I know.

Mr NOLAN - For instance, when I was working with the Planning Commission and we were doing hearings on planning schemes I could at least say the state has an interest in agricultural land, the state has an interest in the coast and the state has an interest in water quality management. I could not say it had an interest in urban areas, I could not say it had an interest in improving urban outcomes and settlements, or in making cities more compact. I could not claim that.

Ms O'CONNOR - So we are moving through this process of planning reform and there is a single statewide planning scheme going to be rolled out. How do you make sure that, for liveability - for want of a better term, this catch phrase - urban design principles that encourage health and wellbeing are imbedded also in a statewide planning scheme or regional planning scheme? At the moment, there does not seem to be any sign of that happening.

Mr NOLAN - The difficulties with a planning scheme is that it is a statutory legal document and it needs to be tested against. That is where you start looking for those hard standards. The old catch cry 'you can't legislate for good design' is very true. I think if there is more direction from the state on some of these as an aspirational thing, and the budget settings and so on that fit it, then you will get the improved outcome - not simply through a statewide planning scheme which is one planning scheme pulled together, which is the hardnose stuff of regulating development.

What we have been talking about today is not so much on private land but it is much more in the public arena - streets, open space, and particularly streets. Streets, in many

cases, are a form of open space which we not only drive down but we walk down, we walk the dog, kids play and ride to school and all those sorts of things. That is what really needs to be understood, and it is not something you really regulate in a planning scheme.

CHAIR - Thanks very much. We have gone a bit over time. Is there anything burning you need to finish with?

Mr NOLAN - Hopefully the conclusion in our submission captures the essential elements of what we have talking about today.

Mr VALENTINE - A very quick last question. What is the take-up of the Healthy Spaces & Places website and the training you provide on a national basis?

Mr NOLAN - That was a collaborative between the Heart Foundation, PIA and the Australian Local Government Association. It is in a state of flux and I believe it is about to be disbanded in terms of the training site. There is a whole mechanism set up around that and it is about to be captured essentially by the Heart Foundation and they will try to run it through that.

CHAIR - Thank you for your time, gentlemen, we appreciate your input.

THE WITNESSES WITHDREW.

Mr GARRY ANTHONY BAILEY, ADVISER, AND **Mr CRAIG ANDREW RICHARDS**, CHIEF EXECUTIVE OFFICER, BICYCLE NETWORK TASMANIA, WERE CALLED, MADE THE STATUTORY DECALARATION AND WERE EXAMINED.

CHAIR - Welcome to the committee hearing. This is a public hearing, so the evidence you are giving is being transcribed by Hansard and will form part of the public record. While you report to the committee you are covered by parliamentary privilege; if you do speak to someone outside, the media for example, you would not be covered, so keep that in mind. If you have any evidence you want to give to the committee in confidence, you can make that request and the committee will consider it.

Mr RICHARDS - Thank you very much for the opportunity to come and talk. I, like a lot of people, am very excited that Tasmania has this great aim to be the healthiest state in Australia by 2025, which is fantastic. We did want to speak about what we think is one of the key things to making that happen, and that is addressing the problem of physical inactivity and how we think bikes are a great solution to the problem of physical inactivity.

It is an interesting coincidence that today is 6 May and the committee is probably not aware that 6 May is the day that a chap called Professor Morris was born. Professor Morris was the founder of the idea that physical inactivity is such a great health problem. He found this in the early 1950s, in post-war Great Britain as a professor. He found that a number of people in Great Britain were dying of heart attacks.

He did research and the first people he studied were people who worked on the London buses. He found that the conductors were half as likely to die of a heart attack as the bus drivers. When he looked into why, it was because the conductors were walking up and down the stairs, so they walked so many stairs a day.

Professor Morris then turned his attention to postal workers and compared letter sorters to letter deliverers, and that is where the bike came in. He found that those who were delivering letters were half as likely to die of a heart attack as those -

CHAIR - On a push bike as opposed to a motorbike.

Mr RICHARDS - Yes, on a push bike, absolutely. Interestingly, back in 1953 we knew the link between physical inactivity and a number of preventable diseases. Interestingly, at the same time the same discovery was made about smoking - that smoking will kill you - by another English professor, Professor Doll. What we have really seen over the last 60 years is that smoking has got a lot of attention, whereas physical activity has not got nearly as much attention, and it has now grown to be our greatest problem in terms of health prevention. That is the area where we can have the greatest impact.

It has great impacts in heart disease as I have mentioned but also type 2 diabetes, and it makes a significant impact in some cancers, particular colon and breast cancer, and also other impacts such as on mental health. Where we have got to for humans is that we know adults need to do 30 minutes of physical activity a day; for young people under 18, it is 60 minutes. In Australia, unfortunately, we have two-thirds of people who do not

get enough physical activity. When we look at what a huge number it is, that is where we are seeing what a great impact that has.

What it costs Australia as a country is about $14 billion annually because of health care costs, mortality costs, and the loss of productivity. If you take that to Tasmania it is about $320 million a year cost to the state of physical inactivity. We have about 16 000 deaths in Australia. Extrapolate that and we have 300 to 400 in Tasmania as a result of physical inactivity and health life diseases. So it is a pretty big problem that we know about.

What are we going to do about it? That is why the bike becomes so important. We have five aspects of our life. Five things we do. The first one is sleep - it is pretty hard to be physically active when we are asleep, so we can rule that one out.

CHAIR - Depends whether you sleepwalk or not.

Mr RICHARDS - We have looked at inventing machines that you can exercise in your sleep but they haven't been terribly successful.

Then we have our occupation. Over time we have removed activity from our occupation - for good reasons, for fiscal efficiency and also for comfort. So it has gone from our occupation and we are unlikely to put that back. Then we go to our household. We used to get a lot of our physical activity around the house but that has been removed from our lifestyle, as well as things have become more comfortable.

We have these two last things that we can put our physical activity back into. That is our transport and our leisure. We look at the five things we do. We have sleep, leisure, occupation, transport and household. If we take those five initials they spell SLOTH. That is an interesting part of our lifestyle. We have created this sloth problem and we need to try to rebuild this into people's lives. How do we do it?

That is why bike riding works because when we look at these things - sleep, you can rule it out; occupation, it is difficult for financial reasons; household, the same. We do not want to go back to doing manual labour. So we have transport and leisure, and bike riding solves those problems.

The great thing about the transport end of it is because people can ride on the way to various things. Riding to school, riding to work. From a time perspective we are all so time poor and what that enables us to do - and we found that humans can't multi-task even though we think we can - on this occasion you can because you can get your exercise while you are replacing one activity for another. So transport is a great way and it saves money.

We have found some interesting things to say that when people start exercising on their way to work, it has as good a mental impact for them as finding a new love. So that is interesting.

Laughter.

Mr RICHARDS - You can meet your love on the way to work and you can ride a tandem - the sky is the limit, which is terrific.

When it comes to leisure we all know bike riding is great fun. We have lots of great memories from when everyone was growing up, because lots of people rode bikes as a kid, which is fantastic. Organised sport has become a more difficult thing in Australia as time pressures have changed and people's consumptions have changed. I am a sport tragic, I still play in sports teams. There is not that many of us around anymore. It has changed the way we have looked for our leisure activities. That is why bike riding gives us a great opportunity.

Where is the demand? That is the question. What we have seen the world over - and this is known as the Portland model because Portland is one of the great bike riding cities in the world - people get divided into four groups and 59 per cent of people are regarded in the interested but concerned group of bike riders. They want to ride a bike, they are interested in it but they are concerned about is the tons of metal thundering down the road, whether it be cars or trucks. If there is a crash with 80 kilos of flesh, it is not going to go well. We need to make sure we overcome that concern because we know physical activity is so important. We have a huge proportion of people who want to ride their bikes and we know why bikes are a such a good solution but there is a concern there we need to overcome. The best way to overcome it is by separating the bikes from vehicles. So infrastructure is really important.

Because you cannot provide bike infrastructure everywhere, speed reduction is very important in areas where you cannot, so on quiet suburban streets, if we reduce the speed of the cars, that overcomes people's concerns.

Interestingly, the third great way to reduce the concern for people is to increase the numbers of people bike-riding because there is a 'safety in numbers' influence and from the point of view of vehicles, they are much more cautious in those areas where there are lots of bikes around.

That is our basic argument. For Tasmania we think it is a great opportunity looking to become the healthiest state. This is a great way to do it. It is a great opportunity to join some of the other great countries in the world like the Netherlands or great cities like Portland or Copenhagen. To do that, we need to increase the speed of things. Bike infrastructure gets built gradually. It is a bit like building the great pyramids, one brick a day, and it is going to take a very long time at the rate we are building it.

Unfortunately, Tasmania is a bit behind in that regard. It spends roughly 85 cents a head on bike infrastructure which is the lowest in the country. There is a great opportunity to pick things up and put the foot down and take Tasmania to a healthier state through physical activity and we think bike riding can be a great part of that.

Ms O'CONNOR - Do you want to add something to that, Garry?

Mr BAILEY - There is lots I can add to this, particularly from a Tasmanian perspective because I have been working for Bicycle Network for six months. I took it because I love riding a bike and hopefully still getting my one hour of exercise a day in this job.

CHAIR - You only need 30 minutes, you are over 18.

Laughter.

Mr BAILEY - That is right but I still do one hour.

Mrs TAYLOR - That is a minimum.

Mr RICHARDS - Yes, I was going to say if I was having a bet I think in 15 years time the research will go up from half an hour.

Mr BAILEY - What Michael Ferguson said recently about making Tasmania the healthiest state in the nation by 2025 is a noble aim and I do not think it is a throwaway line from the discussions we have been having. But it relies on a whole of government approach.

In the health sector at the moment, we are talking about joined-up services, particularly, and we say, 'Yes, great, joined-up services are the way to go', but we need joined-up solutions - that is what they have to deliver.

Mr VALENTINE - You are talking local as well as state.

Mr BAILEY - Yes, and it is everyone's responsibility. Everyone grabs onto the idea that, for example, tourism is every Tasmanian's responsibility - we should all be out there smiling. This health and wellbeing is also everyone's responsibility and that is our view.

There are some very easy ways to start and I will give you a very recent example. At Strahan last week we launched a Ride to School pilot project with the Strahan Primary School. There were 60 kids out there at 8 a.m. in short-sleeved shirts, mums and dads in puffer jackets, gloves and scarves. But they were walking, they were exercising. There are some incentives to keep these kids doing it with trophies in each class. They are doing bike counts every day to see how many people ride to school and it is so easy. It is a lovely compact community.

They have a rail trail that has been converted into a shared pathway from Regatta Point around to Harbour Town. The other key thing is one of the partners in that is the RACT which had two reasons for doing it because they want our roads to be safer. Everyone including pedestrians, cyclists, drivers, truck drivers, have a big investment in Strahan and they want to raise their profile. That is a very good partnership and we are very confident that it will grow even further. It is starting in schools. Like everything, if you want to change behaviour you start by changing behaviour at a young age by basically re-educating.

There is a stand-out example and it is quoted in a recent document on the Greater Launceston Metropolitan Passenger Transport Report - the school at Port Sorell which has actively decided it wants its students to ride and walk to school. There is a photo in this report, a Launceston report, and they have used the Port Sorell example.

CHAIR - The difference there, Garry, is, and this is applicable to a lot of things you have said, it is a new school. That was factored into the design.

Mr BAILEY - Exactly.

CHAIR - Of the school and the community that it serves. One of the challenges for Hobart is the bike lane at Sandy Bay Road. I drove in that way when I stayed there, and it is pretty scary.

Mr BAILEY - The problem is old infrastructure. Retro fitting is an issue and I listened to Rob Nolan earlier. We had a discussion with the Heart Foundation last week about planning. Retro fitting is difficult. Let us make the break now and start, as part of the statewide planning, putting in all these rules and regulations to make sure that infrastructure caters for all users.

Mr VALENTINE - That includes maintaining our major highways, if that happens, and putting in cycle ways.

Mr BAILEY - Indeed. Sometimes retro fitting is not needed.

In my other area of interest which is education - I am one of those pesky education ambassadors - is if one school can do it, albeit it was planned in, why can't others? There are other schools that can quite easily do it. It just needs some changes in behaviour.

There is an interesting thing happening with Metro in Launceston. They are looking at moving the bus stops near schools further away, so a bit of lateral thinking. Instead of dropping the kids off 200 metres away it can be 400 metres and they have to walk. That immediately brings to mind improved signage which is one of the things Bicycle Network advocates for, improved road surfaces, driver behaviour, and particularly speed limits. Launceston, at the moment, is wrestling with the idea of dropping the speed limit from 50 to 40 in some areas. The Bicycle Network can argue it ought to be 30 in some areas.

Mr RICHARDS - We do argue it should go to as low as 30 and where 30 comes from - and I am not an anthropologist - but over the years it has been found that is what the human body is most able to cope with. We grew up on the savannah where animals can run at that pace so the human body is best able to cope with 30 and both our reactions and also our ability to cope -

CHAIR - If you are hit by a landslide running at 30k, you live.

Mr RICHARDS - You live, if you get hit by a Cheetah running at 90 you probably don't. There is an interesting reason why as low as 30 makes sense both for our human ability to react but also to recover and survive if the worst scenario happens.

Mr BAILEY - You need every part of government to be involved. Education can be driving this, obviously health, you have police to enforce these rules, provide education and general guidance. Infrastructure, to do with the changes in things like road surfaces, pedestrian routes and the like. You cannot leave it to one area of government. We all have to buy into it.

Ms O'CONNOR - I think you will agree that the focus in Tasmania for a long time has been on building roads, that the former Department of Infrastructure, Energy and Resources

loved doing roads. That has been a bit of a challenge for making sure there is sufficient bike infrastructure in place. How adjustable is the road infrastructure we have, to be safe for cyclists? Ruth talked before about the Sandy Bay Road, so the painted on cycle ways are a good start but there are some challenges there aren't there? They are quite narrow roads.

Mr RICHARDS - I will make a general comment but then Garry could probably comment more specifically because I know a reasonable amount about Tasmania but I cannot claim to know everything. The painted bike line is a good start. It does make a significant difference. The number of riders increases significantly once you have put in a bare painted lane as opposed to a fully separated type facility. The injury rate also reduces roughly by about half from a painted line as compared to having no lane. For a separated facility the injury rate goes down 90 per cent, so it does make a significant difference.

When you spoke about building roads - and I know that retro fitting does become a challenge - if you can imbed it in the States policy. They call it mainstreaming, which means whenever a road project is built bike infrastructure has to be built that is both the easiest and the cheapest time to do it. To go back 20 years later and say, 'I am going to do it', then is very difficult. That is something the committee could end up recommending and is a fairly simple recommendation that ends up being very low incremental costs but, especially in terms of the future and heading towards 2025, it can have a significant incremental benefit.

Mr BAILEY - A recent example of the plan unveiled for the Perth to Breadalbane Midlands Highway deviation, is provision for cyclists. I went to the unveiling of the plans at the weekend in the Perth Memorial Hall, and there were a lot of people there so there is a great deal of interest. I did not get to ask the questions of the experts there but I will do that because there is some time. There is consultation, there is a Parliamentary Committee, and the Public Works Committee I assume will look at it.

You cannot tell from the maps but we were assured by the minister that the bike infrastructure would be included. What they mean by that we do not know, but we would like to see a separated bikeway or a shared pathway.

CHAIR - It dies not link up with anything. It is all right to do a bypass but it still has to link to something.

Mr BAILEY - That is where you need to start looking over the horizon a bit. For example, one of the first discussion I had in this job was to talk with Launceston airport and say, 'What are you going to do to provide better facilities for people who want to bring their bikes to Tasmania?'. The management said, 'We are one step ahead of you.'. They had already started thinking about it and building it.

They want to improve the road into the airport to allow for bikes in to Evandale. The road from the airport to Evandale is atrocious for bikes. I won't ride on it anymore it is so dangerous, so that links up. The riding along Hobart Road to Breadalbane roundabout, with a couple of dodgy bits around hills with bad sightlines, is very good, but it probably needs, in the interim, marked pathways.

The new bypass is the missing link that provides easy access to an area that is beloved of touring cyclist from Longford west. The Meander Valley Council was an early adopter in all this. They got together a terrific program for touring cyclists with maps, apps, signposting and all the rest, under the beautiful Western Tiers. Fantastic idea but not marketed, it came a bit early.

One of the big things we have been trying to impress on the Government and I think it is being accepted is that there is a great future in bicycle tourism with mountain bikes, touring and the like. Roger has heard me speak about this and quite rightly made the point that at first forum we were at at Ulverstone proved the demand. The demand has to be there.

Ms O'CONNOR - Isn't it also a case of what they call in some circles, 'the spark effect' - that if you build or if you have the infrastructure in place, and you plan for it, the users will come. There should not be a need to prove demand if you know that it is a popular pursuit and also an evolving motor transport that is becoming more popular.

Mr BAILEY - I am not a 'build it and they will come' person necessarily. There is a lot of evidence and the evidence is building in Tasmania. Dorset Council, only last week, said they have over $2 000 000 in development applications as a direct result of mountain bikes. Barry Garvison says it is the best thing he has seen in 30 years in that area and that is an area which was desperately trying to reinvent itself because of the demise of forestry.

CHAIR - Cranky Penguins in Penguin.

Mr BAILEY - Yes. Jan Bond, the Mayor, has a roundtable going at Central Coast Council with 16 interested individuals. I went to it to talk about bike tourism and other matters. Again, I made the point on behalf of the network that we need a regional approach initially. Tourism Northern Tasmania will be doing that as far as bicycle tourism goes and we will be involved in that as well. That hopefully will be a template for a statewide bicycle tourism policy.

Why do we press the bicycle tourism button? I think it is the best strategy in Tasmania to make a government pay attention. It simply is. That is the strategy. There is no secret about that and it is getting attention. This goes back to the term 'liveability', as you say for want of a better word, but I am happy with it at the moment because it is a really marketable commodity, liveability, for visitors and people who might want to live here. You can see how everything knits together. The Government is talking about a population policy. You cannot talk about a population policy without talking about a health and wellbeing policy because it is one of the attractions of the place. Then you can say 'bring your bike and ride on our lovely bike tracks and get fit like the rest of us' because we are going to be the fittest state in the nation by 2025. There is great marketability in the fact we want to be the healthiest place by 2025.

CHAIR - Both of you have outlined this inclusive vision. We have had some discussions with other witnesses and other submissions about a statewide approach. Some people say it could or should sit in Health, or should it be sitting with DPAC or wherever. How do you see that unfolding? You have to have someone who drives it. Every time there is

a proposal for an education reform or a health reform, an infrastructure change or new direction, how do you ensure that happens, what is the best model for that?

Mr BAILEY - We sort of have one and it is a newbie. We have a Coordinator-General for doing stuff, I am not sure what.

Ms O'CONNOR - None of us are.

CHAIR - His task is to attract business and industry.

Mr BAILEY - That is fair enough. I am not sure what. You do need, without creating another bureaucracy, someone who roams across all areas of government and to keep that sort of vision about a healthy Tasmania on track. In discussions with the Heart Foundation, you would have heard it from Rob Nolan I think and we came in late to that, that policy they are drafting, which we talked about last week, is absolutely the way to go. It is something that must be bipartisan as a policy.

Ms O'CONNOR - Tripartisan.

Mr BAILEY - Tripartisan, sorry - multipartisan because there are independents as well - and local government will embrace it as well. God forbid, even the media.

CHAIR - When I asked that question that is what I had in my mind: that is a position that is there. I bet if I rang up the Coordinator-General and said, 'I want you to look at the health impacts of engaging with that new business from China that might come and invest in our state', do you think he would say, 'What?'?

Mr BAILEY - Yes, but when you make a judgement about that sort of business, it is not just what it is going to bring but what is the cost of not doing it. The cost of not doing it is in the figures that Craig has given you.

CHAIR - What I am saying is, with the Coordinator-General's role there needs to be a complete resetting of the brief for that position, I would think.

Mr BAILEY - Yes, there would.

Mr BARNETT - I really appreciate the submission and the sentiment. To respond to that particular question regarding the Coordinator-General, to make it clear, obviously he is interested growing the economy but the answer for Garry and I think for all of us is to turn this health issue into an economics issue. If we do not get it right, it will impact on our economy with so much chronic disease and it will flow through to the working population and to people who are not productive. Garry can still go to the Coordinator-General, in my view, so long as it is presented in an economic sense that if you do not get this right it will affect our growing economy. That is my response, I am helping Garry, in a way, to respond to that question.

Mr RICHARDS - Yes, and from the numbers of when I spoke about initially the significant cost of inactivity, a significant proportion of that comes from lost productivity. We know that across the country slightly under two days a week are lost from workplaces from illness related to inactivity, so it is a huge cost.

CHAIR - The reality is, currently you are saying that inactivity is an economic burden for the state, yes, it does. But I would not believe that the Coordinator-General will currently see it as his role to address the health issues from an economic point of view, so we need a framework as a whole-of-government approach, as you have talked about - whether it is run out of the Coordinator-General's office, I think it will need to change to do that. The budget is only $2 million, isn't it? Whatever it is, to attract business and build the economy, as Guy said. Perhaps it will be considered and perhaps we can ask the Government about their view on that.

Mr BAILEY - You and Guy are right in that you need to make an economic argument, hence the argument we are making as far as bicycle tourism goes. It will deliver an economic benefit if you just look at regionally. Scottsdale is just the first and I am sure there will be others as time goes by.

Mr VALENTINE - Imagine all those little towns in the Midlands if you had a bicycle way next to the railway line. Parattah would come alive, and a few others.

Mr BAILEY - It is one of the wonderful legacies of the horse and buggy era because the towns are so nicely spaced for horses and now for bikes.

Ms O'CONNOR - Like Oatlands.

Mr VALENTINE - Sorry, that was a comment, not a question.

Mrs TAYLOR - Do you have a plan drafted for a bicycle path along the railway line? That is what we want.

Mr BAILEY - We have a plan drafted for a bicycle tourism policy and that will be part of writing a strategy for the north.

CHAIR - When do you intend to have that completed, Garry?

Mr BAILEY - That is up to Tourism Northern Tasmania so we will have to wait and see on that. And of course it is a regional approach with all the councils.

But back on the economic argument, you deliver these economic benefits with perhaps increased business and the like. You will deliver a longer-term economic benefit because people are healthier and then perhaps more able to work, for example. This plugs into the social welfare area, I might say, and how it will start arguing economic benefits. It also delivers by targeting tourists, for example, and saying we need better infrastructure for these reasons. The natural beneficiaries of anything you build are the locals anyway so hence that is our strategic intent.

Mr JAENSCH - I wanted to come in on the back of that Coordinator-General discussion. What I take out of your comment, Garry, was rather that we need a mechanism that is able to walk across the portfolio boundaries. Whether the Coordinator-General is it for cycle tourism et cetera is questionable but it is an example of a commitment to be able to work that way which we could use for other things such as health.

The other thing regarding the bicycle tourism area that I am interested in, and it goes back to some of those earlier discussions that we have both been involved with, is that I do not think we should get caught up in trying to monetise the benefit of cycling and physical activity in order to legitimise it. It should be legitimate in its own right.

Where interesting crossover lies is that it might be that the tourism aspect developed alongside the aspect of physical activity for its own sake might give the critical mass to be able to build infrastructure that you could not build for either by itself. That is where I think there is an interesting challenge, to get the pitch right so you do not look like you are desperately trying to make bicycle tourism look like you are doing it for health or for tourism or for the economy or because it is going to make you more beautiful or anything like that. It is an amalgam of those things and legitimately each of those things. I think the narrative has to be right because otherwise it can look as if you are trying to make an endless list of outrageous claims as to why the thing you are passionate about should happen before someone else's thing.

Mr RICHARDS - That is why we are so pleased to have come to this committee because we know that bikes have a number of benefits and we think health is where it is going to have its massive impact mainly because inactivity is such a serious health problem, and bikes can fix that.

Ms O'CONNOR - I think you put a cost to the Tasmanian community of inactivity of $320 million. How is that calculated and where does it come from?

Mr RICHARDS - I know the Australian cost is $14 billion so I have extrapolated down to the population of 515 000 in Tasmania.

Ms O'CONNOR - Is it possible, though, because we do have some of the poorest health indicators in the country that the cost is higher than that?

Mr RICHARDS - Yes, and I have purposely underestimated rather than over.

Ms O'CONNOR - That is instances of chronic disease or heart disease or cancer?

Mr RICHARDS - The three areas are the actual cost of health care, looking after the person suffering; then there is the cost of mortality; and then the third one is the cost of productivity lost, which I mentioned before. There is a lot of down time if people are ill and not going to work. There is a massive cost there.

Mrs TAYLOR - Does Bicycle Network Tasmania get asked by the government or consulted when roads are being built or planned? I am thinking in particular of the Midland Highway improvements at the moment. There are eight projects this year. Although the road is being widened significantly -

CHAIR - The shoulders all sealed.

Mrs TAYLOR - Yes, but no provision for bikes. Even where there are guard rails along the side they go to the edge rather than going in enough so we could have a separated bike lane. Is there any consultation or opportunity for you?

Mr BAILEY - In an ideal world we would want a bike lane everywhere, of course, but reality is we cannot expect them on every highway. What we do argue is that on the right routes where people can use them safely there is a positive provision policy within roads that they provide bike infrastructure unless it can be argued before a very senior committee that it is not necessary or it is simply too expensive. You could drive truck through the rules; it is quite easy to say no. We have put it to the minister that this should be a ministerial decision.

Our access to government has been fantastic. We can talk freely with the minister, Rene Hidding, and we have been able to put our case. We have done a budget submission to the Government; that was concentrating in all our energies over the last few months. A lot of what is in that submission relates directly to what we are saying today. So it is not just about money to build things -

CHAIR - The economics of it.

Mr BAILEY - The economics of it and how it can deliver better health and wellbeing outcomes. That is the big picture that we are talking about. I was probably a bit narrow. Bicycle tourism is the way in to get people's attention, and the Government has recognised that, but they also recognise there is a bigger picture to what we are on about.

Mrs TAYLOR - When you are actually doing it, widening the highway as we are -

Mr BAILEY - These plans go back quite a while, of course. The verges at the moment are adequate. Poor driver behaviour is the problem of course because you do not have a separated lane - no protection is the issue.

CHAIR - The other issue is all the rubbish on the verge.

Mr BAILEY - There are little things and we have brought these to the minister's attention. The grade of gravel used on the verges is often different. Some councils have responsibility for some other statewide road verges because of something in the Roads and Jetties Act, and roads are not swept regularly. Roadside verges do not wear down to a nice smooth finish, as they do on the main carriageway, because they are carrying lighter traffic. There are all these things to consider. We have put submissions that the grade of gravel should be smaller on the verges to make them more comfortable for bike riding.

Mrs TAYLOR - Then you get lanes where the line is painted on and it is fine but the road narrows for some reason and it goes to almost nothing.

Mr BAILEY - There have been some pleasing things. To get more people riding, some of the road safety initiatives under this Government have been pleasing. They are not everything we wanted, but they have gone a long way. The signage that has just come out, for example, there is a general view in the cycle fraternity that it is making a difference.

Ms O'CONNOR - Which signage?

Mr BAILEY - Metre and a half.

CHAIR - Picture of a car with a bike?

Mr BAILEY - Yes.

Ms O'CONNOR - Is that relatively recent? I thought the previous government -

Mr BAILEY - No, it just rolled out. Cycling organisation were involved in suggesting the best routes to put it on, and there are some more roads that need them. We will be putting that view again post-budget. That is concentrating everyone's mind at the moment so there is not much point in lobbying at the moment. We will take that up.

I think the Government would be happy to roll more out because we want councils to do the same thing as well. That is where the positive provision policy applies to state roads but does not apply to the local government. I would like to see that apply to local government and be consistent.

Again, with the signage, in some cases councils have taken up these signs and used them. In that regard we think speed limits and signage should be a state responsibility. There is a lot of debate going on in Launceston. I will be touring next week in a bus looking at all the areas where they want to drop the speed limit. Our view is that the minister simply thumps the table and makes a decision.

Mr VALENTINE - Bicycles on buses; do you have any traction with that apart from a trial or two?

Mr BAILEY - I am hazy on that.

CHAIR - Do you want to make any closing comments?

Mr RICHARDS - We think there is great opportunity in Tasmania. Interestingly, from the numbers there is a long way to go, of course. Our last count showed about 1 300 people riding to work in Tassie. It is a pretty low number. Embarrassingly, only 261 women are riding to work; that is a low number.

If we think this might be difficult and we have a long way to go, if I think back a 100 years we have a nice analogy around cleaning your teeth. I am hoping most of you cleaned your teeth this morning. If we went back 100 years, it was less than 5 per cent of people cleaning their teeth and that turned around pretty quickly. No-one was convinced that cleaning your teeth is good for your heart, which it actually is; no-one was convinced it increasing your chance of having children, which it actually does. It became a habit pretty quickly and got ingrained in peoples habits. We can see great parallels. We can get people riding bikes and we can change their habits. As a result we can give them a significant improvement in health outcomes and we can turn this thing fairly quickly.

CHAIR - Thank you very much for your time.

THE WITNESSES WITHDREW.