16 September 2012

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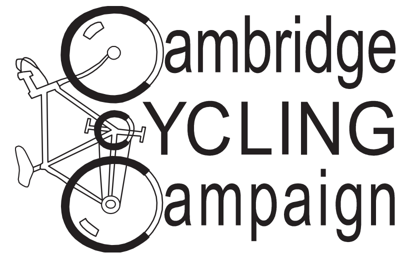

Comments on the Draft Cambridgeshire Health & Wellbeing Strategy, 2012 - 2017

Recent figures about leading causes of reduced longevity suggest that 20 million years of potential life are lost due to transportation impacts. The health impacts of transportation go far beyond the collisions involving motor vehicles (2,000 fatalities and 20,000 serious injuries annually in the UK). They also include respiratory disease due to mobile emissions. But the main transportation impacts take place when driving replaces active transport (walking, cycling). Together with the energy input / output imbalance this leads to well known obesity trends, cardiovascular disease and cancer. This is why researchers like Subramanian consider these wider transportation impacts as paramount. Visit any school in Cambridge to see how parents deprive their children of the exercise of walking or cycling by transporting them in the back of the car. Some researchers say that the competition between active and motorized transportation will determine the health of our nation, and many work now from the basis that it is the car that makes us sick.[1]

A health and wellbeing strategy should be - strategic. It should assess the situation and identify steps to improve it. We hold that it should acknowledge the centrality of transportation impacts outlined above. Some public health professionals rightly focus on dietary improvements. If we can increase the amount of energy expended by getting people out of cars and on to bikes, then the dietary approach becomes part of a larger and more comprehensive perspective.

Once the strategy document has identified what prevents healthy communities, it should proceed to make clear commitments to preventive programmes. It is generally accepted that without a paradigm shift towards prevention, the future costs of treatment associated with rising obesity figures will be very difficult to contain. Indeed, for some populations it has been shown that the youth of today is the first generation which will have a lower life expectancy than their parents.[2] This is why a radical commitment to fund preventive measures is needed. As it stands, the document lacks language which will support moving funding from treatment to prevention and provide the long-term perspective needed.

Preventive medicine may have a bad press. Some consider it an excess of the “nanny state”, an interference with “personal choices.” The document repeats the mantra of respecting such “personal choices” four times, but it fails to state that the impacts of such personal choices are being “socialised” at the hospital door, when the community is obligated to pay for the costs associated with sedentary and vehicular lifestyle “choices”. A public health agency which allows emphasis on “personal choice” to dominate a strategic document has possibly been hijacked by short term budgetary interests of health providers. Public health must be about influencing personal choices through education, encouragement, changes in the infrastructure etc, especially in a locality such as Cambridge which for almost a thousand years has been a hub of excellence in education. We should not disparage the noble and worthwhile effort of education, of nudging our citizens to lead a better and more active life, as “nanny state”.

From the perspective outlined so far, the repeated reference to local initiatives and local ownership is also problematic. A statement like “we will encourage individuals and communities to take responsibility for making healthy choices” is to be applauded, but we fear it may also imply a loss of evidence-based leadership. To press the point: If the good people of Cambridge wanted cheaper cigarettes, free pet-

rol, free soft drinks at the school, what can the present strategic document set against such local choices. Emphasis on local needs surely has a place, but above all our experts must spell out their assessment of where bad health comes from. Outlining treatment demand in the area, the table of unplanned hospital admissions included in the report specifies the locations and age groups. But the table is silent about the leading underlying causes of these admissions. Specifying these causes would offer direction and help to outline the necessary preventative programmes. Failure to supply this information is to be regretted, especially because we suspect that these admissions can be shown to be largely transportation impacts in the wider sense outlined above.

The document conceptualises its geography as marked by a striking divergence of health between, say Newnham and Wisbech. Undoubtedly, this social divide is an important issue. But our geographical area is also determined by another factor that is not mentioned in the document. According to the latest figures, the city and the county are ranking on the very top of the national cycling statistics.[3] It would be appropriate to acknowledge this fact here, and to play to this local strength, to understand the contribution these high rates are currently making to the health of the county, and how the agency can build on them. The document should acknowledge the unique opportunities with regard to active transport in our region, and create a space for innovative interventions appropriate for our unique base line figures. The widespread public acceptance of cycling in our area allows to supersede the old school conceptual bracket of “walking and cycling”.

The document has special significance because it is the first and founding document for a newly formed agency. Opportunities for collaboration between health and planning agencies should be acknowledged in the document, and institutionally embedded. Transport planners and the county cycling tsar should be involved in the board. Together, both agencies should work towards large-scale active transport programmes for the entire county. If it is true that the car makes our communities sick, then bringing closer together the responsibilities for health and transport enables innovative solutions for one of the most pressing problems of our time. In its new formation, the board should ask itself at every juncture: can we control the future acceleration of health costs by investing in active transport solution? And then: how does the language of the plan translate into budget allocations which further this aim? As it stands, these questions are not being raised in this document.

The plan does indeed speak about interventions “to encourage healthy eating and physical activity”. As is evidenced by some of the programmes offered in Cambridge currently (“Move More”)[4], the notion of “physical activity” is rather limited and old school. It seems modelled on the artificial 30 minutes in the gym, a separate “physical activity” drawer. We suggest the document place much more emphasis on the way we design our towns and our transport systems, and how we enable people to use their cars less.

Currently, there are no local health programmes which focus on active transport by bicycle. Doctors are unable to prescribe cycling, nurses receive precious little help to move beyond the widespread hysteria of the dangers of cycling in traffic, both suffer from the absence of a comprehensive education package which enables cyclists to use all roads confidently, assertively, and safely. Is is correct to call for “Encouraging and informing consideration of health needs associated with housing,” but this language should explicitly acknowledge that the main health impact of housing is the way in which it encourages active transport and discourages car use.

The document is correct in stating that there are wide variations in the county, and that social, education and health indicators go hand in hand. Poverty has of course many faces. From the saddle of a bicycle is seems that a poverty of transport choices has the greatest health impact. Again and again local people state that they are afraid of riding their bike in traffic. To give local people a choice in their mode of transport requires an infrastructure which is welcoming and easy to use for all trips and all ages. It also requires educational offerings that enable cyclists to participate in traffic confidently. Every pound spent on car infrastructure has adverse health impacts, because it is a pound not spent

on bicycle infrastructure. It is laudable that the Cambridgeshire Local Transport Plan 2011 – 2026 identifies Challenge 3: “Making sustainable modes of transport a viable and attractive alternative to the private car”, but it is disappointing that the present document, produced in the same building, fails to pick up on this challenge and support it with all the public health arguments and funding streams it has at its disposal. [5]

Even when the document speaks closely to the issues the Cambridge Cycling Campaign represent, it does so in a distant and confused language. For example, non-ownership of a car (20%) is solely represented as a problem in terms of accessing health services (“driving to the doctor”), but not as an indicator of an active lifestyle which will make the trip to the doctor less likely in the first place. We will comment in detail on one paragraph to measure the distance between this document and a fully bicycle enlightened perspective:

> • (1) Transport planning can enhance health by promoting active transport (such as cycling and walking), reducing road traffic accidents, facilitating social interaction, and improving access to green spaces, fresh food and other amenities and services that promote health and wellbeing;
> • (2) Building structures and transport systems that reduce or minimise air and noise pollution have clear health benefits in terms of respiratory illness and stress related conditions; (…)
> • (3) The provision of safe, continuous cycling and walking networks can also help to improve quality of life and wellbeing of vulnerable groups in the community such as young people and help them to access key services such as health care, leisure and recreational (5.5, page 20)

• (1) This paragraph fails to include the discouragement of car use as a health benefit. It speaks about these benefits as something that is delivered by “transportation planning”, implying that the Health Board has no involvement here, sees no opportunity for collaboration here, has no stake in reducing car use
• (2) The language here lacks specificity: does it mean we need electric cars? Or is this about a new special silent asphalt? Whatever the precise meaning, the focus is exclusively on the impacts of the car on its environment (noise, emissions). There is no acknowledgement of the adverse impact car use has on the passengers by depriving them of the active transport experience
• (3) Ignorance here allows the ugly face of prejudice against cycling to make an appearance. Why should cycling be specially beneficial for vulnerable groups? Has the author of this sentence has never cycled in Cambridge? If she did, she would say: The provision of safe, continuous cycling and walking networks will improve quality of life and wellbeing of all groups in the community.

The document is well designed and has two pictures which show cyclists. Sadly, it has been written without an awareness of the potential health benefits of comprehensive bicycle programmes. We are disappointed with the result, but hope that these comments will lead to an improve strategy statement. We have asked to address the board in the past and want to repeat this request again.

Notes:

1 Subramanian 2012, quoted in www.vtpi.org/health.pdf
2 Jay Olshansky et al: A Potential Decline in Life Expectancy in the United States in the 21st Century, New England Journal of Medicine, Vol 352 no 11, (17. 3. 2005), pp 1138-1145.
3 http://assets.dft.gov.uk/statistics/releases/local-area-walking-and-cycling-in-england-2010-11/local-area-walking-and-cycling-2010-11.pdf
4 http://www.cambridgeshire.nhs.uk/Your-health/move-more.htm
5 For instance, Liverpool’s Primary Care Trust part-funds the implementation of 20mph speed limits across residential roads in the city www.20splentyforus.org.uk/Press_Releases/NHS_Part_Funds_20mphlimits.pdf