



COUNCIL OF CAPITAL CITY LORD MAYORS

HEALTHIEST CITIES BY 2020:

**CCCLM response to the National
Preventative Health Taskforce discussion
paper *Australia: the Healthiest Country by
2020***

**Submission 1/09
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Introduction

The Council of Capital City Lord Mayors (CCCLM) commends the National Preventative Health Taskforce on the discussion paper *Australia: the Healthiest Country by 2020*.

This submission focuses on the theme of obesity and physical activity. A detailed response on the alcohol theme has been submitted by ICLEI Oceania. The CCCLM endorses the comments provided in the ICLEI Oceania submission and notes their discussion of the *Cities for Safe and Healthy Communities* proposal, a joint initiative of the National Local Government Drug and Alcohol Advisory Committee and the CCCLM.

Many of the discussion paper's recommendations relate to the core business of capital city government – urban planning and design, transport systems and infrastructure, disease prevention, regulation of hospitality and entertainment venues and community development within disadvantaged communities.

Local government is not seen as a major player by many in the health sector because of the sector's focus on treating illness. However, within the field of preventative health activities, Councils have a long history of provision of facilities, direct provision of services, and facilitating, funding and supporting non-profit services. For example Brisbane City Council manages over 550 sporting and community facilities servicing a residential population of over 1 million people.

Appendix 1 highlights examples of other contributions capital cities make to achieving preventative health outcomes.

The discussion paper significantly understates the potential role for local government and local community-based approaches to contribute to making Australia the healthiest country by 2020.

Capital city councils work to shape their cities as creative, innovative places with efficient physical infrastructure and high levels of social cohesion and equity within a healthy, sustainable environment. The CCCLM strongly supports the emphasis in the discussion paper on innovative partnerships and effective cooperation between all levels of government as key to delivering *Australia: the Healthiest Country by 2020*.

A healthy country depends on healthy cities

Over 60% of Australians live in our eight capital cities. For Australia to become the healthiest country, our capital cities will need to be healthy cities, and most preventative health strategies will need to be closely tailored to the urban environment.

A healthy city is designed to encourage social interaction, lower stress levels, facilitate animation and provide high standards of amenity. Efficient, accessible, frequent public transport is widespread as is infrastructure to encourage 'active transport' – walking and cycling – including bikeway networks and footpaths, and bike racks, showers and lockers at public transport interchanges and workplaces.

A healthy city has accessible and welcoming public spaces, which are pram and wheel chair friendly, with adequate lighting, a friendly ambience, adequate shade, and protection from the elements. Sign posting provides direction to walkers, joggers and cyclists and creates an engaging cultural experience through highlighting historical and cultural sites. Public seating provides rest points. Sports fields and facilities are readily available, while playgrounds provide safe spaces for children and their parents. Individual health and wellbeing outcomes for capital city residents, visitors and workers are strengthened by a sense of belonging to the people, spaces and places around them.

Australia's capital cities already enjoy many aspects of this vision with significant improvement in recent years. However, there is room for improvement and barriers to first-class performance due to a historical legacy of poor planning decisions and underinvestment in community infrastructure. Capital city councils have plans in place to address these issues; however, there are long timeframes for delivery due to resource constraints. For example, Brisbane City Council has quadrupled the average yearly funding for bikeway infrastructure to fast-track the implementation of its planned Bikeway Network.

Capital cities' role in health prevention

The CCCLM sees three areas of activity outlined in the discussion paper where capital city councils can play a key role:

- Encouraging healthy workplaces
- Providing tailored programs for disadvantaged communities
- Delivering urban planning and design that facilitates healthy lifestyles

Healthy workplaces

Australia's national economic well-being is driven by its capital cities – 61% of Australia's economic activity in 2006 took place in Sydney, Melbourne, Brisbane and Perth. For example, while the resident population of the City of Melbourne was 86,340 in 2007, the 2008 Central City Users Survey identified 551,900 central city users in 2008.

Capital cities are home to large commercial and administrative precincts full of tall buildings full of sedentary workers. Australian workers are working longer hours and the global economic crisis will contribute to further stress in the workplace.

Increased incidental and casual physical activity during the working day will contribute to healthy forms of stress relief (reducing reliance on junk food and alcohol) and improved physical fitness. In general, incidental and non-organised forms of exercise are becoming increasingly important to national physical wellbeing.

The Australian Sports Commission's 2007 Annual Report reported that an estimated 1.8 million persons aged 15 years and over participated at least 3 times per week in organised physical activities, a regular participation rate of 11.2%. Of that 11.2% only 7% participated in club-based sport.

An estimated 5.5 million persons aged 15 years and over participated at least 3 times per week in non-organised physical activities, a regular participation rate of 33.6%. The regular participation rate in any physical activity increased by 6 percentage points between 2001 and 2007 and this increase was almost entirely explained by an increase in participation in non-organised activities.

The top 5 physical activities by participation in 2007 were walking (33% - up 23% since 2001); aerobics/fitness (20.2% - up 68.4%); swimming (12% - down 18.6% since 2001); cycling (9.7% - up 10.6% since 2001); running 7.6% - up 14.8% since 2001).

Facilities and programs to encourage physical activity during the working day could make a significant contribution to the health and well-being of Australia's workforce. For example, the City of Perth is currently developing a pilot physical activity framework that can be adopted by corporate organisations in the CBD, *Out of the Office into Active Health* and the Adelaide City Council partners with *Life Be in It* to provide a range of lunchtime physical activity programs available to all city workers.

Counteracting the urban heat island effect through increasing the reflectivity of hard surfaces and increasing shade cover is important to improve the amenity central city areas and make them “physical activity friendly”. This would also significantly contribute to reducing greenhouse gas emissions through reduced energy use. As the discussion paper has identified, many health prevention actions have additional sustainability outcomes.

Presently, capital cities have individual shade strategies, but Australia lacks a national shade policy. Capital city centres are already seen as commercial, retail and cultural destinations. They can also become centres for daily physical activity.

Promoting social inclusion

There is great potential for a national preventative health program to reinforce the Commonwealth’s aim of building social inclusion, in which capital cities have a crucial role.

The need to support social inclusion springs from the fact that some Australians are socially *excluded* — they have poor outcomes in employment, income, housing, disability, information access, family breakdown and health. Whole localities have high levels of disadvantage in each of those areas — social exclusion can affect the health of people and places.

Groups at particular risk of social exclusion include those of low socio-economic status, people with disabilities, people from non-English-speaking backgrounds, homeless people, Indigenous people, older people and unemployed people. Such people have much higher rates of chronic disease. People living in low socio-economic status areas are generally less likely to be sufficiently active for health and the less educated are also less likely to participate in physical activity. To ensure it is a socially inclusive program, the national strategy will need to focus on disadvantaged populations and locations.

Promoting social inclusion involves acknowledging the complex causes —among them poor health, addiction, and mental illness — that result in people being excluded from society, unable to fully participate.

Some communities have higher levels of poor health and are less able than others to support their members. Local government is often closest to such communities, becoming aware of problems early and being well-placed to gather information and respond quickly.

Health and wellbeing are among the main definers of a community’s degree of social inclusion or exclusion. For example, as noted in the Commonwealth’s recent *Green Paper on Homelessness* (2008), homeless people suffer poor health because of their diet, living conditions and limited access to health care which, in turn, exacerbates their exclusion from social support and networks.

That may be countered through effective policy and programs. For example, the Adelaide City Council has a long standing, strategic partnership and funding relationship with *Reclink* SA who provide recreation services to homeless and vulnerable people who frequent the inner city. Reclink, through the use of inclusive recreational activities, often have success in engaging people with high needs who do not connect elsewhere in the health and welfare system. The program succeeds both in improving physical well-being and in connecting isolated and disengaged individuals with social, health and other services.

Social exclusion may also be tackled in less noticeable ways that integrate small but significant measures into everyday service delivery. For example, in all of the capitals, homeless people can find free, safe space in city libraries. It is standard practice in capital city libraries that homeless people are

made welcome, and are able to take advantage of the shelter, warmth and safety of the library's quiet areas.

Responses targeted to at-risk communities need not be stigmatising if done well and using mainstream avenues. For example, as well as catering to the needs of homeless people, mothers of young children who attend reading groups routinely use libraries. Mechanisms such as these can be used to deliver targeted, non-stigmatising support to high risk communities.

Targeted responses are beneficial to the broader community as well. Generic information – “smoking is bad for you” – is of little value in actually changing behaviour. Information needs to be targeted to specific audiences and include locally relevant and actionable suggestions. For example, Brisbane and Perth City Councils significantly increased public transport patronage through a program which provided individuals with detailed information about their personal travel options through a travel planning service.

The CCCLM's vision is of capital cities where people enjoy universally high levels of health and wellbeing, irrespective of income, race or disability. Councils have significant experience in local community development.

Urban planning and design

Capital cities play a major role in maintaining Australians' health and wellbeing through the management of local physical environments. There is a clear link between community health and wellbeing and a physically and socially supportive environment.

Neighbourhood characteristics have a strong impact on physical activity levels. Characteristics such as higher residential density, land-use mix, urban sprawl, traffic, street connectivity, access to destinations such as shops and parks, aesthetics and safety are all linked to the amount of walking people doⁱ. The built environment also affects the choices people make about which mode of transport they useⁱⁱ. Urban design also can promote or discourage social interaction and people's sense of belonging, important contributors to community wellbeing and health outcomes.

Along with other local government authorities, the capital cities are increasingly aware of the influence that planning and urban design have on health, and are seeking to shape their cities in ways that promote positive health outcomes. Practical measures that facilitate physical activity and social interaction include things such as:

- Providing places to be active: for example, strategically located parks and recreation space and facilities such as parks playgrounds, sports grounds, BMX tracks, fitness circuits, recreation hubs, and community and youth facilities
- Making it easy and safe to walk or ride: high quality, well lit and shaded pedestrian and bike paths, accessible to the aged or disabled and with strategically located street furniture to create bike-friendly and walking-friendly cities
- Encouraging people to walk or ride: connecting local streets with street furniture, shade and signage and linking local amenities and shops so that they can be easily reached on foot, by bicycle or by using public transport, avoiding cul-de-sacs or other urban design that discourage active transport

While the principles of healthy urban design are well understood, applying them in practice is difficult. Barriers include:

- **Costs:** Open space and sport and recreation facilities come at a cost. Some established communities are well endowed with these assets, others are not. Retro-fitting existing communities

is expensive, and for green field developments the cost of these assets is invariably passed on in higher housing costs.

- **Historical Legacy:** There has been a significant evolution in urban planning methodology over the last decade, with measures such as social and health impact assessments now a standard part of planners' thinking, and of development assessment processes. With the capital cities' historical legacy of major development, there is a dwindling supply of new land and a massive task of retrofitting existing centres and suburbs. For example, the suburban cul-de-sac layout discourages walking and promotes car use.
- **Capacity:** Councils are now much more conscious of the ways that urban development impacts on community wellbeing, and attempt to mitigate the negative effects as far as their legislative powers will allow. There are significant policy and legislative barriers to Councils taking stronger action to demand improved design in new developments.
- **Incentives:** In the absence of stronger legislative powers, many local governments have used incentives to encourage desirable planning outcomes. For example, Brisbane City Council has developed guidelines for sustainable development aligned with sustainable development incentives. Incentives may also be effective in encouraging healthier development.

Councils can play a leadership role in embedding health and wellbeing goals in local area plans and planning policies. The CCCLM would welcome the involvement of the Taskforce's proposed National Preventative Agency in working with the CCCLM, the Australian Council of Local Governments and developers to develop integrated national social and health impact assessment standards, health and wellbeing planning policies, national urban design guidelines and incentive packages.

Ways of developing capital city collaboration

Capital city councils will be key partners for federal and state governments, non-government organisations and the corporate sector in any national effort to deliver local, community-based preventive programs aiming to reduce the number of people requiring medical intervention as a result of "lifestyle diseases".

Intergovernmental arrangements

The CCCLM believes that capital city councils have a strong role to play in building healthy cities. Local government brings a wealth of experience in place-based community development to the issue of improving the health and wellbeing of local communities.

The CCCLM would be particularly interested in exploring the concept of city specific "Preventative Health" tripartite agreements for all three levels of government that outlines distinct and explicit roles for each.

While the 2020 targets for the Healthiest Country appear suitable given the goals of the strategy, interim targets and local targets need to be developed to effectively inform changes required in approach over time.

Preventative Health agreements specify particular public health outcomes. For example, a Sydney Health Partnership might set a target of increasing walking in Sydney by 10 per cent by 2010, stating specific roles for local councils and the State.

Learning by doing

The CCCLM applauds the discussion paper's recommendation of adopting a 'learning by doing' approach for newly emerging areas of health risk such as obesity. The staged trialling of interventions, accompanied by comprehensive monitoring and evaluation, provides the best hope of identifying

innovative and effective interventions which can be refined and more broadly applied. The capital city councils are keenly interested in being a part of testing new approaches to preventative health. (See also Appendix 1 for examples of preventative projects councils are already trialling.)

Leading by example

All of the capital city councils are involved in wellness strategies for staff. Councils often lead by example in their local communities and this can have significant impacts on the behaviour of industry and other corporate entities. For example, In 2001 Brisbane City Council used its significant buying power to secure production of ultra-low sulphur diesel (50ppm) for use in its diesel buses - the first major fleet operator in Australia to do so. Motivated by Council's experience, BP expanded production of ULSD in 2003, ahead of national standards introduced in 2006 and began producing BP Ultra-low Sulphur Diesel, which has a sulphur content of less than 10 parts per million (10ppm) in 2007 – two years before being required by new standards which took effect from the 1st January 2009.

Conclusion

The CCCLM's health policy work, which is based on four "pillars of healthy cities" – healthy people, healthy places, healthy lifestyles and healthy communities – is strongly aligned with the discussion paper's three focus areas: obesity, tobacco and alcohol.

Councils' core business could be modified to include preventative health actions. For example, the City of Sydney already supports the implementation of state government smoke-free environment legislation. City Rangers enforce cigarette butt littering fines, and work with the public and businesses to control cigarette pollution. Smokers are also encouraged to quit, or reduce their tobacco use as part of the, primarily, anti-littering campaign.

Councils also have responsibility for food safety and have relationships with food service businesses across the city. While this is currently focused on disease prevention, there is scope to include providing advice on healthy food options.

As previously stated, the role Councils currently play in preventative health, and the potential to expand and build on that role, has not been fully explored in the discussion paper. A representative of the CCCLM Social Infrastructure Committee would be available to help further develop the Taskforce's work, including the development of a National Preventative Health Strategy.

APPENDIX 1 - EXAMPLES OF EXISTING CAPITAL CITY HEALTH PROGRAMS

Following are brief examples of health programs currently run by capital city councils:

Creating New Outdoor Space for Active Living — Adelaide City Council

Adelaide City Council has acquired 72 hectares of open space in the Adelaide Park Lands for redevelopment to accommodate adventure play areas, wetlands, a community plaza for cultural events and markets, and sports fields. The area will provide significant opportunities for passive and organised recreation.

All Ages, All Abilities, All a Healthy Weight — Brisbane City Council

Brisbane has set itself a target for 2026 — by that year it aims to be the city in the OECD with the highest percentage of people within the normal weight range.

To that end, Brisbane City Council provides a wide variety of Active & Healthy programs for target groups including families (Active & Healthy Parks), young people (Chill Out), seniors (Growing Old, Living Dangerously) and Indigenous people aged 7 to 25 (Black Diamonds).

The city also uses urban design and infrastructure to encourage physical activity as people move around the city's public spaces and pedestrian and transportation systems.

Activate NT – Darwin City Council

Darwin City Council and the General Practice Network of the Northern Territory have formed a partnership to deliver to residents an annual 10-week program of activities such as cycling, walking, tai chi, aqua aerobics and group fitness classes.

These activities combine with special events such as shopping tours to learn about food labelling and the importance of healthy shopping as well as nutrition information nights run by a dietician to discuss weight management initiatives.

The program encourages residents to live a healthy lifestyle and to sustain this approach by building social and community networks to assist them to do so. The inaugural Activate NT program took place in 2008 and planning is underway for the 2009 program scheduled to commence in March.

Fostering Wilderness Recreation — Hobart City Council

In 2008 Hobart City Council opened the first stage of a seven kilometre cross-country mountain bike track on the slopes of Mount Wellington. The track was developed in response to the overwhelming popularity of mountain biking in Hobart's bushland reserves.

Designed in accordance with international design principles, the three kilometre first stage of the North South Track takes riders on a scenic but challenging ride through the mountain's wet forests and boulder fields. It is designed for riders of varying abilities with a well-graded main trail, and optional technical features such as log rides and jumps for experienced riders.

The Council has been widely praised, both for the quality of construction and design of the track, as well as the strong commitment to mountain biking as a legitimate recreational activity in Hobart's bushland areas. Work on the second stage will commence in early 2009. When completed, the track will connect to the Glenorchy City Council's Mountain Bike Park, furthering its appeal and accessibility.

Managing Alcohol and Drugs — City of Melbourne

The City of Melbourne is a leader in responding to drug and alcohol issues in the municipality, addressing issues both legal and illicit drug use. Council is committed to minimising the social, economic and health-related harm associated with drugs and alcohol, both for individuals and the community.

The City of Melbourne's *Strategy for a Safer City 2007–2010* is the key policy document providing strategic direction for Melbourne's promotion and support of safety, and responses to drug and alcohol issues. Its initiatives include multimedia drinking and pedestrian safety campaigns and a safe needle and syringe disposal program.

Out of the Office into Active Health — City of Perth

The City of Perth has a seat on the WA Premier's Physical Activity Taskforce and is implementing its own *Physical Activity Plan*, which makes physical activity core business for the City. That includes providing infrastructure that supports physical activity, and health promotion and physical activity campaigns for both within the organisation and in the community. Perth is developing a pilot physical activity framework that can be adopted by other corporate organisations in the CBD, targeted mainly at people in sedentary jobs. The City is also planning a new Community and Recreation Centre that will focus on active ageing.

Targeting Tobacco and Alcohol – City of Sydney

The City of Sydney is targeting alcohol safety through Safe City initiatives including its *Drug and Alcohol Strategy 2007–2012*, Alcohol-Free Zones, licensing, and regulation for Places of Public Entertainment, Restaurant Seating on Footways and Development Consent. The City's Drug and Alcohol Project Coordinator works with the government, NGOs and communities to address addiction and dependence and develop preventative and educational campaigns. Sydney also supports the implementation of state government smoke-free environment legislation. City

Rangers enforce cigarette butt littering fines, and work with the public and businesses to control cigarette pollution. Smokers are supported to quit, or reduce their tobacco use.

APPENDIX 2 – Investing in Cycle ways (submission to Infrastructure Australia)

The attached paper is a case study of cycle way projects using the Benefit Cost Ratio methodology (BCR) to guide planning for cycle ways as an integral part of the transport network. A key underlying premise is that an increase in cycling as a percentage of mode share will improve traffic congestion and assist the national economy. The paper is not meant as a bid for those projects, but is intended to highlight the benefits of investing in projects that 'link up' the cycle way network.

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- ⁱ McCormack G, Giles-Corti B, Lange A, Smith T, Martin K, & Pikora T. 2004. "An update of recent evidence of the relationship between objective and self-reported measures of the physical environment and physical activity behaviours." *J. Sci. Med. Sport* 7:74-80. Giles-Corti B. 2006, "The impact of urban form on public health", paper prepared for the 2006 Australian State of the Environment Committee, Department of the Environment and Heritage, Canberra. <http://www.deh.gov.au/soe/2006/emerging/public-health/index.html>
- ⁱⁱ Newman, P.W.G. & J.R. Kenworthy, "Sustainable urban form: The big picture" in *Achieving Sustainable Urban Form.*, K. Williams, E. Burton, and M. Jenks, Editors. 2000, E and FN Spon: London. p. 109-120. Buxton M (2000). *Energy, transport and urban form in Australia in Achieving Sustainable Urban Form*, K Williams, E Burton and M Jenks, Editors, E and FN Spon: London. Pp54-63. Naess, P., *Energy use for transport in 22 Nordic towns*. 1993, Norwegian Institute for Urban and Regional Research: Oslo. Timperio, A., Crawford, D., Telford, A., & Salmon, J., (2004). "Perceptions about the local neighbourhood and walking and cycling among children." *Preventive Medicine*, 38, 39-47.