LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH

(Reference: health of school-aged children)

Members:

MS K TUCKER (The Chair)
MR B SMYTH
MS K MacDONALD

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 20 JUNE 2002

Secretary to the committee:
Ms S Leyne (Ph: 62050490)

By authority of the Legislative Assembly for the Australian Capital Territory

The committee met at 2.05 pm.

NICOLA DAVIES was called.

THE CHAIR: Our first witness is Nicola Davies from the conservation council. I would just like to let you know your basic requirements as a witness to an Assembly committee. You should understand that these hearings are legal proceedings of the Legislative Assembly, protected by parliamentary privilege. That gives you certain protections but also certain responsibilities. It means that you are protected from certain legal action, such as being sued for defamation for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter.

Thank you for your submission. Would you like to address the committee?

Ms Davies: As most of you know, the conservation council is the peak environmental advocacy group in town, and it is not often that we appear before a committee like the Health Committee. However, a number of the things that we work on do have health consequences, and the work that we have done over the last 10 years on wood smoke pollution, for example, is one that we have spoken to health committees about in the past. Increasingly we are seeing the work that we are doing in progressing the ACT towards a sustainable transport system as a health issue as well as an environmental issue.

We welcome the opportunity to appear before the Health Committee to talk about the health of school-age children because it is particularly appropriate at this time. The Smogbusters Network, which is a network of the conservation councils, is a travel demand and sustainable transport awareness program brought out from the UK not long ago.

Professor John Whiteleg has done a lot of work on issues of sustainable transport and also the impacts of transport on human populations. Unfortunately, whilst the conservation council here in Canberra is obviously a conservation council, it doesn't have a Smogbuster and we weren't able to get a presentation from John Whiteleg to the ACT government, which was something that I had hoped to do.

But the submission that we put in to the committee and some of the brief comments that I am going to make now draw very heavily on his work. We do have a copy of the book which is called *Critical Mass* that a number of our comments are drawn from. We had hoped to buy more copies, but $60 is the cost of it when you are importing it from the UK. So I have made a copy of some of the bits that I think are particularly appropriate to what the committee is doing at the moment. If anybody would like to borrow the book or get the reference so that they can actually have a look at it in more detail, then I am very happy for that to happen.

THE CHAIR: We can see if we can get it for the library here.

MR SMYTH: That is John Whiteleg?

Ms Davies: Yes. I did in fact copy the first page with the details, so I will tender that in evidence. When you are looking at it you will see that a lot of the research is obviously done in the UK and also the US, and it does draw pretty heavily on examples of cities that are more heavily polluted, for example, than Canberra is. But we would argue that we need to ensure that we don't get to that point before we start realising that transport, particularly car-based transport in cities, has major impacts on human health.

The conservation council would argue that we need to be putting in policy approaches now that ensure that we don't get to that point, so that we do protect the health of our populations in the longer term. It is that preventative health aspect that the conservation council sees as very appropriate in a number of the things that it is working on.

I have also photocopied a couple of pages out of the *Daily Telegraph* last weekend—I don't know if you have seen them—which were particularly appropriate and I was very grateful to see them before having to appear before this committee. Actually it fits in very nicely with the fact that the work that John Whiteleg has done is mainly overseas.

The University of Sydney's Warren Centre for Traffic Research has been doing some work on the impact of car use on human health, and particularly on the issue that we would like to talk about in a bit more detail in this forum, which is the contribution of the increase in car use to the increase in obesity and the related impacts on human health. I have been so busy that I have not managed to actually follow this up with them, but this article reports that they are releasing a report called *Healthy Transport, Healthy People* in the next couple of weeks. We will obviously be getting a copy and we can make that available to you, or I would urge you to get in touch with them and follow that up.

THE CHAIR: We can follow that up.

Ms Davies: The quote in the paper is that they have found that increased car use has displaced active transport, walking, cycling and using public transport, and that this is actually contributing to the rising levels of obesity in our population, which is obviously a major issue when you look at the run-on health effects that are related to that.

Some of the work that John Whiteleg has been doing in the UK relates directly to the rise in obesity in school-age children, and the decrease in use of public transport; but also particularly cycling and walking to school, and the impacts that that actually has on their health. We are very interested in exploring the reasons for that. We believe that there are a number of institutional responses that can be put in place that will help to promote walking and cycling to school, and they fit in very well with the sorts of conversations that the conservation council has been having about the sorts of community activities and the sorts of things that also are beneficial environmentally as well as to the population.

One of those is obviously our 50-kilometre per hour campaign. There is a substantial amount of research that shows that decreasing the speed of cars in streets makes those streets much safer. What people say to me immediately when I say that is that we have 40-kilometre per hour zones in front of our schools, and that is very true, and that is obviously very necessary. However, for example, the trial for the 50-kilometre per hour speed limit in the ACT has specifically excluded the main streets in our suburbs, many of which have schools on them. And even if they don't have schools on them, they are, of course, the main thoroughfares through the suburbs, which is why they have been left at

60 kilometres per hour. But they are not only the main thoroughfares through the suburbs for cars: they are also the main thoroughfares through the suburbs for the other forms of transport, namely walking and cycling.

So in terms of making our streets safer for our children to walk and cycle to school, we believe that the 50-kilometre per hour speed limit is an appropriate discussion to have in that context as well, and we believe that the whole conversation about 40-kilometre per hour zones in front of schools is part of that.

We do recognise that safety is increasingly being seen as an issue, and it is one of the reasons why parents are reluctant to allow their children to walk or ride their bikes or even catch public transport to school. In terms of the walking and cycling, there have been a number of initiatives in Sydney, for example, to do with school children where communities are getting together and they all walk to school together. We certainly think that those sorts of approaches could be very usefully investigated in the ACT.

We also believe that that will have a beneficial impact on the sense of community and community relationships within the suburbs. Our schools in the past have been very much centres of community development and community activity for the people in Canberra, and certainly doing some of these initiatives at the school-based level, getting the parents together, getting them to know each other, will be very important.

Another one of the things that John Whiteleg has found in his research in the UK is that, whilst one would generally think that the car has increased mobility and that is one of the things that are considered most important—that you can get around—it has also massively increased the sense of social isolation that people are actually feeling, and that is relevant to children as well as to adults.

There is a lovely quote in one part of the book. It is a bit old now, but it was about the fact that this child's family hadn't had a car, his friends had so he had been able to access further away activities and that kind of thing; but he had also really appreciated his environment and his suburb and had really created relationships with the people in the neighbourhood et cetera which were very important to his sense of social well-being. It extrapolates that it would appear that there is—and this is obviously way out of my area of expertise—an increasing level of research being done on the impacts, the psychological impact, of the social isolation that children are feeling as a result of not being so connected into their neighbourhoods, and the whole issue of walking and cycling to school does seem to be very much a part of that.

We expected that probably this information and this research isn't readily available to people in Australia and we felt that it was important that we appear before this committee to bring this information to your attention. And I guess we would also urge the committee in its consideration of obviously the range of health impacts on school-age children to have a think about some of these less obvious ones, and to have a think about some of the policy responses that are slightly more long term and are slightly more nebulous than, I guess, some of the other things that would immediately be seen to be relevant to the health of school age children.

I was fascinated to see—and it would be very interesting to see what the statistics are in the ACT—the statistics relating to the number of children killed in cars, for example, simply because of the large proportion of trips that are actually made by car. This is actually quite substantial as well. I was quite appalled. I read them in that book last night when I discovered that Kathy wasn't going to be here to appear before the committee. So, if you've got time, I would really urge you to have a look at that.

MR SMYTH: Currently in the ACT we have car accidents at about half the national rate. But that is no excuse. My memory of the number of children involved in those is very, very small. But one is still one too many.

Ms Davies: I suspect that is right.

THE CHAIR: Yes, but there is also the fact that they are not on the road because the parents are frightened that they will be killed. So there is an issue there as well.

Ms Davies: And I guess that the council would urge the committee, in thinking about how it is going to couch its report, to have a look at it from the preventative health aspect as well. Some of these things might not be too bad in the ACT at the moment but please let us not have to get to the point where we do have to have however many hundred children killed on the road before we realise that this actually does have impacts on children.

THE CHAIR: Yes. I think the point you have raised that is interesting too, is how does the concern about safety of the roads impact on the travel decisions that are made by parents on behalf of their children.

Ms Davies: That's right.

THE CHAIR: Because parents do take that into account when they make those decisions.

Ms Davies: That's right.

THE CHAIR: And it is hard to determine that. Obviously, you would have to do some kind of research to work that out—how many parents; that is a factor for them.

Ms Davies: I have done some reading in the past—I am generally interested in physical fitness, for example—about the economic costs associated with the rise in obesity levels, both in our children and also in our adults. But I do understand that in children it is really very, very concerning. Certainly we are seeing statistics that 50 per cent or more of children actually could be classified as obese. I think the ongoing health impacts, both for them and also for society as a result of that, are substantial. If part of the solution is something as simple as making some adjustments so that our transport systems are more supportive of non-car-based transport, I think it is important that we have a discussion now about how we make that happen.

There was another article in the same edition of the *Daily Telegraph* which was just generally talking about the rising levels of obesity and also attributing perhaps the lack of walking and cycling in terms of a transport alternative as part of that problem as well.

THE CHAIR: Thank you. Do you have any comments? I realise that weren't expecting to give this evidence. But I am also interested in any comments you might have about the impact of chemicals. Have you done any work on that one?

Ms Davies: We have done a lot of work on the impact of fine particle pollution, for example, on human health. Not specifically children, but children are in a major risk category when it comes to asthma, for example, which is one of the major health impacts of fine particle pollution.

Most of the work that we have done on that relates to fine particles coming from the burning of wood as a heating source here in the ACT, particularly in Tuggeranong, obviously, and a number of the members of the committee know all about the work that the conservation council has done on that.

The research that has been done in the ACT shows that the general level of background pollution as a result of the transport system is quite low. It is certainly quite low when compared to some of the other major capital cities. However, particularly in winter when the load from fuel wood stoves is actually added, it is becoming a significant issue and it is the very small particles, what we call PM 2.5, that are the major issue.

Once again, we would argue that we need to put a policy framework in place that ensures that we don't have to get to pollution loads like Sydney, for example, before we actually realise that we have a pollution problem. This is something that has frustrated the conservation council for a long time. The federal government, for example, over a number of years has put money into community development projects as a result of air pollution in major cities but Canberra isn't assumed to have a pollution problem. So we haven't been able to actually participate in that.

The levels of asthma in the ACT, for example, are very, very stark. Katherine would have been able to talk about this in a bit more detail. She had the information on it, so I might get her to provide some of the more detailed information.

THE CHAIR: Yes, that would be interesting.

Ms Davies: The recent ABS statistics on health, for example, are showing that, in relation to a whole lot of the indicators, the ACT is actually doing very well in comparison to the other states and territories, but on asthma it's quite a lot worse. Obviously there needs to be more research done to know how much of that is actually related to background environmental effects. A lot of people talk about the pollen, for example, potentially being a problem.

MR SMYTH: And the grass.

Ms Davies: But there is no doubt that, even if we have an underlying predisposition to asthma, the sorts of environmental pollution that we see from both wood stoves and also cars are going to majorly exacerbate those problems.

As I said before, children are one of the major risk areas when it comes to asthma, and certainly asthma in ACT children is at pretty high levels. Certainly, the anecdotal evidence—for example, from Tuggeranong, once the wood smoke pollution kicks in particularly—is that families will say that you can almost define to the day when the next door neighbour started up their wood fire by how the children's asthma is going.

There are also obviously a number of other chemical pollutants that are important in relation to the health effects associated with cars. And there is actually quite a lot of information in here. But once again, it is not Australia specific. I will see what I can do to get some Australia-specific information.

THE CHAIR: I was interested in chemical use generally in the school as well, such as through insecticides and cleaners and stuff like that.

Ms Davies: Yes. Sorry, I totally misunderstood.

THE CHAIR: Your answer was interesting anyway, and totally on the subject.

Ms Davies: One of our member groups, the National Toxics Network, has actually done a lot of work on that.

THE CHAIR: And they are coming to see us, so maybe we can wait for their evidence.

Ms Davies: That is probably a good idea because they will be far more expert than I am.

The other thing I was going to mention was the health effects, particularly on children, of noise. Obviously we don't have too much of a noise problem in the ACT at the moment but, once again, if we get to that point the impacts of noise on particularly young children would be quite considerable.

THE CHAIR: That is interesting.

MR SMYTH: Like what? What is the effect of noise on children?

Ms Davies: Information in here talks about learning difficulties, attention deficit-type situations as well as just generally sort of physiological problems. The studies that have been done in here are related to streets in London that have a 30,000 cars a day sort of situation. So it is very large. But noise isn't something that I had given very much thought to.

MR SMYTH: I was thinking more of the noise impact on parents and temporary insanity and other sorts of things.

THE CHAIR: From the children?

MR SMYTH: From the children, yes, which may impact upon the child's health.

MS MacDONALD: "Let's see how many decibels we can get in one hit."

THE CHAIR: Do you have any questions?

MS MacDONALD: No.

MR SMYTH: I am curious. I think there is a lack of walking and riding, which is how I got to school most of the time. I would walk to the bus stop if there was a bus, et cetera. What about the change of sports regimes in schools? Is there any comments you would like to make on the move away from, say, compulsory sport and the reduction in the amount of sport; and often PE being seen as an elective rather than a critical part of the curriculum and personal development?

Ms Davies: From an organisational perspective, no. It is not something that we have done any work on.

THE CHAIR: Thank you very much.

KAREN HARMON was called.

THE CHAIR: As you will be addressing the committee, I need to make you aware of certain privileges you have. You should understand that these hearings are legal proceedings of the Legislative Assembly protected by parliamentary privilege. That gives you certain protections but also certain responsibilities. It means that you are protected from certain legal actions such as being sued for defamation for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter.

Thank you for your submission. Would you like to address the committee?

Ms Harmon: Certainly. Thank you for the opportunity.

MR SMYTH: Sorry, Madam Chair. Can the witness identify herself?

THE CHAIR: This is Karen Harmon from Directions ACT.

Ms Harmon: Formerly known as Assisting Drug Dependents Inc. The reason I was prompted on behalf of the organisation to make a submission was our concern about the use of licit and illicit substances within school and the effects on young people who attend school and who take illicit and licit substances outside of school—the quite obvious health impacts that that has as well as the social impacts and the impacts in the justice system.

We have found that the age that young people start using drugs is becoming lower and lower. Generally when we speak about drugs we tend to think specifically about illicit drugs, and I'll talk about those, but the thing that concerns us most is that the first drugs many young people use are those that are well sanctioned within the home, such as coffee and drinks that have a high caffeine content—cola drinks, et cetera. Young people have access to cigarettes and access to alcohol. There is even some prompting by parents for them to try alcohol.

When we talk with young people, we find that their use started at a very young age, maybe seven or eight, when they were encouraged to take a sip of dad's beer, a sip of mum's wine or whatever. They have access to cigarettes that their parents or older siblings might use. They may go to school and boast a little about some of these experimentations and encourage peers to participate in some of these uses.

Many people seem to believe that drugs in schools are there as a result of behaviour by nefarious characters, when in fact a lot of drug use at school is perpetrated by young people who've accessed drugs, including licit drugs, in their home.

One of the more concerning aspects of this is that licit drugs have been normalised in social behaviour, which encourages experimentation and curious young people to try the more dangerous drugs, the illicit drugs, and even those drugs that are prescribed legally but are used illicitly, such as drugs that are used for attention deficit disorders, such as Ritalin, maybe some benzodiazepine that has been found in the medicine cupboard at

home, even over-the-counter drugs like paracetamol and aspirin. We're finding that many young people use these at a much higher rate than they would have a generation ago.

There seems to be a lot of reasons for that. A lot of it has got to do with normalising the use of the drugs through exposure to advertisements on television, parents popping an aspirin or a paracetamol at the drop of a hat for headaches and other emotional problems.

I guess the main issue for us is that young people do have the opportunity to access drugs at a much earlier age, and we're not really addressing that problem. We're addressing the problem of illegal drug use, and we're pouring a lot of resources into that. But we're not looking at how we can intervene at a much earlier age to identify what the causes are. Why do young people feel they need to experiment with drugs? Why do young people believe that this is a rite of passage for them? I know that there are very complex social circumstances that young people grapple with now that they didn't need to grapple with, say, a generation or two generations ago. But what are we doing about it?

When we have the opportunity to have an interaction with a young person who is still attending school in relation to drug use, they're usually well entrenched in the drug culture. They've been using cannabis for quite some time. A problematic behaviour has presented. They've dropped out of school. Their parents are concerned about their behaviour. The teachers express concern. They're very well along the road of entrenched drug use. What we need to do is look at how we can address this problem much earlier.

A lot of resources have been invested in both zero tolerance approaches and harm minimisation approaches. But in the ACT our experience has been that the approaches have been very fragmented. There's a lack of coordination, a lack of collaboration, a lack of focus and some conflict in the approaches we take. Some schools practise zero tolerance, some schools practise harm minimisation, and some schools don't want to know about the problem.

We offer a program aimed at the colleges. We provide an on-site counsellor on a weekly basis to every government college in the ACT. In the last 12 months access to that counsellor has increased dramatically. That is mainly because the young people know that we're not mandated and we're not required to report what they confide in us to another agency. There's a level of comfort in disclosing the problems and a greater opportunity for us to address their problems.

On request, we go into secondary schools and non-government schools to provide drug and alcohol intervention. Sometimes it's an education program aimed at parents, sometimes an education program aimed at the student body, sometimes an education program aimed at the teaching staff. Very rarely is it an education program aimed at the whole school community. So there's not really a whole-of-school approach to the problem. We have instances where we are asked not to talk about certain drugs, and that makes it very difficult to look at it in a holistic way.

MR SMYTH: Who asks you not to talk about certain drugs?

Ms Harmon: Some of the school principals, the schoolteachers. They say, "We just want to talk about alcohol. We don't need to talk about heroin use."

MR SMYTH: That was going to be my next question. What are the particular drugs they ask you not to address?

Ms Harmon: The hard-core drugs, if you like—heroin, amphetamines, cocaine, those drugs that usually mainstream society looks at as being used by those people who have opted out of society or those who are deeply entrenched in the drug culture. Recent research and recent surveys have identified the extent of heroin and amphetamine use in schools. We do not believe that they offer a true picture, because of our privileged position, inasmuch as we have the opportunity to reach into certain sectors of the community that other agencies aren't able to reach into and to gain information. We know that the incidence of illicit drug use in this jurisdiction is far greater than what's represented in any research that has been done so far.

THE CHAIR: Would you also say it's not a true reflection of the use of licit drugs, or are you more particularly concerned about illicit drug use?

Ms Harmon: I think the picture of licit drug use is reasonable, but it's not being treated seriously. We could intervene at a much earlier stage to prevent a fulmination of the use of those drugs that are not illegal. But it is important to consider the damaging health effects that these drugs have, particularly on young people. The reason they have such damaging effects on young people is that they're still growing. Obviously there are major effects on anyone who uses drugs to any extent and misuses them in a way that has impacts on their heath and on society generally. But young people are still developing. It interferes with their education in a very dramatic way as well. I think that has been covered in my submission.

I come back to the issues that I see need to be addressed. When we go into the schools there needs to be greater clarity about the preparedness of the school community to accept the messages we take in. There needs to be a greater level of collaboration amongst the agencies providing drug and alcohol services to schools, because there are many agencies going into the schools. It's not that there is not the opportunity to present these issues to young people and to talk about them with them, but there are too many people providing that information. The information is inconsistent. There's not even any congruency in some respects. There are different approaches, there are different methodologies for how these messages are provided, and there has not been any real in-depth research that has been able to disclose the efficacy of the education that's provided, the quality of the information and how it's provided. There is also the issue of zero tolerance versus harm minimisation.

We also need to address the problem at primary school. This is an area that hasn't been explored as fully as it could, we believe. Often the issue at primary school is not so much that the young people might be using drugs, either legal or illegal drugs, or licit or illicit drugs, but that their parents are using drugs to an extent that is impacting on their lives and impacting on the way in which they can effectively move through the school system and whether they're being cared for in a way that's going to promote their health and their ability to learn in a way that's going to make them meaningful citizens down the track.

We also need to look at the use of drugs like Ritalin. That's a concern, and I don't think that concern has been addressed as fully as it could be. I guess everyone knows someone who has a child who has ADD. There are other names too—attention deficit disorder and hyperactivity disorder. Ritalin is prescribed very readily, and it's prescribed at ever-increasing rates. Some studies have been done, even within the ACT, on the increasing level of prescription of Ritalin.

One issue is whether with the young people who are being prescribed Ritalin other approaches have been examined to see whether it is appropriate to go straight to a chemical solution or not. Another issue is whether these young people are using those drugs appropriately or whether they're sharing them or trading them off. We know that many young people use Ritalin illicitly—that is, they inject it and use it in a way that is very detrimental to their health. Ritalin was never intended to be ingested through the intravenous route, and there are dangers associated with injecting anything into the body and the use of needles and syringes. That's another area of drug use that needs to be explored more fully, we believe.

THE CHAIR: I was interested in your comment about the need for some kind of evaluation of programs that exist now and your comment that some of them are even contradictory or inconsistent so there are a lot of mixed messages. I'm interested to know how you think that can be resolved. If you're trying to evaluate the quality of a program, there has to be fundamental agreement about what the approach should be. Clearly that's a controversial issue because, as you said, some schools take a zero tolerance approach, probably because of the influence of the board. Supposedly we have an overarching drug policy informing schools' work in this area, but you can end up with a random approach and, as you said, inconsistency across schools. How do we evaluate the efficacy of programs? Do you think there's a way we can do that, a way that would help deal with the political differences? Some people see this as a moral issue. If we see it as a health issue, which I assume this committee is addressing it as, I would like to get a sense of how you think you can evaluate programs. I take your point. I think it would be very important to understand what's happening now and what's working.

Ms Harmon: My understanding is that a range of organisations and agencies provide this education. Schools themselves provide education around drug and alcohol use through their own curriculum, often through their physical education programs, as I understand it. So there is an issue around what information is being provided and how it is being provided. Other agencies provide information. The AFP provide education. The YWCA provide education programs. We provide education programs. Youth Junction provides education programs. The list goes on and on.

There has been no attempt to examine the approach that each of these organisations uses in delivering education programs. Often these programs are being delivered to the same student groups. They're getting a multitude of messages and a multitude of information, and often that information is slanted as a result of the philosophy of the agency that's presenting the information.

Whether each of those education programs has been evaluated, we don't know. Often they've been plucked from another program that may have worked well somewhere else, and there may be good research results. But there are unique attributes to each

jurisdiction, and whether they are taken into consideration in the education provided is unclear.

I think the first thing to do before we look at the evaluation is to do some sort of baseline assessment of what's being provided, how often it's being provided, the aims and objectives of each education and information program, the age groups they're intended to be applied to, and then look at the needs. There's a primary school focus; there's a secondary school focus; there's a college focus. We should look at whether these programs are going to be appropriate for those age groups. I don't know that any of that has been done.

In evaluating a program, we do have some baseline information that tells us about use and trends here in the ACT. The recent report provided by ACT Community Care and the Australian Cancer Council has given us some good baseline studies already. We need to look at how these results are going to inform us in the development of an evaluation that is going to be embracing enough to capture the information about and around the education approaches that are being implemented through this variety of programs and agencies. That's not hard to do. But it is hard to do it when everything is so disparate and fragmented. That's the difficulty. The evaluation is not difficult; it's what you're evaluating.

MR SMYTH: So what's the answer?

Ms Harmon: The answer is some way of pulling together all the education programs, looking at the validity of those programs, looking at what is required to provide a consistent approach, coming to some agreement about what a consistent approach is, engaging the schools in the consultation process. A lot of the education programs that are being provided are not being provided in consultation with the schools themselves.

Often the schools see the opportunity to bring someone else in as a way of them not having to deal with the problem. They can just ask someone to come in and do this, because they're concerned about their lack of experience and expertise in providing the education, and they don't have the human resources or physical resources that might be required to conduct the sessions.

I don't think the parents are involved enough. A lot of the concern that schools have is around what impact agencies like us will have on their young people and the impact that message might have on the parents and whether there's going to be some sort of outcry from parents whose understanding of the issues is lacking.

MR SMYTH: Is yours a zero tolerance message or a harm minimisation message?

Ms Harmon: We work under a harm minimisation philosophy, which is consistent with both federal and ACT government approaches.

MR SMYTH: So how many schools would be pushing zero tolerance?

Ms Harmon: Mostly the private schools. That's another issue. The private schools are often being left out in the cold in the provision of informed health education around the use of drugs and alcohol. That's a concern as well. It should be an approach that embraces all of the education institutions within this jurisdiction.

THE CHAIR: And do you see the results of that in your agency? Are you saying that you can see, through the young people who come through your agency, different experiences, different levels of knowledge and a different understanding?

Ms Harmon: Absolutely, regularly, on a daily basis.

MR SMYTH: What impact are parents that use tea or coffee, cigarettes and alcohol having at home? The other aspect is parents that are illicit drug users. What guidance can you offer us?

Ms Harmon: I can give you a case study. We have a client couple where both the male and female partner have been long-term drug users. The female is a second generation drug user. They've had brushes with the law, so to speak, and have been incarcerated on and off over time. They have a daughter who is 11. This young person is basically looking after her family. She's an only child, but she's looking after her mother and father. The roles have been completely reversed.

This young girl has not been able to participate in school activities in the way that other young girls of her age have been able to participate in school activities. She's the carer. She has also suffered quite profound health impacts as a result of things like physical abuse, nutritional neglect, physical neglect, emotional neglect. This young girl is requiring intensive support from a range of agencies just to keep her from sinking into a role that is irretrievable.

At the moment everyone is battling very hard on behalf of this young girl. But at the same time enormous resources are being poured into this young girl's parents as well. All her parents' associations are with the drug-using community, so she sees this sort of lifestyle as a normative way to live. That's incredibly sad. That's just one example. There are many examples of that.

MR SMYTH: Do you get students questioning what their parents are doing in that regard? Are they coming to seek your help, or is it mainly the students that are actually using?

Ms Harmon: Young people have come to us because they're concerned about their father's alcohol use or their mother's use of drugs like Valium. Parents come because of a problem they have with one of their children. Entire families that are affected through their use of drugs seek assistance. But many families abandon a spouse, which leaves a family as a sole-parent family, or they abandon a young person to fend for themselves, to protect the rest of the family. Again, there are a lot of health issues—physical and psychological/emotional issues.

MS MacDONALD: You were talking about young people in the home having access at a younger age to societally accepted drugs such as alcohol, caffeine and tobacco, although tobacco is becoming less societally accepted. You obviously have current

statistics you are using. But you made a comparison with a generation ago. Do you have statistics from a generation ago and before that on which you made the comparison?

Ms Harmon: Yes, we do, but only on tobacco and alcohol use.

MS MacDONALD: Not for cocaine?

Ms Harmon: While nicotine use amongst young men is dramatically falling, nicotine use amongst young women is dramatically increasing compared to general tobacco use across the board. On heroin use, we do have information from the 1960s, which is really a generation ago. Certainly there has been an increase. There's no doubt about that. Cannabis use is about the same, interestingly.

THE CHAIR: Since the 1960s?

Ms Harmon: Yes.

THE CHAIR: It doesn't surprise me.

MS MacDONALD: I just slide into the 1960s.

MR SMYTH: Thank you for the suggestions at the end. They are very interesting.

THE CHAIR: Yes, they are good suggestions.

MR SMYTH: It's nice to get suggested solutions from time to time.

THE CHAIR: The suggestion of a youth health summit is interesting. We need to try to understand why there are different levels of substance use and abuse. Obviously it's a huge question. Mr Eckersley might have something to say about that.

Ms Harmon: It's incredibly complex but, as I said in my submission, we just can't abandon it to the too-hard basket. It might take a long time to come to a solution that provides a light at the end of the tunnel for us all, but there are ways of doing it. I think engaging the young people in the decision-making is clearly a very appropriate way of doing it, and maybe a young persons summit would be useful.

THE CHAIR: We have a substance abuse task force too now, so maybe there's an opportunity there.

Ms Harmon: It could be a subcommittee of that or something.

THE CHAIR: Maybe, yes. Thank you very much. We appreciate it.

RICHARD ECKERSLEY was called.

THE CHAIR: Our next witness is Richard Eckersley from the National Centre for Epidemiology and Population Health. Did you hear what I read out to the previous witness?

Mr Eckersley: Yes, I did.

THE CHAIR: So you're okay?

Mr Eckersley: Yes, sure.

THE CHAIR: Do you want me to read it again? You understood?

Mr Eckersley: Yes.

THE CHAIR: Then we'll start straightaway.

Mr Eckersley: Did you want me to launch into a bit of a spiel about the work I'm doing?

THE CHAIR: Yes.

Mr Eckersley: I'm from the National Centre for Epidemiology and Population Health. As the name implies, we take a very broad social view of health issues, looking at them at a population level rather than at the level of individuals.

My work with young people is part of much broader research and an agenda looking at relationships between economic growth and quality of life and ecological sustainability, and how we measure and define progress and things like that. So my interest in young people's wellbeing basically involves looking at whether health issues amongst young people are occurring within a social context that's either improving or deteriorating for young people generally. That has a lot of implications for how you deal with the problems.

If the health issues facing young people are occurring within a social world that's getting better, then you can legitimately focus on those ones that are perceived to be at risk. If, on the other hand, their world generally is deteriorating, then you've got to look at the much broader social, economic and cultural factors that are shaping the lives of young people today.

I suppose most health approaches tend to assume that the vast majority of young people are thriving and doing well and that there is a particularly small subset that for various largely personal reasons are having trouble. For evidence for that point of view, you can look at the statistics that suggest that the seriously disturbed, for example, are only a very small minority of the population. Youth suicide directly affects 0.02 per cent of young people in any one year. Surveys suggest that 90 per cent of young people say that they're healthy, happy and satisfied with their lives. The crude indicators of wellbeing, like life

expectancy and mortality rates, are continuing to improve. Standard of living, which is the way in which we tend to measure overall social wellbeing, is rising quite rapidly.

On the other hand, you can look at other evidence that suggests that things are getting tougher for young people generally. For example, there's no evidence that I'm aware of that suggests young people are getting happier over time, or are happier now than they were a generation or two ago, but there's a wide range of evidence that suggests that their emotional and physical wellbeing is deteriorating. That includes things like the statistics on drug deaths, suicide, depression, crime and also in the physical area problems like asthma, obesity, diabetes type 2 and so on.

Evidence also suggests that those people most affected don't represent a small minority that's clearly segregated from the majority of young people, but rather there's a continuum or there are gradients of suffering or distress that include quite a large number of young people at their less serious margins. For example, the survey suggests that large minorities of young people, extending to majorities in some cases, often experience depression, tiredness, feeling stressed, having trouble sleeping, lack of energy and thinking of suicide at one level or another.

The factors that are creating those broad social patterns and trends interested me in my work rather than looking at specific interventions or programs or policies to deal with those that are at the extreme end when it comes to suffering and distress amongst young people.

I'd prefer to take questions as much as possible. My picture is a very broad one. To focus on the issues that interest you, it's probably better if I respond to questions. I can wrap up by saying that of interest when you're looking at the broad social determinants of health are inequalities in health, inequalities between groups within the community in terms of their health status. A lot of the research is focused on socioeconomic status. You get health differences, with people lower down on the social scale tending to have worse health than those higher up.

You can split that health inequalities cake in a number of ways. You get differences, for example, according to gender, race and ethnicity. Marriage is another one. I am not talking about young people so much here. Marriage tends to confer health advantages, as does religious belief.

I've been looking particularly at the broad cultural characteristics of modern Western societies, things like individualism and consumerism and the extent to which these are having a very pervasive effect on people's health and wellbeing, which doesn't explain why one individual rather than another takes to drugs or takes their own life, but makes it more likely that in the population as a whole more individuals will do things like this.

MS MacDONALD: Your speciality is looking at the increase in depression and suicide and looking at population health generally; is that right?

Mr Eckersley: Yes.

MS MacDONALD: I know that your work is not based on the ACT; it's Australia-wide. Are populations being compared city to city within Australia and is the Australian population being compered to overseas populations for possible increased prevalence?

Mr Eckersley: Within-Australia differences by state and capital city and so on are probably available fairly readily from the ABS. My recent work in the youth suicide area has been based on making international comparisons. One of the things I did with a colleague at NCEPH was to look at youth suicide rates in the developed world, OECD nations, and analyse them against 32 different economic, social and cultural variables.

Let me emphasise that I'm looking at the characteristics of whole nations here, so I'll take the national youth suicide rates and compare them with things like youth unemployment, inequality, child poverty, divorce rates. They are the sorts of socioeconomic variables I looked at to see what statistical associations I could find, and a whole range of cultural variables that might indicate the extent to which kids feel they belong or feel isolated. That included things like meaning in life, importance of God, national pride. Tolerance of suicide was another one—whether in that society suicide was relatively tolerated or not.

Then there were a number of measures of individualism—the extent to which people felt they had control over their own lives, freedom of choice and so on. That showed that there were no significant associations with the socioeconomic variables like poverty, youth unemployment and so on, which is not to say that those factors aren't involved. If you look elsewhere in the literature, they're often cited as risk factors in suicide, but they didn't show up in that fairly broad-spectrum crude analysis I was doing.

What did show up, however, was a strong correlation with individualism. In other words, the more individualistic the society, the higher the male youth suicide rate tended to be. The correlation wasn't as strong with female rates, but it was there to some extent.

That leads into a fairly complicated analysis of exactly what that means. I've argued that it reflects the failure of societies to provide appropriate sources of belonging, an attachment to young people, and conversely a tendency probably to promote unrealistic or inappropriate expectations of freedom of choice, autonomy and independence. While our culture tends to promote those things as good things, the psychological literature suggests that they can often be harmful to wellbeing by isolating people from other people in the broader community.

THE CHAIR: Our terms of reference are to look pretty broadly at emerging health problems and solutions that may be working. Listening to what you say, I'm a little bit confused. There are many broad factors that can come into play. I've heard you speak before, so I understand that you think a sense of belonging is important. Is that correct?

Mr Eckersley: Yes.

THE CHAIR: Self-esteem is often raised in this discussion. Self-esteem can be about individualism, can't it? You can feel good if you're the best or whatever. Self-esteem can also be about not being the best but just belonging. In the culture of a school, what would you try to achieve if you wanted to maximise the health of the children within the school, given that they have a whole other life outside and you might want to bring the families

in as much as you can. That can be a response to try to make it a whole-of-society thing as much as possible within a school. Can you say what you think?

Mr Eckersley: I did a bit of talking to colleagues so that I could offer you something a bit more concrete than that very abstract analysis I've given you. But it is interesting that at that level the issues get very complicated and difficult to understand. You mentioned self-esteem. There's a whole debate going on now, in America in particular, about whether high self-esteem is good or bad. The Americans have long felt that the source of the problem was low self-esteem and that if you raised kids' self-esteem the problems would be fixed. But there's a bit of a backlash to that now. A number of psychologists are saying that high-self esteem can be part of the problem; that people with very high-self esteem tend to be risk takers. They can be bullies, obnoxious, and so on and so forth.

I suppose you've got to distinguish between a sense of self-worth and a sense of self-esteem which becomes almost narcissistic and requires constant validation. People are wanting that esteem validated. Moving away from that, I wouldn't be advocating a program to build self-esteem on the basis of that sort of evidence.

On the other hand, it is tricky. Some of the work on parenting programs suggests that they've been beneficial—fairly general programs in schools, or through schools, particularly targeted at people that show evidence in surveys of inappropriate or adverse parenting. They're either too authoritarian or too permissive or whatever. It can work. But then I was speaking to a colleague yesterday about this, and he came back to the problem you were raising earlier about evaluating these programs carefully. He's not convinced that the rigorous evidence is there that parenting programs work.

One that has worked quite well in Victoria—and I don't know a lot about it—is the Gatehouse program that was undertaken by the Centre for Adolescent Health. As I understand it, that was involved in developing fairly school-specific programs that took into account the school's particular qualities, characteristics, neighbourhood and the issues that it faced and looked at ways of getting the kids more involved in schools and looking at ways of improving the teachers' approach to education and the kids. I don't know enough about it to get into more specific details than that.

THE CHAIR: We've heard it mentioned before. I think we might need to follow that up.

Mr Eckersley: It has apparently produced some fairly good outcomes in reducing health problems amongst that school community.

Another one that is probably promising is one that has been done in some schools in America, with some good results. It introduces values education into schools. This is becoming more popular these days. Educating kids about something as fundamental as values is important when it comes to the more specific issues of health and wellbeing.

MR SMYTH: You mentioned earlier that there wasn't a stereotypical group, the mythical 1 per cent that are afflicted by everything. You said that there were a range of issues that encompass the broad. Who are the broad and what are the issues?

Mr Eckersley: If you look at any of the problems like crime, depression, drug abuse or suicide, you don't get a picture of where the problems are all located or even of a heavy concentration in a particular sector of the community. Sure, you get a small group that might commit crimes more frequently or be more seriously depressed or more seriously suicidal. But beyond that you get a continuum of lesser criminal activity, lesser depression, lesser suicidal ideation. As you go across that spectrum it includes a large proportion of young people.

It's very difficult to identify a cut-off as we often tend to do. One of the issues with population health is that we tend to think that individuals either have a problem or don't. A very eminent British epidemiologist, Geoffrey Rose, said that it's more a matter of how much of the problem you have. There is this continuum and there's therefore a relationship between the average of a characteristic in a population and the prevalence of deviance—in other words, how serious a problem you've got. So one of the principles of population health is to reduce the risk of the whole population rather than target the high-risk individuals.

MR SMYTH: So early intervention programs can make sure of that?

Mr Eckersley: Yes.

MR SMYTH: A kid may have an extreme problem. We need solutions tailored to his or her need. But in the main we ought to be addressing early intervention strategies to minimise the potential which is inherent in all of us for some sort of weakness, flaw or fault?

Mr Eckersley: That's right, yes.

MR SMYTH: Is there a No 1 issue that worries you? As a committee, we're going to write a report. We'll make suggestions to the government and hopefully they'll act upon them. From your research, what's the No 1 problem facing us as a country, if you can't designate it for the ACT?

Mr Eckersley: The thing that most interests me in my work and that therefore I tend to call No 1 is a very broad one, and that is the values that are promoted by our society. The values our society promotes tend to be detrimental to people's health and wellbeing. We tend by and large to focus on material things like poverty, inequality, marital breakdown or whatever. While those factors are important, the work I've been doing suggests that much more abstract cultural qualities—where people find meaning in their life, a sense of identity and belonging and some sort of moral order in their world—are very critical. They're unfortunately much harder to measure and assess.

If you look across history, most societies and most religions tend to promote values that promote strong, harmonious personal relationships and social attachments and the strengths to endure adversity. They're the virtues. The vices by and large have tended to be the unrestrained gratification of individual wants and desires and the surrender to human weakness.

What a lot of our society does, particularly through the mass media, is reverse those things. A culture of consumerism is really a culture based on an ethic of envy and greed, for example. Individualism places the individual self at the centre of a framework of values and priorities. That works against that sense of attachment and belonging that has often been promoted in other cultural systems.

These are fundamental issues. My work addresses the very broad public discussion about the sort of society we want to live in rather than specific interventions and policies.

MR SMYTH: Would it be fair to say that that impacts on how we might approach our physical fitness, our nutrition, whether we resort to drugs, how we interact with other people, whether we get tied up in crime? Is it because we lack a sense of core values?

Mr Eckersley: It's linked into that, yes. When you look at a lot of these issues, they come back to the fundamental question of the values that are promoted by societies and the extent to which they meet human needs for meaning and purpose in their life or identity and belonging. When people don't have that, it makes them more likely to seek some sort of relief or distraction through drugs or to feel suicidal or whatever.

MR SMYTH: So teaching values at school, teaching comparative religion and giving people sources or places they can go to to find strength are of value?

Mr Eckersley: I think so, yes. We need to be clear about what we're talking about in value education. This isn't being as prescriptive as the churches have been in the past. We have to appreciate that times have changed and people no longer want to be told what values they ought to uphold and what they should do.

MR SMYTH: Religion is no longer the opiate of the people?

Mr Eckersley: That's right. Accepting values as fairly abstract principles to guide how we live and not to translate them into highly prescribed behaviour and rules is an appropriate thing to do. The psychological literature, in particular, shows that values matter in providing what humans feel they need for wellbeing.

MR SMYTH: Is there someone or something we could refer to on values education? Is there a document or a text?

Mr Eckersley: I do have a book that was sent to me by an American colleague, Dave Myers, a social psychologist. The book is called *The American Paradox: Spiritual Hunger in an Age of Prosperity.* It's a Yale University Press publication. He does have a chapter on educating for a moral compass, which talks about trials in America in introducing values education in schools.

THE CHAIR: I saw a interesting program recently in America on teaching philosophy to young students. It enabled children to have ethical discussions. That not only facilitated active thinking and listening but engaged the children in an ethical debate. That, for me, was getting to what you're saying. It wasn't about saying, "These are 10 commandments; these are your values." It was giving them an opportunity to determine what their values were.

MR SMYTH: Giving them a toolkit to build their own.

THE CHAIR: That's right. You end up with some fundamentals if you work that out. If you have that discussion you tend to end up with similar principles, to a degree.

MR SMYTH: At least all of our primary schools are now teaching philosophy.

THE CHAIR: Are they?

MR SMYTH: Yes.

THE CHAIR: In that way?

MR SMYTH: For exactly that reason.

THE CHAIR: That would be interesting for us to look at. I'm afraid we're going to have to bring this to a close. I thank you very much for talking to the committee. We'll follow up those references.

Mr Eckersley: I have a couple of short articles here I can leave with you.

THE CHAIR: We will regard them as an exhibit. Thank you.

ANNE-LOUISE PONSONBY was called.

THE CHAIR: I welcome Dr Ponsonby from the National Centre for Epidemiology and Public Health. You should understand that these hearings are legal proceedings of the Legislative Assembly protected by parliamentary privilege. That gives you certain protections but also certain responsibilities. It means that you are protected from certain legal action, such as being sued for defamation for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter.

Can you identify yourself for Hansard?

Dr Ponsonby: I am Anne-Louise Ponsonby, a medical epidemiologist and a public health physician. I am here representing some of the work on asthma, allergy and other immune disorders that is going on within NCEPH at ANU and also in collaboration with my colleagues at the Academic Unit of General Practice and Community Care at Calvary Hospital.

The issues I thought that you might be interested in hearing about today that particularly pertain to school-age children are those in relation to childhood asthma, childhood allergy and immune disorders more generally, and some of the recent information about sun exposure and immune disorders.

I put in a submission that had quite a lot of facts and figures and I will just briefly revisit it. From the point of view of childhood asthma, Australia has one of the highest prevalences of childhood asthma in the world, with the international study of asthma and allergies in childhood reporting that 27 per cent of Australian children aged six to seven have asthma as reported as a wheeze within the past year.

We have done some work in the ACT over the last three years on asthma and allergy, particularly amongst eight- to 11-year-old children. What we found was that the prevalence of asthma amongst ACT children was also high but it was similar to the other locations in Australia. It wasn't very largely higher. However, the rates of hay fever and rye grass allergy did seem to be quite high, and I will come back to that.

Can I just put a caveat on that. Asthma is a funny disease. It is a very global, broad diagnosis, so in a way it is a diagnosis on a symptom—wheeze. It is similar to things like fever. Within childhood asthma there is irritant induced asthma from tobacco smoke and so on, there is allergy induced asthma and there are other types of asthma as well. But they all get put in under this broad spectrum of asthma, so if we are comparing rates for ACT children to the rest of Australia we are just looking at this global asthma label. We may well have a higher proportion with the sub-group with allergic asthma and a lower proportion with irritant tobacco smoke induced.

MR SMYTH: Do we know that?

Dr Ponsonby: We don't know that. No, we don't, because we haven't had the same study happen nationwide. But I think it is a point to be considered.

The other thing that has come out of these childhood asthma and allergy studies is that it is a significant burden of morbidity for school-age children. If we look at night wheeze, we have got 9.4 per cent of the children surveyed. It was a fairly representative group. We had a good response rate for this study—more than 81 per cent of eligible randomly selected children participated. So we have got 9.4 per cent who would have sleep disturbance with wheeze over the past year, but less than one night per week. And we have got 3.3 per cent of children that would have had sleep disturbance with wheeze at night in the past year once or more per week. So although that doesn't sound a lot, when you are thinking about every class room of 30-odd children or so, you are likely to have a child that has got significant nocturnal waking due to asthma.

One of the things that the Academic Unit of General Practice and Community Care has instigated in conjunction with ACT Community Care is school-based screening for childhood asthma at school entry. Nick Glasgow, who is actually interstate today, published a paper in the MJA last year on this asthma screening occurring within ACT schools. I brought this along today in case you wanted to make a copy of it.

I think it is a useful thing to do. There are other health screens that happen at schools that aren't as useful as asthma when you consider how common asthma is with one in four or one if five children having asthma. Earlier intervention does improve symptoms amongst children. By having this facility in the ACT, hopefully we will be able to monitor asthma trends over time and also asthma management over time. So I just wanted to bring that to your attention. It is the one with the asterisk if you want to get a copy of it.

Let me talk about childhood allergy. Again, we haven't got studies that are done in a nationally comparative way, so it is difficult. But one national study was done by the ABS in 1995 and it looked at adult hay fever and found that adults who lived in the ACT reported more hay fever than did adults within other locations. And certainly within our study we had 34 per cent, so a third of children reported to have hay fever between the ages of eight to 11. Hay fever is the type of thing that tends to increase over time, so it is likely that the proportion will be substantially higher amongst high school children or young adults.

THE CHAIR: What do you mean by "more people get it as they get older"?

Dr Ponsonby: As they get older. It is an accumulative thing.

THE CHAIR: The same people get it worse?

Dr Ponsonby: With food allergies, a lot of two-year olds seem to be allergic to egg and so on and they tend to grow out of that and tolerance occurs, but with the inhaled allergies, house dust mite inhaled allergy happens fairly early on and so you get quite a good idea early on, even by age 10 or 12, of who is going to be allergic to house dust mite or not. But with rye grass and grass allergies, they tend to accumulate over age, so someone might become allergic to grasses for the first time at the age of 16 or at the age of 30.

MR SMYTH: At 28 I started sneezing, just suddenly.

Dr Ponsonby: Right, yes. So we had a substantial proportion of these children allergic to one of the three grasses that we tested for. And when we say "allergic", we mean a skin prick test reaction of three millimetres or more according to a battery of allergens that are placed on the arm and then lightly pricked through the skin. This test shows quite good correlation with more invasive blood tests and it is often used in children as a way of screening for allergies and so on.

We also have a significant proportion of children that were allergic to house dust mites. A quarter of children were allergic to house dust mite. That was of interest to us because some people have said, "We all know there are a lot of grass pollens in the ACT. You would expect grass allergy to be high but house dust mite tends to grow in warm, moist locations like Sydney and Cairns. Perhaps it's not such a problem in the ACT." We don't know from our data. We don't have these children's residential history, so we can't be sure of how many of these children were born in the ACT. But we do know that modern housing provides these warm humid micro-climates these days in bedrooms, no matter what the outdoor conditions are. So we didn't find it surprising that house dust mite allergy was high but it indicates to us that it is well worth while to try and go in with house dust mite avoidance strategies as well as other activities relating to grasses.

THE CHAIR: Are the grass allergies seasonal?

Dr Ponsonby: Yes, they are. Yes, very high. Late spring and summer is when most of the grass hay fever symptoms tend to occur.

There is something I thought you would think was interesting from the results. We often also get people inquiring about wattle and whether that is causing a lot of allergy. Nine per cent of the children were allergic to wattle, but that was a similar proportion as the children who were allergic to silver birch.

One of the things about these introduced tree species is they tend to have very different pollen loads when they get put into different climates. When you take UK-based trees or whatever and you translate them into Australian conditions it is a bit of an experiment as to what the pollen load is and how that affects people in the general population. So I would just like to bring out the point that the same proportion of children are allergic to the introduced tree species of birch as are allergic to wattle, which is so much more obvious in people's minds.

Dr Charles Guest from ACT Health said to me two weeks ago that they had had an inquiry about pine tree plantations in Weston and how that related to allergy. So I went back and got a little bit of data on that to add to the submission. When we did this study we did it on this representative set of school children—758 school children.

We also looked at all children who attended hospital for asthma over the same year and a half period—it was 1999 to 2000. We had 78 children who presented—predominantly to Canberra Hospital, but sometimes to other hospitals—for asthma. And we skin prick tested those children as well. So we don't have pine allergy data on the general school population. But amongst the hospital children—these are children who are sick; they are presenting to hospital with asthma—14 per cent were allergic to cockroach but only 1.4 per cent were allergic to pine radiata.

That suggests to us that it is not such a big problem. These are children who are ill and tend to have a very high proportion of allergies anyhow and yet only 1.4 per cent of them were allergic to pine radiata and 4 per cent were allergic to pine. So my view would be that that is not a big public health issue.

THE CHAIR: Did you say cockroach?

Dr Ponsonby: Yes. And that is lower again than some of the data from the US or even from Sydney with—

MR SMYTH: There are smaller roaches here. Anne-Louise, we heard from the conservation council earlier on about an unsubstantiated fear that particles from wood smoke was causing asthma, particularly in Tuggeranong. Did that come out? I am pleased to hear that you have a survey of the 78 kids that presented in a year to Canberra Hospital. Was wood smoke a trigger?

Dr Ponsonby: We didn't have that as one of our specific research questions. I am happy to go back to the database and try and get out more data on that issue. One issue we were concerned a little bit about and we did a paper on—all this work I am talking about has been published in international medical journals—was home gas appliance use. There is quite an amount of literature suggesting that high exposure to fossil fuel combustion products is not only detrimental to the airways of individuals but also it might enhance allergic responses.

There had been a lot of outdoor monitoring of fossil fuel combustion in ACT but not a lot of indoor monitoring. What we found was that, in general, of the ACT children we surveyed—which was a fairly representative group again; 71 per cent of eligible randomly selected children—the levels of total nitrogen dioxide exposure that these children had—nitrogen dioxide is one of the most common fossil fuel pollutants produced by car fumes, but more importantly by gas heaters and gas cooking—were fairly low, which was encouraging. We didn't find any relationship between nitrogen dioxide exposure and asthma, wheeze or baseline lung function. We found a slight relationship in that the children that had higher personal nitrogen dioxide exposure after cold air challenge, after these children breathed in cold air for more than 10 minutes, tend to have a little bit more twitchy airways, but it didn't seem to be a very major problem.

Looking at the home heating types, in which home heating types were associated with higher levels of fossil fuel combustion products, the stand-alone gas heaters, either flued or unflued, stood out. The other point I would like to mention is that gas cooking is also an important cause of fossil fuel combustion products within the home and childhood exposure to nitrogen dioxide. Sometimes people tend to think, "I've fixed up the home heating, that's fine," and yet they have their children in the kitchen where they are using gas cooking, they are not ventilating the room, and gas cooking is associated with high levels of this pollutant.

So the focus of this paper was really looking at gas heating within the home. My general work with children, both with infant health and sudden infant death syndrome which I used to work in, is that the proximal environmental determinants of health often get fairly neglected. They are not as obvious. Children spend a lot of time indoors, they

spend a lot of time in bed—and I will come to that in a minute—so they really should be receiving quite a lot of attention.

MR SMYTH: Sorry, before you go on. Table 2 on page 1,208 of the submission: I have to admit that I am not sure what this table means. It talks about home heating type and actually does mention wood heaters. What is the interpretation there in terms of—

Dr Ponsonby: We took as our baseline the homes that had electric heating, and homes that had a wood heater tended not to have any more of the fossil fuel pollutant nitrogen dioxide than homes that had electric heating. But if you look at homes that had the gas heaters, the top line there, you will see that the homes that had the unflued gas heaters had a 1.8 times increase in the mean of nitrogen dioxide, and P values less than 0.05 are significant, so that is highly significant. So the homes with gas heaters that are unflued are much worse with this nitrogen dioxide level.

If I can bring your attention down to line 3, you will see also that homes that had gas heaters, even if they were flued to the outside, tended to have high levels of nitrogen dioxide pollutants.

THE CHAIR: Can gas cookers be flued?

Dr Ponsonby: You can use ventilation above the stove, but sometimes people don't. They are not even aware of it as a health issue. So they are cooking with woks, they have got this gas combustion in the kitchen and, especially in cold weather and so on, they have got no windows open.

MR SMYTH: And they are not turning on the evacuation fan.

Dr Ponsonby: All the doors are closed and they are not putting the ventilation on. So it's a source of nitrogen dioxide within the homes.

MR SMYTH: Could we get you to check your previous data on whether or not the wood smoke is causing asthma?

Dr Ponsonby: Yes. I will only be able to look at home heating questionnaire data.

THE CHAIR: You mean outside—the general air pollution in Canberra?

MR SMYTH: Whatever data was there.

Dr Ponsonby: Yes, whatever. I can look at wood heaters specifically within the home. My data would be within the home level, rather than in the area level. Also Nick Glasgow has got school maps of asthma rates by locations, so that would be of interest to you and I will ask him to send you that formally.

THE CHAIR: Yes. That would be very interesting.

Dr Ponsonby: There is a lot of interesting work at the moment about the interaction between pollen load and pollutants, such as diesel exhaust particles. Because Canberra does have this high grass pollen load, I think it is going to be very important that we try and have low levels of outdoor pollution.

For example, diesel exhaust particles from cars and so on can enhance the allergenicity of pollen particles. So if you get a certain increase in air pollution in city A that has got hardly any pollen load, you are not going to get the same types of allergic or health effects as you would get in city C, being Canberra, with a high pollen load. So that interaction between pollen allergen and vehicle pollution or other sources of outdoor pollution is going to be important to watch in the future.

Childhood asthma. One of our major pieces of work at the moment is looking at bedding and childhood asthma. We had a paper published earlier this year on association between synthetic bedding and adverse respiratory outcomes amongst allergic or non-allergic ACT children. Synthetic bedding has now been associated in more than seven studies with increased levels of wheeze. It is not proven to be causal at all, but there is a lot of work going on looking at the causality.

What people do know now is that, rather surprisingly, synthetic bedding holds five to eight times more dust mites than does feather bedding—modern feather bedding. When you think of ACT children, in our survey 90 per cent of children slept with a synthetic pillow. We are talking about an exposure one centimetre away from their airway, and you have got 90 per cent of children exposed to it. That is huge in terms of population attributable fraction if this exposure was causing wheeze.

A lot of our work at the moment is directed to trying to look at the health effects of that very proximal exposure. It is not just that it is close to the children; it is also that they are exposed to it for more than a third of their day—eight hours out of 24. If we were awake and we had something like this eight hours a day—

THE CHAIR: So when you talk about bedding, you are talking about pillows. Are you talking about linen sheets?

Dr Ponsonby: I am talking about pillows and upper bedding in particular. The Japanese have done quite a lot of work—there is some good work—showing that even though there are lots of house dust mites in carpet and mattress, if you are looking at actually what people inhale then upper bedding is a very important source because it is so close and it is disturbed during sleep. So they found that when they took off old used quilts and put new quilts on children, the levels of dust mite right near the nose dropped 12 fold. So even though these products might have a lower density of house dust mites, they might be much more biologically important because they are so close to the face and they are disturbed. So we are doing some work at the Academic Unit of General Practice and Community Care trying to evaluate whether different types of upper bedding can be of benefit to children who are house dust mite allergic with severe asthma. That is probably all.

THE CHAIR: We are running out of time, I am afraid. Did you want to make some concluding remarks?

Dr Ponsonby: I will raise one other issue: immune disorders and ultraviolet radiation. Ultraviolet radiation is an exposure that we have been evolved to have. It's a U-shaped exposure. You get adverse effects if you get excess sun, and you get adverse effects if you get no sun. It is not an exposure where a zero level is a benefit. What we should be getting is the amount of ambient UVR that our skin type is evolved for.

Over the last 10, 15 years, we have heard a lot about the adverse effects of excess sun. But now in the immune area, there is some more work coming out suggesting that a lack of sun may also be detrimental to children's health. In December 2001 in the *Lancet* there was a paper—I don't think it is a good time to go through all the details now—in respect of vitamin D synthesised by sun. Childhood diabetes has been going up in most modern communities over time. It is an immune disorder. It has a different mechanism than childhood asthma, but it has been going up. What they found in the Finnish studies is that children who are supplemented with vitamin D were much less likely to develop childhood insulin-dependent diabetes mellitus.

There is a whole lot of animal work to suggest that perhaps getting some sun during immunological development is actually beneficial to the immune system and helps damp down some of this auto-immune processes that might be involved. That is an issue that I think you could recommend with school-age children—that someone reviews the "hats on policy" for the winter period. Sure we need hats on in summer, but do we need it for very dark-skinned school-age children who have come to Australia and who are at risk of vitamin D deficiency? They have come from locations where they are evolved to cope with a certain amount of sunlight. We have got them in Canberra and we are telling them to avoid the sun all winter. Is that in their health interests? No, it's not. So I think that would be a useful thing for someone to review outside of this inquiry. Obviously, they will need to go through all the literature and look at all the pros and cons. But that is an issue, too.

THE CHAIR: Okay, thank you very much.

MR SMYTH: Can I just as one last question? What is the No 1 issue that needs to be addressed, in your opinion? What is the No 1 thing that bugs you that we should be working on?

Dr Ponsonby: Well I just think it is environmental determinants of diseases. I just think if governments can support it. I mean, basically, if I do something that has got commercial interest or biotech interest or whatever, you can get lots and lots of support, but if you try and look at things like sunshine and air quality and so on it comes back to governments. Governments are very important in looking at all of these environmental factors. And, yes, 100 per cent of children are exposed to these environmental factors. This is very, very important.

THE CHAIR: The conservation council has talked to us as well, so the environmental influences are coming. I appreciate very much what you have put before us. Thank you.

Dr Ponsonby: My pleasure. Thanks. Good luck with your inquiry.

TRACY SOH was called.

THE CHAIR: Welcome. Thank you for appearing before the committee. You should understand that these hearings are legal proceedings of the Legislative Assembly, protected by parliamentary privilege. That gives you certain protections, but also certain responsibilities. It means that you are protected from certain legal action, such as being sued for defamation for what you say at this public hearing, but it also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter. Is that okay?

Dr Soh: Yes.

THE CHAIR: Please state your name and the capacity in which you are appearing.

Dr Soh: My name is Tracy Soh. I am a general practitioner. I work with the ACT Division of General Practice as a project officer for the youth health project.

THE CHAIR: Thank you. Would you like to address the committee?

Dr Soh: As I said, I am a general practitioner with the ACT Division of General Practice. I work in the youth health field in a clinical capacity at both the Junction youth health clinic in the city and at the Bay youth health outreach, which is based at the Canberra College in Phillip. I also do some policy work around youth health at the division offices. Apart from that, I also work in general practice at private practices in both Queanbeyan and Kippax.

THE CHAIR: You have on-the-ground experience of youth health issues, obviously.

Dr Soh: Some experience. I have been working in the field only since 1999, so it is fairly recent. In terms of general practice, the main thing about general practice is that GPs are out there in the community already. They are in most suburban areas; they are close to where people live. In the ACT we have approximately 350 general practitioners and they provide about 1½ million episodes of service to the ACT population. It takes these days roughly 10 years of training, six years undergraduate and four or five years postgraduate, to become a general practitioner, so there is a high level of skill out there.

The issue facing general practice in general at the moment is one of a shortage of GPs in the area. We have had numbers quoted of anywhere between 30 and 60 GPs short for the precise population that we have in the ACT and there is anecdotal information around that general practices are basically not accepting new patients, so things are getting a little bit tight at the moment. In spite of that, GPs are out there providing services to basically people in the age groups that we are talking about, school-age children. They provide primary health care, immunisation services and immediate care for injuries—all sorts of things that would be seen in general practice.

The ACT division was established in 1992. It is an organisation of which more than 85 per cent of the GPs in the area are members and it provides support services for GPs to provide medical services to the community. We have a variety of programs, one of which is the one I am working in, which is youth health.

In terms of issues which are important to the health of children and young people of school age, I listened with interest earlier to the evidence about the research that has been done on asthma, which is certainly a very important health issue in the ACT and in Australia. In the Australian Institute of Health and Welfare study on the health of children, asthma, respiratory infections, skin conditions, and injuries are listed as main causes of presentations for medical care of young children and young adults. These are things which are commonly seen in general practice.

Youth and adolescent health is a bit more complex because of access issues. Young people, teenagers, young adults do suffer the same illnesses as all the rest of the population, as well as these additional issues of alcohol and drug issues, sexual health, sexual infections, pregnancy, contraception, at-risk behaviours, injuries, motor vehicle accidents, all that sort of thing. It is difficult for young people to access health services. In terms of accessing mainstream general practice, the way general practices are geared up is that they tend to be small businesses, they tend to run on appointments, there is a decreasing rate of bulk-billing, and often they are not well structured to allow young people the time that they need or the health care they need.

Young people, especially disadvantaged young people, often have very complex issues, and they are not always simple medical issues. If, again, we take the example of someone with asthma, if that young person also happens to be homeless, maybe staying above a friend's garage or something like that where there is poor heating and their nutrition is not good, you are not going to get their medical status, their health status, any better unless you deal with the background issues.

Studies that have been done—I have got some references at the back of the submission I wrote; I cannot quote them off the top of my head—have shown that young people do find it difficult for social reasons to see mainstream services. They feel that the reception areas, the staff themselves, the doctors and the nurses are judgmental and they do not feel comfortable about seeing people in mainstream services. They feel uncomfortable in just the physical settings. Most general practices are not set up for young people. They have magazines which are geared to probably an older population. They do not have trendy music playing in the background or anything like that.

There are financial reasons. Again I mention that the rates of bulk-billing are decreasing and the ACT does have one of the lowest bulk-billing rates in Australia. Young people are often financially more challenged. The work available if you do not have qualifications is often not particularly secure and not particularly well paid. People find it difficult to afford to see doctors. In the absence of bulk-billing, being able to afford that up-front fee is often very difficult. There are logistical problems in trying to get to a medical practice or health centre. If you are too young to drive a car, you have just got to hope that the bus timetable suits when you have to get to your appointment, will get you where you have to and things like that.

In terms of the difficulties from a GP's point of view, young people often do not keep appointments well, because being organised is a learned skill and, if they have not learned that skill yet, they do not make their appointments at the right time and they do not make appointments of an appropriate length for the often complex issues that they have, so they will book in for a 10-minute appointment and come in and their life is

a mess and it takes hours to deal with. Because they are complex issues, GPs often do need to cross-refer to other services, to counselling, mediation, alcohol and drug, and sexual health services, and the cross-referrals do make it difficult from a GP's point of view to deal with young people.

From the experience at the division, from the outreaches we have run in the past and from reading about what other agencies around Australia have done, there have been a few models which have approached youth health in various ways. What we do here in the ACT predominantly is to do with the multidisciplinary youth health specific services. For example, at the Junction, where I do some work, there are doctors who work there and there are nurses there who are provided by ACT Community Care. There are youth workers who work there and they have got counsellors, plus there are other services which come into the Junction on certain days of the week, such as people from the drug and alcohol service. Centrelink was coming in last year. They had to drop that because the officer who was coming in left his job.

There are various projects at work through the Junction, such as young carers projects and things like that, so it is a bit of a one-stop shop for a young person. If they have got something that bothers them, they can come in and talk to a youth worker. If it is medical, they can talk to a nurse or one of the doctors. We have clinic rooms where we can provide medical care, if that is appropriate. Certainly, because it is set up as a youth-specific service, there are no appointments needed and the staff who work there are basically salaried, so they do not need to access Medicare, they do not need to have a Medicare card and they do not need to have money to pay for up-front services. That makes it very accessible.

Recently at the Junction, looking at the statistics, predominantly the people who access it are the people who do find it easy to get to that location, so more than 50 per cent of the people who use the Junction are from inner-suburb areas. Some from Belconnen do make it there. It is not too hard from the Woden area. North-west Belconnen finds it tough, Gungahlin finds it tough and Tuggeranong finds it very tough to get in.

The other outreach work that is doing quite well at the moment is the Bay at the Canberra College, and again there are medical services there. Canberra's sexual health service attends there. They have pastoral services and they have employment services. I think the Quest employment service goes there. It is all based within the school environment, so it is easy for the kids to get to. No appointment is needed. The kids can wander in there in their breaks, in their lunch and recess breaks, and the accessibility is very good.

Other models that have been used elsewhere in Australia have been general practice based models—general practice training, which helps upskill GPs to deal with more of the youth health issues, such as alcohol and drug issues and sexual health issues, as well as training in some of the stuff in which GPs probably do not get as much training as they should, such as the more legal issues involved with young people. A person between the ages of 14 and 18 does run into a slightly grey area in terms of what is legal, what they need parental permission for and that sort of thing.

There are other divisions throughout Australia that have run GP support services in that way. Other possible models are things such as the Division of General Practice here already provides other projects where we provide support workers available to general practitioners to help support them in providing the services to other people. For example, we have an opiate program that was launched earlier this year whereby specially-trained drug and alcohol nurses are available to help GPs deal with opiate-dependent patients. We have a similar project for HIV/AIDS where the care is coming to the patients from the GPs but the GPS are supported in their practice by workers paid for by the division.

I am open to questions because I am not sure what else you want to know.

THE CHAIR: Thank you very much.

MR SMYTH: The word "access" seemed to crop up. How big a problem is it for a young person to access appropriate health care?

Dr Soh: It is very variable, depending on the young person. Financially, it can be very hard. A lot of the general practices in Canberra have stopped bulk-billing altogether. A lot of them only bulk-bill people with health care cards. A young person who does not have a lot of money but whose parents earn a fair amount will not be able to access our services and they have to get the money from somewhere.

The other thing is the degree of comfort in approaching general practitioners. Just prior to starting up work at the Bay, in our planning process we had a few informal forums with teenage kids at schools. One of the things that they expressed was they had very little confidence in general practice confidentiality, especially if they happened to be seeing a GP that also saw the rest of the family. They had issues with being seen in the waiting room. If they are living in that community as a young person they just do not want people to know that they are seeing a doctor, especially if it is about a personal issue such as contraception or something like that. Even though no-one could really tell, in their minds they think that people will know that they do not want to be there. Some people handle it really well. There are really together young people out there who have no problems with accessing mainstream services, but there is also a fairly large group of people who just do not.

MS MacDONALD: Leading on from that question, are there added impediments, depending on your ethnic background, sometimes? If you come from a certain community, you may feel less inclined to go to a doctor.

Dr Soh: There are, absolutely. It is probably less relevant in the ACT than in some of the other cities in Australia. I noticed just listening to the news reports on the census recently that we actually do have a fairly small proportion of indigenous people here in the ACT. I haven't got the figures to back me up on this, but from someone working in general practice and the people who walk through my door, we do not seem to have as big an ethnic mix here in the ACT. A lot of it is language. Certainly, accessing medical care and providing medical care need communication, and language is a very big problem in ethnic communities. I am not sure if I have answered your question.

MS MacDONALD: No, that is fine.

THE CHAIR: You said that there was a grey area about parental permission.

Dr Soh: Yes, there is.

THE CHAIR: What is your experience of that?

Dr Soh: Different doctors handle it very differently. I ran a few one-on-one information sessions with GPs when I first started work at the division. By common law, at age 14 people can consent to treatment. However, under the age of 16, parents can still access their child's records if they choose to, which does cause problems with confidentiality. If you cannot assure a 15-year-old of confidentiality, because legally you can't—

THE CHAIR: They are less inclined to come again if it is a difficult issue for the family.

Dr Soh: Yes. On the whole, in practical terms, I have not had personally too many problems. I have had some parents who have asked about things I have seen their children with, but they haven't created too much of a fuss when I have said that I would prefer not to discuss it without permission from the teenager, but it does feel like a very difficult position, because your obligation for confidentiality is to your patient, who is a teenager. Legally, I don't know how legitimate my position was, but ethically certainly the obligation is to the confidentiality of your patient.

THE CHAIR: You talked about the Junction and the Bay as alternative medical settings for young people and said that transport was an issue. Do you think that it would be useful for there to be one more alternative medical setting for young people placed around Canberra? Also, do you think that different models need to be looked at or do you think that, say, the Junction is working pretty well as a model?

Dr Soh: The Junction works very well as a model because it is able to provide all those services in the one place and it is located fairly close to transport through the bus systems and such. I think it would be very useful to have similar settings, similar services, in the major centres—Tuggeranong, Woden, Belconnen. Considering the shortage of GPs in the ACT, finding the staff for these centres may not be easy.

I think it is important to examine other potential models and get the GPs that are already out in the community involved more. That needs more investigation. Different places in Australia have done it with differing degrees of success in terms of general practice education, in terms of getting some sort of general practice accreditation in youth friendliness. There are lots of "youth friendly" programs in Australia where GPs have gone through certain training or have gone through a certain process and got on a list as youth friendly GPs and such.

THE CHAIR: In a previous inquiry we were told that it is difficult for people who are homosexual or bisexual to feel comfortable with going to GPs about sexuality issues, so there seem to be some issues there about people accessing medical services.

Dr Soh: Certainly, when it comes to young people who are only just discovering their sexuality, it is doubly hard, because often they have not totally acknowledged it to themselves and they are not comfortable in themselves about it anyway, so being comfortable about it with someone else is very tough.

THE CHAIR: Would you say that centres such as the Junction for young people in that circumstance would be much more likely in their minds to be less threatening?

Dr Soh: Very much so, because it is geared up to be very non-judgmental and it is a lot less intimidating. There is a very casual wander in setting.

THE CHAIR: The Bay is actually located in a college. Do young people feel that there are confidentiality issues there, or is it really felt to be quite separate from the school personnel?

Dr Soh: It is intentionally in an annexed building, but a separate building to the school. We keep our own files and the students are aware that the only persons who has the access key to their filing cabinet are the clinical staff. We get students who feel very comfortable with us there; there does not seem to be too much of a problem. In fact, the real issue is that it is only the school students that are using it. When the Bay was set up, they were hoping to promote it to the students of the feeder high schools as well as the students at the college.

THE CHAIR: That hasn't worked.

Dr Soh: Yes, it hasn't really worked. I think it is mainly transport that is the issue and timing it with getting all the way to the college and then back to their school during lunchtime and such.

THE CHAIR: I have to wrap it up as we cannot afford the time for further questions. Thank you very much, Dr Soh.

FRANCOIS ROBERT de CASTELLA was called.

THE CHAIR: I need to read you certain requirements regarding giving evidence. You should understand that these hearings are legal proceedings of the Assembly protected by parliamentary privilege. That gives you certain protections but also certain responsibilities. It means that you're protected from certain legal action such as being sued for defamation for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter.

Could you state your name and the capacity in which you appear.

Mr de Castella: My name is Robert de Castella, and I'm appearing as managing director of SmartStart Australia.

THE CHAIR: Would you like to address the committee?

Mr de Castella: First of all, I'd like to thank you for the opportunity to present some of the information we've collected over the last three years. I applaud the establishment and the work of the committee in focusing on children's health and very much look forward to the outcomes you will table. Certainly the information, data and activities that we've been involved in have indicated that there are a number of significant issues that we're very keen to see addressed at a government level.

I've got a number of overheads that I'd like to go through. I've also got copies of the overheads which I'd like to present now or present at some later time. By way of background information, I also have some of the material that SmartStart uses in the operation of the program. I'd like to highlight the fact that the information I'm presenting now is information we've identified in regard to children's health and fitness in the ACT, not specifically about SmartStart. It's really the findings and some of the issues and recommendations that we believe need to be highlighted.

THE CHAIR: You can leave that information here for the committee. That's fine.

Mr de Castella: By way of background, SmartStart was developed here in the ACT over the last five or six years, has been launched and has been in operation over the last three years. During that time we've measured the physical health and fitness of some 12,500 ACT children and profiled over 30 ACT primary schools. About half of those we've done on more than one occasion. So we've started to build up a very interesting longitudinal database on the physical health characteristics of the ACT's child population.

In the development and the operation of the program we've consulted and used a whole range of experts, ranging from Dr Alan Roberts at the University of Canberra through to Dr Deb Hoare from the Institute of Sport; Professor Richard Telford; Dr Peter Larkins, who was president of the Sports Medicine Association of Australia; Dr Xiaoli Jiang, who has a PhD in psychology and works out of Ballarat University; and Dr Tim Armstrong from the Australian Institute of Health and Welfare. We have worked in conjunction with a number of other organisations such as the National Heart Foundation here, and

also with dietitians and nutritionists, especially those working in body image and eating disorder activity among children here in the ACT.

The operation of SmartStart uses a team of qualified personnel. We target these specific areas of body composition: cardiovascular fitness, flexibility, isometric strength, strength endurance, power and coordination. We use a multidimensional settings-based approach to educate, empower and promote self-responsibility to hopefully lead to improvements and change in behaviours and health profiles. The operation of SmartStart has been a self-funded program.

I turn to some of the things we've found from our data analysis, starting off with something relatively simple—height. This data compares the heights of ACT children ranging from five years of age through to 12 years of age, or from seven to 12 for comparing it to data collected back in 1985 by ACHPER, the Australian Council of Health, Physical Education and Recreation. As you can see, the height of ACT children today is relatively the same as it was back in 1985.

We have seen an increase in the weight of ACT children over that last 15 to 17 years, in both males and females.

MS MacDONALD: You don't have figures from the previous study in 1985 for children over 12?

Mr de Castella: No. Our program concentrates on primary school age, so we work from five or six through to about 12.

MS MacDONALD: I see. I was misreading the graph.

MR SMYTH: It's getting worse.

Mr de Castella: Yes. The 1985 data is in the darker shaded box. The 2002 data is in the lighter shaded box.

Body mass index, which is weight for height, is a standard measurement used back in 1985 in ACHPER. This is an indication of the increases in body mass index that we're seeing across the board for ACT children.

MR SMYTH: How do you determine body mass?

Mr de Castella: Body mass index is kilograms of weight per square metre. It's the weight of the child divided by the height of the child in metres squared. It's weight for height. Unlike adults' BMI—which enables you to identify underweight, healthy weight, overweight and obesity—children's BMI changes quite significantly as they grow in age. So it's difficult to come up with healthy weight ranges for children, because of the growth and maturation issues.

One of the other measures we do which was also done back in 1985 is a standing long jump. This is an indication of explosive power and upper body/lower body coordination. The kids stand on a mat, swing their arms and power their legs. Obviously, the better coordination you have between upper body and lower body, the further you can jump.

This shows that there is a significant decrease in our children's ability to perform that task.

As I mentioned, we've operated SmartStart in a number of schools over consecutive years. I was going to ask Alan Roberts from the University of Canberra to speak to this, seeing he did some of the data analysis. This is from one of the large schools, comparing children in 2000 to children in 2001. We saw in excess of a 10 per cent improvement in their percentage of body fat over a 12-month period, which is quite an amazing achievement over a relatively short period of time.

This highlights the fact that children, especially at primary school age, are what I would call responders. They respond to interventions very quickly. Not only are their minds absorbing information and they're learning a lot, but their bodies are growing and developing, and if you expose them to the right sorts of interventions and activities, their bodies can respond and improve quite quickly and quite dramatically.

To my knowledge, very few, if any, studies have been able to identify and track the same children over successive years, let alone the same children over three successive years, which is what we have now done in compiling our data.

I come to some of the other interesting statistics that Dr Roberts has identified, looking at two different schools. One school has a physical education teacher who works three days a week. Out of the 30 schools we have measured, it's the only school that has a part-time PE teacher. This slide compares that school over two years to another school where there is no dedicated PE teacher. The dark line is the school that has the PE teacher. In both the boys and girls you can see a significant decrease in the percentage of body fat. For the school where there is no PE teacher, there is relative stability across that period of time, and for the girls a slight increase.

Next we look at aerobic fitness, cardiovascular fitness. This is probably not quite so conclusive. This is data compiled over three successive years. We would like to see an improvement in their shuttle run score, which is in indication that they've gone on further in the activity, in the measure. The solid line shows that for the school that has a PE teacher there is quite a significant increase from 2000 to 2001. The dotted line, which is for the school where there was no PE teacher, shows that the boys improved their cardiovascular and aerobic fitness.

MS MacDONALD: But that could have to do with physical activity out of school hours?

Mr de Castella: Absolutely, yes. It could have to do with a whole range of things—what takes place in the school setting, what takes place in the home setting, what takes place with their peers. Part of the message I'm trying to get across is that a comprehensive settings-based approach needs to be put in place. If you are targeting one individual setting, it is very difficult to achieve significant results.

They're some of the statistics and some of the graphs that we've been able to compile over the last few years. There are a whole range of additional cohorts that we could investigate from the database we have established. This is something that we've done so

we can try to identify some of the significant factors that contribute to a positive outcome for primary school children's physical health.

There is a legitimate role for health and physical education in education. It is one of the eight key learning areas. Research links academic development with physical health, in a whole range of things from self-esteem through to fine motor and gross motor skills. Primary school-age children are establishing lifelong attitudes and behaviours, either positive or negative, at a very young age.

Primary school age is a very interesting age, because the children for the first time ever are starting to take some self-responsibility for their lives. They move from a home setting where the parents predominantly control the children into a school setting where they have to start wearing uniforms and they have to start doing homework. It's a very interesting period in a child's growth and development and getting them to accept and take on self-responsibility.

Here in the ACT there are very few, if any, PE teachers. I haven't come across one school that has a full-time dedicated PE teacher. As I said, out of the 30 schools we've measured there's only one that has a dedicated part-time PE teacher. That's a mixture of both government and non-government schools.

Certainly schools are very stretched to cover all of their curriculum areas. They are under enormous pressure just to do all of the work they have. There are a whole range of service providers that cover sport, health, physical activity and a whole range of additional services that can contribute to the health of children and assist what schools can do.

At the moment there's no independent government benchmarking analysis and reporting process on children's health and fitness, but certainly academic reports are expected. I saw in the paper this morning that it looks as though they are even going to be strengthened. There seems to be some additional interest in exploring the whole issue of academic reporting.

Literacy and numeracy is an area that has been benchmarked and targeted. Schools, states and individuals have been profiled, and parents have received reports on their child's literacy and numeracy.

One of my favourite sayings is that if you can't measure it you can't manage it. In the children's health and fitness we've never been able to measure. We've never been able to know what areas to target, and we've never been able to identify what works and what doesn't work, because we don't have any data.

When I talked to a group of New South Wales principals last year, one of them said that literacy and numeracy had hijacked the education agenda because of the accountability that schools and teachers were put under. He was saying it was very difficult for schools, with the pressures they had, to adequately focus on health and PE, because they are held so accountable for the literacy and numeracy profiling.

Prevention and early intervention are key strategies. At the recent health summit, early intervention, prevention and a whole-of-government approach were all identified as significant issues.

I believe we need to target children to create and produce a healthy society. Longitudinal data reporting and analysis was identified at the health summit as something that we're very much lacking and require, even from an evaluation perspective.

There's an enormous amount of health research now indicating that a settings-based approach is necessary where you target individuals where they work, live and play and try to create healthy environments which produce and lead on and flow on to healthy individuals and healthy communities.

A minimal government contribution is required to create anything which is commercially sustainable. I'll go into a little bit more detail on that in a while.

There are a number of cultural issues with regard to health care and the expectation of health care being a free service that make a user-pays type program such as we run a little difficult. The health budget, as is the education budget, is stretched. But unfortunately, with predictions of increasing levels of weight and decreasing levels of health and fitness, we can only expect that treatment costs will continue to increase.

Health and physical education are not a high priority in health. Children's health and fitness is not a high priority in health. I say that after having done numerous presentations to people at a Commonwealth level and at a state level. It is not one of the key health-targeted areas, although there is now talk about overweight and obesity becoming one of health's priorities. But children's health is not a health priority.

Physical health and fitness of ACT children is worse now than it was 15 years ago. The future burden to the ACT in health care and hospital costs and to the Commonwealth in some of these other areas will increase.

The government has no longitudinal data or a system in place to collect it. Early intervention and prevention are now acceptable health strategies. It is possible to identify high-risk individuals and put in place programs to assist them at a very early age—again, I'm talking about primary school age—to modify and change some of their behaviours and hopefully circumvent some of them turning up at the doorsteps of the hospital in later life.

There are a number of cultural issues in health care.

Physical health and fitness of children can be improved, as we've demonstrated by some of the data I showed earlier.

Children's health and fitness is not a high priority in ACT education at the moment. Let's hope that things change as a result of your committee. Many primary school teachers are not equipped or trained to deliver effective PE and health programs. Professional development structures do, however, exist within the ACT education framework, and it is possible to target teachers. Some teachers are concerned about being

held accountable for the health of their students, and I understand some are also concerned about being held accountable for literacy and numeracy.

The physical health profiles of schools can also be improved. The school is an ideal setting to target a whole range of children's health issues.

I turn to some of the issues we've identified regarding parents. Children's health and fitness is not a high priority for parents either. They're not looking good, are they? The older the child, generally the less interest parents have in their child's health. When we first launched the program in 2000, we delivered it to three government high schools. The uptake of reports within that environment was very minimal, and was unsustainable from our perspective, so we focused more on primary school children.

Parents of fit, healthy and active children are generally the ones that are more interested in purchasing reports on their child and are not necessarily the ones we want to specifically target. Indeed, participation in our program is an optional thing that children can decide to opt out of if they so choose. The parents of the unfit and the least healthy children are the ones that tend to support their child's non-participation. They come up with a whole range of excuses and reasons for that.

The social gradient as we well know from work on the determinants of health, affects the health of individuals. One of the great challenges we face is that because we are a self-funding program, a user-pays program, the children that probably most need the support, intervention and assistance are the ones that can least afford it. That's a dilemma we face. It is far more commercially viable for us to target the affluent private school market, which we have not specifically done, but we really are struggling with a way to reach the more financially disadvantaged children in the community.

Parents sometimes change their own behaviour because of their children. We've seen that through things such as the environment, through recycling, through road safety and seat belt usage. I think it is possible to modify and change behaviour of adults by targeting children.

There are also cultural issues that parents have with regard to a user-pays approach.

Again, the home is another major setting to target. My profile has benefited the ability for the program to reach parents and to generate the interest they've taken in having their children participate.

MS MacDONALD: You said that the parents of the unfit kids are often the ones saying that they don't want their kids to participate. I'm making an observational statement here for myself. Do you think that is coming down from their own lack of fitness; that it's not part of their norm?

Mr de Castella: That may well be one of the significant contributing factors. They themselves probably would not like to do it.

THE CHAIR: Is this presentation nearly finished? We're over time.

Mr de Castella: I'll just go straight to the recommendations then.

THE CHAIR: Yes, we can look at your presentation later.

Mr de Castella: We'd like to see children's health and fitness made a high priority in education and in health. It needs to be addressed in a cross-portfolio approach. Targeting it with a silo mentality of having health, education, sport and whatever is not, I believe, going to achieve significant improvements.

A benchmarking process in children's physical health and fitness needs to be implemented so that we can get the data.

We need to provide reports to the parents and also to the principals and to the teachers on physical health and fitness, similar to what is done in literacy and numeracy.

The costing for this, we believe, needs to be shared between schools, parents, sponsors and government, possibly both at a state or ACT level and at the Commonwealth level.

A mechanism needs to be developed to assist financially disadvantaged families.

A mechanism needs to be developed to increase the interest that parents have in their own children's health and fitness. It needs to be made a priority for parents as well.

Physical education needs to be compulsory in all primary schools, as it is. We'd like to see that continue, but with professional development opportunities to skill up the existing primary school teachers. I don't believe it's financially achievable to put in place dedicated phys ed teachers in primary schools, but we have a wonderful network of primary school teachers out there, and we have a good professional development structure. Let's use that to skill these individuals up so that they can deliver more effective health and physical activity programs.

There are a whole range of excellent external organisations that can be used and rallied to the cause, and can contribute to this issue.

I believe it also needs to be pursued at a national level, and we need to do this in a coordinated and a consistent way. We need to build up a national database of children's health and fitness and be able to monitor that over consecutive years. That national database needs to be developed and utilised to evaluate strategies and programs and identify areas to target and focus on.

THE CHAIR: Thank you very much.

Ms MacDONALD: You said there were no dedicated PE teachers within primary schools in the ACT. A long time ago when I was doing my second prac teaching in New South Wales, there were no dedicated primary PE teachers in New South Wales schools. But I recall a program that operated in South Australia. The teacher I was with was very much interested in the physical health of the kids in his class, and he looked at the program in South Australia and designed one for the kids in his class, a holistic program with a whole lot of other areas as well. Does any state or territory in Australia have PE teachers?

Mr de Castella: Not to my knowledge. I think the ACT and Victoria are the only two states that mandate that physical education must be allocated a certain amount of time in the school curriculum, the school program. I showed you the data at a national level before. In the ACT we're probably ahead. The situation is probably significantly worse around Australia.

South Australia is a leader in the field. They recently launched the program called Active for Life. They have provided roughly $20 per student to every school to implement programs to improve physical activity. They have also produced a lot of the material and resources.

We have what we call a curriculum development resource that a lot of the schools here in the ACT are using in conjunction with our program. We analyse the school, identify the areas that they need to target. We use this curriculum resource to give them a whole host of activities and lessons that specifically relate to the issues we've identified. We're trying to make it as easy as possible for the existing teaching staff to identify, develop and implement really effective and targeted PE programs.

MS MacDONALD: That answers my second question about whether or not South Australia was still operating that program or something similar.

Mr de Castella: I'm not sure. I think they may have moved on from there. I'm not sure exactly what the—

MS MacDONALD: It is something like 10 years ago.

Mr de Castella: But they have been leaders for quite a while.

MR SMYTH: In the 1985 report was the ACT better off than the other states or jurisdictions?

Mr de Castella: Not to my knowledge. Dr Roberts was heavily involved in that study.

MR SMYTH: Was it analysed on a state-by-state basis?

Mr de Castella: No.

MR SMYTH: The cost of your program for students is what?

Mr de Castella: Here in the ACT we charge $2 for participation, and the reports range from $5 to $15. I'll leave copies of the reports with you. For the school analysis and the school report the cost ranges between $200 and $500 or thereabouts, depending upon the size of the school.

MS MacDONALD: Have you looked at the Get the AIS into Your Classroom program?

Mr de Castella: No.

MS MacDONALD: We had a presentation.

Mr de Castella: SmartStart is not a sports program. It is a children's health and fitness program specifically.

THE CHAIR: You've recommended several times that there be some kind of benchmarking and reporting on health and physical fitness. Are you aware whether indicators have been developed to measure the health of children? I'm interested to know whether you know of anywhere that is done and how you measure the health of children. Do you know if anyone is doing that?

Mr de Castella: The physical health of children?

THE CHAIR: Are you just focusing on physical health?

Mr de Castella: Yes.

THE CHAIR: Sorry. I misunderstood.

Mr de Castella: We're really targeting issues of overweight and obesity and coordination.

MR SMYTH: Are there benchmarks as to what a child should be at a given age?

Mr de Castella: Not to my knowledge, no. There's very little data.

MR SMYTH: Because you grow fast or you grow slow.

Mr de Castella: Yes, and kids mature at different rates. We don't make recommendations that a child should be at a specific point. We recommend that all children aim to improve relative to themselves, and we tell the parents where their child is relative to their peers, but really just for information for the parents.

THE CHAIR: You are using indicators—body mass and so on. They're some indicators. Health is broader than that. I was interested to know—and the committee can find out—whether work has been done on broader benchmarking. We could have asked the ANU people, but we can do that later. You made the point that no priority has been given to children's health.

Mr Castella: Let me focus on physical health as opposed to asthma and—

THE CHAIR: I think you're right generally. I don't think there is a focus on children's health, whether it's physical fitness or whether it's health as we broadly understand it. This committee will be continuing to look at the need for health policy for children and making it a priority. It obviously has lifelong implications.

Mr de Castella: Absolutely.

THE CHAIR: Thank you very much.

MR SMYTH: You said there are clear links between academic development and physical fitness. Can you provide some of those?

Mr de Castella: Some of the studies I can.

MR SMYTH: Yes, studies that you find useful and that show that clear link?

Mr de Castella: Yes.

The committee adjourned at 4.55 pm.