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STANDING COMMITTEE ON ENVIRONMENT AND PLANNING

REFERENCES COMMITTEE

Inquiry into environmental design and public health

Melbourne — 23 August 2011

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Associate Professor J. Fitzgerald, acting chief executive officer, Victorian Health Promotion Foundation.

The CHAIR — Welcome, John. I am sure you are familiar with this sort of process, but I am obliged to indicate to you that whatever you say in your evidence today is covered by parliamentary privilege. Outside of the confines of this hearing your comments will not be covered by parliamentary privilege. You will be provided with a copy of the transcript in the next week or so for checking. You can liaise with Keir in relation to that. We request a 5 to 10-minute presentation from VicHealth to then allow us maximum time to ask questions and get some interaction going. Given that we are on the record, I ask you to start by stating your name, the organisation you represent and the address, please.

Assoc. Prof. FITZGERALD — Yes. My name is Associate Professor John Fitzgerald. I am from the Victorian Health Promotion Foundation, or VicHealth, and I am the acting CEO in that role.

The CHAIR — And the address?

Assoc. Prof. FITZGERALD — 15 to 31 Pelham Street in Carlton.

The CHAIR — Thank you.

Assoc. Prof. FITZGERALD — Thank you for the opportunity to speak with you today. Our submission contains a number of elements in each of these headings. What I have in the presentation is a potted version of that submission. In the spirit of interactivity I would say to pick the one you want to start with and focus on the ones that are of most interest to you rather than have me present material that you have already got before you.

I suppose the important starting point which may be at the end of the paper is the recommendations, so if you want to cut to the chase, we can go straight to the recommendations, if you want. As a starting point for us, VicHealth, as you know, is a statutory body. Our mission is to improve the health of all Victorians and to improve the capabilities not just of individuals but of organisations and communities, but the real focus on changing the environment is a mechanism to improve health, so for us the opportunity to talk with you today is core business for us.

The work that we do in the environment encompasses virtually every aspect of our work. One of our objectives in our strategic framework is to improve the environment to improve the wellbeing of Victorians, so we see this as very much an opportunity to articulate the opportunities of putting health into design and planning, the opportunities that that provides, rather than engage in a discussion around what would be the most appropriate mechanics or deliberative process.

What we want to focus on are the opportunities that are before you to improve health for Victorians. What you are noticing here is it is a fairly positive document actually saying we should do things rather than we should not do things. So I just wanted to give that as a starting point: that we think that you have an enormous opportunity now to improve health. A key part of that is to embed health into planning. At the moment we are in a relatively privileged position, because we fund activities in areas that cover everything from food and liquor licensing through to nutrition, physical activity, sport and social inequalities. Each of these elements are structured by the built form.

A key term for us is around what they call 'spatial programming' — the opportunity to program space, not just the attributes of the built form but how the built form structures the potential for social interaction, because that is a core mandate from VicHealth. We believe in the social model of health — that is, health is born out of social processes and social interactions but embedded in physical space, so the way you actually construct and constrain and program that space is fundamental to how you compose the opportunities for the social world to build healthier bodies. That is the connection, so if you are wondering why we are talking about this, that is why. That is the core kind of fundamental premise on which we speak in this place.

I suppose looking at that it sort of makes sense that in terms of improving the health and wellbeing of Victorians we need to have the opportunity to program in ways of improving the social, economic, cultural and physical environments to improve the health and to strengthen the understanding and skills of individuals in ways that support their efforts to achieve and maintain that health. So you can see that the focus is not just on the individual and their individual behaviours; the focus is on what we call social determinants of health — the way that the social, economic and built form allow healthy choices to be easier choices. It should be a positive and a promoting thing to allow the built form to make it easier for people to make healthier choices. I can give you some examples for that or we can walk through, or whatever you would like. Some examples? Okay.

In Maribyrnong they did a mapping exercise where they looked at what they call 'food deserts', where they looked at the capacity of people to access fresh food in a certain crow-flies distance. So they mapped that out, and what they found was that there are areas of that built local government where people had to travel over a certain distance before they would even encounter fresh food and in some cases encounter food, full stop. So we think at a planning level — and this probably poses a dilemma for you, I do not know; I am putting myself in your shoes — there is a dilemma in planning where one of the premises around planning is around appropriate land use. That is the basic premise. However, one of the challenges for public health and for health promotion is to look across the individual lot or the individual package of land and to look across at a broader level and to say, 'Okay, across this level, across the broader landscape, what are the opportunities? What are the things that constrain individual choices?', and the food desert example is one of those. If you actually go to one particular site where there might be a cluster of three or four fast-food outlets, you might go, 'There's nothing wrong with putting a fast food outlet on that site', but if you look across the landscape and look at it from a health planning perspective, you might see that the only access to food in that half a kilometre area is a cluster of four or five fast-food outlets offering what they call 'choice reduction', where for families in that area if they have 10 minutes to get dinner on the table that night, that is where they are going to go. So in effect you make a less healthy choice the easiest choice.

The programming of that space, not just at the individual lot level but across the broader level, from a health planning perspective is absolutely essential. As a point in principle we say in one of our recommendations that there is an opportunity here to take into account healthy design principles, and that means not just at the level of the individual lot but across a broader landscape, so to take into account health planning principles in your planning regime. That is one example where it is actually the unit, in effect, thinking about how you incorporate health, not just at the point of decision about an individual lot but from a broader perspective.

One of the premises on which we work is that health is not just about the absence of disease. A particular focus for us and for this government has been about chronic disease prevention, and as you can tell from our perspective, chronic disease prevention is not just about this disease and its treatment; it is actually about looking at those determinants that shape the choices people make. In this case those social determinants are not just about attitudes; they are actually about things that shape attitudes, so access to education and meaningful employment, and the consequence of that access to education is around health literacy. People need to be able to make healthy choices; they need to have a sense of literacy about what it is that they are going to be putting into their bodies or what a kilojoule is and how it might be different from a calorie. These are important determinants of the choices people make.

What you will see in an early section in the submission is a focus on time. You will see infused across the submission a real interest in master-planned communities and growth areas. The reason we are interested in growth areas and master-planned communities is that they offer a great opportunity to build in features of the built form — not just of individual lots, but across precincts — that can actually promote health at a population level. It is much more expensive and tricky to actually go and retrofit built or pre-existing communities, but if you have actually got a huge area of growth around Melbourne and Victoria, then these are opportunities where you can easily place elements in your precinct structure planning guidelines that actually make it a lot easier to do healthy things in your design. For instance, one easy get would be to put into your precinct structure planning guidelines the requirement that whenever a technical panel is composed for a growth area you put a health promotion specialist in there — currently there is not. That is a pretty easy thing to do.

When we go to the Planning Institute of Australia and work with them on collaborative projects at the moment we say to them, 'Listen, can we get you to put the health into the design on this master-planned community down in Cranbourne. Wouldn't it be good to put in some particular things that make healthy food choices better?'. But then we say, 'Hang on a minute. We're going to get a push-back from the planners in this place and the planners over there'. Then we say, 'Hang on. Why are planners making decisions around health?'. And they say, 'Well, that's who we've got'. And I ask, 'Why haven't we got health people on the technical panels?'. 'It's not part of the guidelines'. So it is a pretty easy fix just to get the conversation up at what is a critical stage in the precinct structure planning process. At a critical point you actually have a conversation between health planners and statutory planners. It is a pretty easy thing to do, because a lot of these things are pretty common sense.

One of the features of why we are interested in growth areas is because the effects of a time-poor community are most profoundly felt in growth area communities. I see lots of nodding. People are travelling long distances,

and spending a lot of time in their cars or other forms of transport effectively has an impact on the capacity of people to participate in their local community in the areas of sport, recreation, family time, cooking time, food preparation — just the simple spending of time with family. So in a sense we say time is a determinant of health. It sounds a bit trite, but in those environments where people are time poor it is absolutely real. When it takes you 6 minutes to get a pizza delivered to your house but it takes you 45 minutes to cook a meal, you know which choice people are going to make. In this case time is an important determinant of health for all the reasons we have documented there.

With access to jobs, opportunities and transport, not everyone feels the impacts in the same way. It is often in growth areas where you have got low-income groups who are under both mortgage stress and time stress that these things have a cumulative effect.

Regarding the cumulative effects around time, what we have said — and you will see it in one of the recommendations — is that we think time needs to be understood and appreciated within the programming of space. It sounds a little bit abstract, but planners really get it. Planners look at points of transport. We are working quite closely with the planning institute at the moment and with Stockland, one of Victoria's leading residential developers. We are working quite carefully with them at the moment on a number of locations in growth areas, and managing and programming time across the residential developments is actually crucial. For instance, one of the developments we are working on down in Cranbourne is called Selandra Rise, which, no doubt, some of you would have heard about. Simply locating the shopping centre at a different place across the master-planned community has a really important impact on creating a destination for walking paths and bike paths. That is about time. It is about structuring in and programming the space so that people actually do not have to spend, or have an anticipation of spending, unusual amounts of time to get to a destination. It also means making destinations timely. Programming time is actually an important part of our recommendation.

The CHAIR — John, I am just conscious of the fact that we are going to run out of time to ask you some questions and that we have had the opportunity to read the submission. The majority of the committee did attend the planning institute's day in Collins Street, so we were there for the presentation on Selandra Rise, which was excellent.

Can I just make the point before we go to questions that often when we talk about environment and health and time we focus so much on the impact on urban health. I know there are differences, but there are some very serious health issues in regional and rural Australia too. You only have to look at the chronic diseases that are attributed to farmers in terms of their working lives. Also the travel aspect, the fact that everyone needs to get into a car to access basic services, is often forgotten when we talk about these sorts of things.

Ms PENNICUIK — In your submission you talked about some programs aimed at making fresh food available for people. You talked about that a bit in your evidence. I hear the thing about Selandra Rise, but there are an awful lot of communities in the outer suburbs where we do need to fix the problems and make it easier. I just wondered if you could name two or three things that we need to do in those outer suburban areas to make it easier for people to be healthier.

Assoc. Prof. FITZGERALD — Around food choices?

Ms PENNICUIK — Food choices, exercise, sport and recreation and just incidental activity.

Assoc. Prof. FITZGERALD — If we talk just about, say, organised sport, the crucial thing that we have noticed is that sometimes, for all the best intentions, we structure our organised sport without taking into account all of the opportunities for the various parts of our communities to participate. One of the key ones is simply making sure that sporting ovals have women's change rooms. It is pretty simple, but it is simply because we think about a cricket oval as a cricket oval, and boys play cricket. That is not the case. In regional Victoria in particular there was an incredible change that occurred where the netball and football clubs merged for a whole range of reasons, which meant that their facilities had to actually work in a number of different ways. What we are finding is that, especially in suburban and urban areas, the viability of organised sporting organisations is not great. It is quite hard, and so what they tend to do is make their facilities multifunctional. One of the really clear things you can do with your sporting facilities around structured and organised sport is to make them multifunctional.

Mrs PEULICH — It is the European model.

Assoc. Prof. FITZGERALD — Yes, and that is a pretty simple thing to do, but a lot of it is about capital, and that is not cheap, especially if you are retrofitting. That can be important.

Food is a tricky one, because it cuts across a number of different regulatory regimes, some of which are not familiar to government. We do not usually limit the capacity of fast food restaurants to locate their stores. It is not something we usually do. But in terms of the capacity of local governments to do reasonable health planning, there is an approach we would suggest. We get local governments coming to us saying, 'Listen, we really want to be able to provide fresh food opportunities, and we do it by giving rate incentives in certain places'. They use the various instruments that they have got to provide incentives. We would say, 'Go for that. Try to have some flexibility in your existing tools to promote and give incentives to provide fresh and healthy food'. The alternative to that is actually a more onerous impost on the fast food restaurant industry.

In terms of a responsive regulatory approach, you would probably want to see that as kind of a next step down the chain. I do not think we have had a serious discussion with the fast food industry to date where we have actually talked about the density of fast food restaurants in suburban Victoria. I do not think we have had that conversation — I do not know; I might be wrong. However, I know that public health advocates, especially healthy eating advocates, have been very critical of choice reduction, especially in outer suburban environments. I do not think we have actually had that conversation with industry.

Mrs PEULICH — I will just ask a question in relation to what you were talking about in terms of the drive-throughs — you know, the Maccas on one corner and the Kentucky on the opposite corner and so forth. I guess for the Casey community, in which 95 per cent drive out of the municipality for employment, it is an issue, especially for, as you mentioned, those who are time poor — and obviously many of them would be. The drive-throughs are not an easy issue, but they reflect the phenomenon of the clustering of retail activities. If you had one dress shop in an area, it would be less successful than if you had four dress shops. If you had one bulky goods store, it would be less successful than if you had a string of them, because people are going out and spending time targeting particular goods and services that they want. They know where to go and where there are better promotions and so forth.

In view of that, and I think that is also reflected in the structure plan that councils that develop, have you looked at other ways of getting a better balance and promoting choice than, say, limiting the number? For example, have you done any studies in food choice behaviour in food courts, where you might have Maccas and Kentucky but you also have a whole range of other choices — you will have a healthy food bar and you will have kebabs and so forth? What sort of study has been done? It is easy to legislate against, but how realistic is it and will it actually be effective? Do we just need to perhaps look at how we can cluster more similar food outlets with a greater choice? In Europe, for example, a lot of them start early and finish earlier, but their fast food may be a burek, a chevapchichi or a kebab or something like that, and they will have that with a yoghurt. It is very different to Maccas. They still have fast food, but it is just healthier fast food — and they walk a hell of a lot more. Have there been consumer behaviour studies done on the impact of having a broader choice?

Secondly, can you just talk about how we can inject, through education, greater awareness of the need for healthy eating? I am thinking about home economics. Once upon a time boys and girls did food preparation. I understand there is a resurgence now because of MasterChef becoming very popular. Young people are more interested in knowing about food preparation. Do we need to do more in schools, especially when you are talking about emerging communities, where they may not have a rich history of being able to shop for or prepare foods, as is the case for many of those who have spent time in refugee camps?

Assoc. Prof. FITZGERALD — There are about four or five in there.

Mrs PEULICH — There are. They are all related.

Assoc. Prof. FITZGERALD — I will exercise my memory. In regards to the first point, I honestly believe that we need to start a discussion around distribution at a precinct level and about what might be positive ways of going about it.

Mrs PEULICH — Is there anyone doing any study on it?

Assoc. Prof. FITZGERALD — There is a literature on it, but I think in the Australian context we really need to sit down and do some serious auditing of what our densities are and what the choices are for different

parts of our population, because it is quite mosaic. It is quite scattered; some communities have excellent access to fresh food, and others do not. We know that there is some research that looks at the fact that it is not just at the level of the retailer. It is even within supermarkets that you get different access to healthy foods within a supermarket compared to non-healthy foods, and that varies according to the socioeconomic area. If you are getting that variability within the store, you are getting that variability within the community as well, so we probably need to do a bit more work on that.

Mrs PEULICH — Different socioeconomic status may also reflect how much time people spend working — for example, people who work in factories leave early and come home late because they are doing overtime. We work long hours too, and my favourite form of vegetables is the pre-diced stuff because it is going to save me time.

Assoc. Prof. FITZGERALD — For sure. In terms of education, the general principle around food of education is that it probably has a minimal impact. The residual cultural framing in which we approach food is pretty powerful, and simple things about time and access are actually much more powerful. As much as you might want, need or have a very good understanding about what good food is, if you have to actually spent an extra half-hour to get there, you probably will not. So education as a kind of priority is important, but it is probably not as important as the other ones we are aware of. I say 'culture' in a positive way, because there is a really demonstrable impact of things like MasterChef and Jamie Oliver. They actually work through a cultural register, and they produce impacts commercially, so I think it would be silly to ignore culture and culture change strategies around healthy eating now. I think we are actually moving away from planning a little bit, but they are kind of related.

I am conscious that there is one aspect that was included in this submission but was not actually in the public forum that I presented to. I just wanted to alert you to that because I am aware that there is material here that you did not hear about, and if you need some clarification on that, I can do that now if you wish. That is this graph here, which is around respiratory illness. At the time of the public forum we did not have all our clearances regarding the use of this data, but I am happy to share it with you now, following confirmation.

The CHAIR — Okay. Are people relaxed with that?

Mrs PEULICH — Yes. Talk us through the numbers, because I do not have my glasses on.

Assoc. Prof. FITZGERALD — It is in your submission as well. Effectively this is an opportunity around planning where we did some analysis of the presentations of different population segments to emergency departments for respiratory illness, so effectively we are talking about kids aged 0 to 16 with asthma. On your right-hand panel, where there is lots of red, the colour scale goes from green, being low, to red, being high. We are looking at the total number of presentations to emergency departments for respiratory illness. Those with red areas have a high number of presentations, and those with green have a low number of presentations. This is for 0 to 16-year-olds. What you will notice is that the growth corridors actually carry a high proportion of the number of 0 to 16-year-olds presenting with respiratory illness.

We do a correction to this data, which is called denominating or basically making it per capita to see if there is anything particular about growth areas. When you actually correct for the number of people living in growth areas, it dilutes the effect, so there is less red in those growth areas — but it is still high. What we say in the way we interpret this graph is, 'Listen, there is nothing particularly wrong with growth areas in terms of them causing respiratory illness amongst 0 to 16-year-olds, but we would say that it is high'. Where this is an opportunity to improve outcomes for young people with asthma by putting planning measures in place to reduce particulate matter — so, things in the air — this is a real opportunity for you to insert into the guidelines for growth areas mechanisms that reduce particulates.

There is a really simple mechanism: planting trees. If you plant the right trees — not the wrong ones, which is a discussion we had — in an environment where you basically bulldoze and start to build from scratch, you have a great opportunity to improve the long-term health outcomes for children. It is not the only thing that causes respiratory illness; there are many things that cause respiratory illness. Particulate matter — that is, the little particles that cause things — are just one factor, but if you can reduce the impact of that factor, then you have great potential for reducing asthma amongst young kids, in particular in growth areas. I do not know about you,

but for me this is probably one of the most important things we can do for the future wellbeing of Victorians. If you have got the opportunity to do it, I would really implore you to build that in.

The CHAIR — Thank you for raising that, because it did make it hard to work out the colours in the photocopy of the submission, so this absolutely highlights the needs.

Mr SCHEFFER — And it is some help for those of us who are colour blind.

Mr TEE — Thank you for your submission. I suppose there is a consistent message emerging about the importance of planning and health and in terms of access, whether it be access to bike paths, open spaces or trees. In looking at your recommendations and even the physical activity and built environment section, there is almost an imploring to make sure those things are factored in. I am also struck when I read ahead to the submission we have from the City of Wyndham. They say that all of this is known and that all of this is set out in preset structure plans, but there is so much wriggle room that on the ground in Wyndham and elsewhere it just is not being delivered.

I like some of the ideas you put forward in terms of simple things, like making sure the technical panel has a health professional on it. That is something that the Growth Areas Authority can ensure occurs as part of that. I suspect that might go a long way to helping the likes of Wyndham. However, it is that situation where at the theoretical level we are all in furious agreement but it is not being delivered on the ground. You have given that and tree planting as examples, and I know you did not want to talk too much about the mechanical and process side of things, but what can governments do to embed health into planning so that we can move from the theoretical, in which everyone is in furious agreement, to actually getting something on the ground? Is it around more mandatory standards? What are the sorts of things we should be looking at?

Assoc. Prof. FITZGERALD — Fantastic question. Clearly there are philosophical differences about the degree to which governments should impose requirements on development. Obviously this is one of the trigger points for your engagement.

Mr TEE — That is the rub.

Assoc. Prof. FITZGERALD — One approach we have is that we try not to approach this as an either-or situation. We try to approach it as a both-and — that is, there are opportunities both to impose requirements and to encourage the market to see the potential and the incentive for building health into their designs, especially for residential developers. That is why we have engaged with Stockland. We saw that Stockland were using health as its selling point around Selandra Rise, and it sold. It has been selling units off that development very quickly. The important thing is that if there is a mandatory aspect to that, then in the same way that health claims are made around food or medicines, the health claims made around planning need to be absolutely right. That is why we made a $650 000 investment in research down at Selandra Rise, because if Stockland is making claims around the health benefits of its planning there, then we want to make sure it is right.

The both-and in this case, then, is that mandatory conditions on health claims around planning need to be right. We encourage the market to put health into their work, but the claims need to be ascertained and verified. It was the same way with motor vehicle safety. One of the most important things was that the market was not an impediment to motor vehicle safety. When the market picked up on motor vehicle safety, that was when we got most of our public health benefits. When the motor vehicle industry put safety into their designs, that was when we saw massive changes to motor vehicle safety. In the same way with residential development, when developers see health as part of the value proposition for their developments, then we will see great outcomes in health.

Mr TEE — Is that a situation where you continue to do what you are doing in terms of working with developers and then promote the health outcomes, or is there still a role for government to kick that process along? If so, what is that role?

Assoc. Prof. FITZGERALD — I think there is a fantastic opportunity for government to reward those who do it and do it right and to not reward those who do not do it.

Mr TEE — How would government do that?

Assoc. Prof. FITZGERALD — Clearly there are rewards appropriate to different industries. I hate to use it again, but at the moment time is a critical factor for developers. They do not like their developments to get strung out with long consultation periods, impact assessments et cetera. One of the incentives that is given to developments is fast-tracking. You could build incentives around fast-tracking their developments if they do not just tick the boxes but embed health into their designs. That would be one very easy way to do it in a mechanical way — that is, building in incentives to put in health. Rather than a punitive thing, it is a much more positive thing to encourage people to do healthy things.

The CHAIR — I am really conscious of the time. We have got the next witness in 8 minutes, and we have not had a lunchbreak. So if there are no other burning questions — —

Mr SCHEFFER — I have, building upon that discussion just then. You talked about health as fundamentally being a social process. I would say that the two very vexed issues around that social process are gambling and alcohol. You mention in your submission the work done by Tanya Chikritzhs in Western Australia, including the valuable work she has done in separating out the impact that the distribution of hotels in the community, as distinct from that of packaged outlets, has on alcohol outcomes. We also know that second to tobacco, alcohol has the most damaging health effects on the community. So it is the serious issue, but we cannot seem to get enough movement around price — look at the alcopops issue — or around the density of packaged outlets. Do you have any views about how we start to transact and shift that? Because we have the evidence that alcohol and gambling are much loved in Australia.

Assoc. Prof. FITZGERALD — From a planning point of view there are some fundamental problems at the level of VCAT in terms of how VCAT manages the appreciation of risk and harm associated with alcohol. It fundamentally turns on the issue of deterministic causality versus probabilistic causality. I can cite two or three cases — for example, where they have got a packaged liquor outlet and they present their case by asking, 'What is the evidence that this packaged liquor outlet is causing harm or has the potential to cause harm in this community?' If you do it as a case of deterministic causality — that is, does A cause B? — then it is extremely difficult to assert that this sixpack is going to cause that bit of domestic violence. However, using the evidence of Tanya Chikritzhs from Western Australia and Michael Livingston from here in Melbourne, if you take a probabilistic point of view and you ask, 'Given the density of outlets, how much they are selling and what is the number of violent assaults that occur in that area?', then you can actually assert that there is a close relationship between the high density of outlets, the consumption of alcohol and the harm that occurs. However, because that probabilistic evidence has been rejected by VCAT on a number of occasions as it is probabilistic and not deterministic causality that evidence has been disregarded, which has caused a massive — —

Mr SCHEFFER — Can the law be changed to admit a wider evidentiary base?

Assoc. Prof. FITZGERALD — Yes, there is a very simple mechanism. There are a number of different avenues to go down. Obviously I am not a lawyer, but there is a very simple mechanism of actually just giving advice.

Mr SCHEFFER — Could you provide that to us as a recommendation later on?

Assoc. Prof. FITZGERALD — Yes, sure. Around the causality thing?

Mrs PEULICH — The two communities with the highest level of domestic violence in the state also have very high levels of drug usage, so does that intersect with drugs?

Mr SCHEFFER — Are you talking about illicit or licit drugs?

Mrs PEULICH — Illicit drugs.

Mr SCHEFFER — Illicit drugs are different, because there are no outlets yet.

Assoc. Prof. FITZGERALD — It is somewhat different, because the data around the access to drugs is nowhere near as reliable as the data on alcohol. We actually do not know the number of dealers — —

Mrs PEULICH — It is easier to legislate against the drug outlets but not the drugs?

Assoc. Prof. FITZGERALD — Yes, we cannot really assert how many dealers there are in an area.

Mr SCHEFFER — I do not think you go to VCAT over an illicit drug outlet.

Assoc. Prof. FITZGERALD — You could, but — —

Mr SCHEFFER — Are you going to send us some stuff on that? Because that is an important issue from the legal side.

Assoc. Prof. FITZGERALD — The causality stuff? Yes.

The CHAIR — Yes, that one is important. We thank you very much, John, for your presentation today, for your handling of the questions and for some really good ideas that came out of that, which I am sure we will have lots of discussion over. Again, thank you for your submission.

Assoc. Prof. FITZGERALD — My pleasure, and best of luck with your deliberations.

Witness withdrew.