Integrated planning for healthy communities: Does Victorian state legislation promote it?

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Abstract: There is increasing Australian and international interest in integrated planning that promotes health and wellbeing. Melbourne is experiencing unprecedented rapid population growth, especially in the outer suburban Growth Areas to the north and west. This is creating public health challenges associated with low-density, single land-use, car-dependent suburban developments. Because of the state government's leadership role in the planning system, integrated planning across state policy sectors is critical for creating healthy communities. This paper examines the extent to which key Victorian legislation supports integrated planning that promotes health. It involves a content analysis of three statutory documents: the *Planning and Environment Act 1987*, the *Transport Integration Act 2010*, and the *Public Health and Wellbeing Act 2008*. These documents are assessed against criteria that reflect best-practice principles for integrated planning for health. While the Acts contain some supportive features, they also present significant barriers to integrated planning that promotes health. Recommended changes to the legislation are outlined, to assist policymakers to create healthy communities.

Introduction

It has long been understood that the way cities are planned has a critical effect on human health. The modern urban planning and public health disciplines both arose in the mid-19th century in response to the crowded and squalid living conditions of newly-industrialised European cities (Hensgen, 2009; Kent, Thompson, & Capon, 2012; Macintyre & Ellaway, 2003; Northridge, Sclar, & Biswas, 2003). City planning successfully tackled the spread of infectious diseases by improving sanitation and separating polluting, industrial land uses from residential areas (Kent et al., 2012).

Chronic diseases such as cardiovascular disease, cancer, mental illnesses and Type 2 diabetes are now the leading cause of death and disability amongst urban populations in developed countries (Kent et al., 2012; World Health Organization, 2011a). Since the advent of mass-produced affordable motor vehicles, sprawling, land-use segregated, car-dependent suburbs, with inadequate walking, cycling and public transport infrastructure, have become a common characteristic of major cities in developed countries, including Australia (Barton, Grant, Mitcham, & Tsourou, 2009; Capon, 2007; Frumkin, Wendel, Abrams, & Malizia, 2011; Rao, Prasad, Adshead, & Hasitha, 2007). These urban design attributes contribute to chronic diseases and their risk factors, including physical inactivity, unhealthy diets, social isolation, crime and fear of crime, the temperature of urban areas and air quality (Cannuscio & Glanz, 2011; Ewing & Cervero, 2010; Frumkin, 2002; Gebel, Bauman, Owen, Foster, & Giles-Corti, 2009; Giles-Corti, Ryan, & Foster, 2012; Saelens, Sallis, & Frank, 2003; Sallis, Millstein, & Carlson, 2011; The Healthy Built Environments Program, 2012).

Many built environment features can be viewed as 'social determinants of health'. This term recognises that health outcomes are determined by numerous physical, social, economic, and political factors outside of the health domain (World Health Organization, 2012). Thus, different sectors need to work together in an integrated way to create healthy built environments and communities. Broadly speaking, a healthy and liveable community is one that is "safe, attractive, socially cohesive and inclusive, and environmentally sustainable; with affordable and diverse housing linked to employment, education, public open space, local shops, health and community services, and leisure and cultural opportunities; via convenient public transport, walking and cycling infrastructure" (Lowe et al., 2013, p.11).

The Melbourne context

This paper is concerned with the urban planning and public health challenges facing Melbourne. Melbourne's population is rapidly expanding - particularly in low density greenfield developments in the outer north and west - with the population projected to grow from just over four million at present, to between 5.6 and 6.4 million by 2050 (Australian Bureau of Statistics, 2011; Ministerial Advisory Committee for the Metropolitan Planning Strategy, 2012). Low density fringe development is creating inequities between the established inner city and outer suburbs areas where the provision of essential infrastructure and services, such as public transport, parks, schools and health and community

services, is often delayed or is insufficient for meeting growing demand. There is also a deficit of local employment opportunities in outer suburban areas (Essential Economics, 2012). Moreover, the available jobs, shops and services are too far from homes to walk or cycle and there is inadequate infrastructure for active transport modes (Essential Economics, 2012; Legislative Council Environment and Planning References Committee, 2012; Perkins, 2012).

These factors are likely to be contributing to the greater burden of chronic diseases experienced by outer suburban residents compared with Victorian and Melbourne averages (Essential Economics, 2012; Outer Suburban/Interface Services and Development Committee, 2012). This may be correlated with higher rates of disease risk factors such as physical inactivity, due to local environments that discourage exercise, poorer air quality due to motor vehicle traffic and lack of green space, reduced access to healthy food, difficulties accessing health services, and higher rates of social isolation due to a lack of social infrastructure and opportunities for social interaction (Donovan, Larsen, & McWhinnie, 2011; Essential Economics, 2012; Legislative Council Environment and Planning References Committee, 2012; Pereira et al., 2013; Pereira et al., 2012; The Healthy Built Environments Program, 2012)

Integrated planning for health

In response to such challenges, there is increasing interest in integrated planning that promotes health and wellbeing. Integrated planning or policy integration "refers to management of cross-cutting issues that transcend the boundaries of established policy fields and that do not correspond to the institutional responsibilities of individual government departments" (Holden, 2012, p.306). Integrated planning seeks to overcome the problems when governments operate within traditional sectoral silos, resulting in fragmented governance, inefficiencies, and/or counterproductive policy outcomes (Kidd, 2007; Rayner & Howlett, 2009). Integrated planning aims for coherence and consistency of policy goals and policy instruments (Rayner & Howlett, 2009). This requires inter-sectoral governance that supports effective partnerships and collaboration between different sectors and stakeholders from within and outside of government (Holden, 2012; Thomas, Hodge, & Smith, 2009). Policy can be horizontally or vertically integrated. Vertical integration refers to integration between different organisations and/or levels of government (Holden, 2012). Horizontal integration, refers to integration across policy domains within the same organisation or level of government (Holden, 2012; Kidd, 2007).

Health is one cross-cutting issue that can be addressed by integrated planning (Kidd, 2007; Olowoporoku, Hayes, Longhurst, & Parkhurst, 2011). Integrated planning for health normatively suggests that improving human health is a desirable policy outcome and that all policies should support the social determinants of health (Health in All Policies Unit, 2011; McQueen, Wismar, Lin, & Jones, 2012). Whilst it is beneficial for policies to explicitly aim to promote health and/or wellbeing, integrated planning for health does not necessitate this. A policy can contribute to integrated planning for health if it implicitly supports health, such as providing affordable housing with easy access to jobs and services.

Examples of integrated planning aimed at improving health include the World Health Organization's Healthy Cities initiative, which promotes the integration of health concerns into the political, social and economic agendas of local governments (Rydin et al., 2012; World Health Organization Regional Office for Europe, 2012). This initiative has grown into a global movement with over 10,000 projects (Butterworth, Palermo, & Prosser, 2005; de Leeuw et al., 2006). In Australia, the South Australian government has been leading the way on horizontal policy integration since 2007, with its innovative Health in All Policies (HiAP) approach. Their model is characterised by a whole-of-government mandate for HiAP; leadership from central agencies; and having a dedicated HiAP Unit within the Health Department to facilitate integrated planning (Health in All Policies Unit, 2011; Kickbusch, 2010). In Victoria, *Environments for Health*, the state-wide framework for Municipal Public Health Plans provides a framework for horizontal integrated planning for health at the local government level (de Leeuw et al., 2006). The Heart Foundation's guidelines such as *Healthy Spaces and Places* (Planning Institute of Australia, Australian Local Government Association, & National Heart Foundation of Australia, 2009) and *Healthy by Design* for Tasmania and South Australia (National Heart Foundation of Australia, 2009, 2012), also aim to assist urban planners to design healthier urban environments through integrated planning.

Integrated planning for health in Melbourne

Under Victorian legislation, local governments are responsible for most land use and development decisions and must also prepare Municipal Public Health Plans (de Leeuw et al., 2006; Williams & Maginn, 2012). However, the state government maintains an important role in spatial planning,

through approving local planning schemes and producing metropolitan planning strategies for Melbourne, such as the one currently under development (Department of Transport Planning and Local Infrastructure, 2013; Municipal Association of Victoria, 2009). The state government also provides major infrastructure and services such as roads, public transport, and government schools and hospitals (Australian Social and Recreation Research, 2009; Williams & Maginn, 2012). The responsibility for spatial planning is spread across a number of different state departments. Thus, integrated planning across the various departments is critical for creating healthy communities.

The continued development of poorly-serviced neighbourhoods on Melbourne's urban fringe suggests that there are opportunities for enhanced integrated planning at the state level. In 2002, a Planning for Health and Wellbeing project commenced, funded by VicHealth and based at the Planning Institute of Australia (Victorian Division). However, results from an interim evaluation in 2005 found that the project had not increased the integration of health into everyday planning considerations (Whitzman, 2007). A recent parliamentary *Inquiry into Environmental Design and Public Health in Victoria* also noted the lack of consideration of health in state planning legislation and policies (Legislative Council Environment and Planning References Committee, 2012). The previous metropolitan planning strategy, *Melbourne 2030*, attempted to promote integrated planning. However, insufficient attention was paid to funding the implementation of this strategy (Mees, 2011; Moodie, Whitney, Wright, & McAfee, 2008). In addition, Curtis et al (2010) analysed the capacity of state and local government to deliver land use and transport integration, finding that Melbourne only had a basic level of vertical integration between levels of government.

To date however, no comprehensive research has examined the extent of, or barriers and enablers to, integrated planning for health across Victorian state government policy sectors. Thus, this paper examines the extent to which key Victorian legislation supports integrated planning that promotes health. It begins by outlining the methods used to analyse Victorian state legislation, before presenting the results of this analysis. The discussion section highlights enablers and barriers that the relevant Acts present for integrated planning, and makes recommendations about how the legislation could be improved.

Methods

This paper is part of a larger project examining the extent of, and barriers and enablers to, integrated planning across the state government policy sectors of transport, employment, education, housing, and health and social infrastructure. The intention is to analyse all relevant state government policy documents and conduct key stakeholder interviews. This paper reports on the first stage of this research, which involved analysing three Victorian statutory documents – the *Planning and Environment Act 1987*, the *Transport Integration Act 2010*, and the *Public Health and Wellbeing Act 2008* (incorporating all amendments as of July 2013).

These Acts were chosen as the initial focus of analysis, as they are the most important overarching legislation for planning healthy communities. The *Planning and Environment Act 1987* designates land use planning powers in Victoria, establishing the Victorian Planning Provisions and local government planning schemes (Victorian Government, 1987a). The *Transport Integration Act 2010* dictates responsibilities for the provision of transport infrastructure (Victorian Government, 2010) and the *Public Health and Wellbeing Act 2008* is the overarching legislation for the protection and promotion of population health (Victorian Government, 2008). For integrated planning for health to occur, all three Acts must be aligned.

Content analysis was used to evaluate these statutory documents. This is a systematic, replicable approach for collecting data from textual sources (Curtis et al., 2010; Putt & Springer, 1989). It involves detecting, recording and analysing the presence of words, phrases, or concepts (Sproule, 2010). Categories or criteria are developed, and documents are coded according to their match with these (Curtis et al., 2010; Putt & Springer, 1989). Coding can be either explicit, where documents are coded according to the easily identified content of the text (words or phrases), or implicit, where texts are coded for their underlying or implicit meaning (Sproule, 2010). This research involved both types of coding.

Content analysis criteria were developed to reflect best-practice principles for integrated planning for health and policy more generally, derived from the literature. The criteria fitted into four categories (Table 1). These criteria were developed to analyse policy documents in addition to legislation. While all criteria were applied to the Acts, it was recognised that some of the criteria may be less relevant to legislation.

Table 1: Content analysis criteria

Criteria category	Criteria
Overall goals in relation to the social determinants of health	A. Is there explicit mention of human health and/or wellbeing as a policy goal?
	B. Is there explicit mention of 'liveability' as a policy goal?
	C. Is there explicit mention that the policy aims to support the social determinants of health?
	D. Is the content of the policy supportive of the social determinants of health?
Integrated planning	E. Is there explicit mention of how the policy complements or works with other relevant policies?
	F. Is there explicit mention that multiple departments/levels of government worked together on developing the policy?
	G. Is there explicit mention that multiple departments/levels of government will work together on implementing the policy?
	H. Does the policy explicitly aim for or promote integrated planning across sectors?
	I. Does the content of the policy implicitly complement the content of other relevant policies?
Commitment to implementation	J. Are roles and responsibilities clearly articulated?
	K. Are there clear targets and is there a clear monitoring plan?
Community and stakeholder participation	L. Was there an appropriate level of community participation in the policymaking process?
	M. Were other important stakeholders outside of government (such as NGOs and the private sector) adequately involved in the policymaking process?

Content analysis typically involves numerical coding of the text (Kvale & Brinkmann, 2009; Putt & Springer, 1989). This study built on a numerical approach used by Curtis et al (2010). Individual statements relating to each criterion were coded by the first author on a three point scale, from 0 (does not satisfy the criterion/works against the criterion), to 1 (partly satisfies the criterion) and 2 (satisfies the criterion). Statements could be coded as relevant to more than one criterion. Additional information was gathered for Criterion D, where the particular social determinant of health referred to in the document was recorded. There were eleven possible categories of social determinants, representing the major determinants of healthy and liveable communities (Lowe et al., 2013).

Coding of the statutory documents was completed with the assistance of the data management computer software NVivo. Prior to analysis, a code book with detailed coding rules was developed and the methods were tested on a sample of policy documents not included in this study. This enabled the coding rules and content analysis criteria to be modified as required, to maximise intra-rater reliability and ensure that the criteria were as exhaustive as possible, with minimal overlap between them (Stemler, 2001).

To summarise the results for each document, the number of 0, 1 and 2 scores for each criterion were recorded, along with the percentage of the text coded as relevant to each criterion (calculated by the NVivo software). No percentage was recorded for a '0' score on criterion where a '0' reflects the identifiable lack of content that satisfies the criterion. Together, these statistics provide an overall measure of how the legislation performs with regards to best-practice integrated planning that promotes health. This methodology allows policies to be assessed individually, as well as enabling qualitative comparisons between documents.

Results

Table 2 summarises the results of the content analysis. The results are discussed in relation to the four categories of content analysis criteria.

Table 2: Results of the content analysis

Criteria category	Criteria	Score	Planning and Environment Act 1987		Transport Integration Act 2010		Public Health and Wellbeing Act 2008	
			No. of each score	*% of text coded as relevant*	*No. of each score*	*% of text coded as relevant*	*No. of each score*	*% of text coded as relevant*
Overall goals in relation to the social determinants of health	**A**	**0**	3	-	2	-	0	-
		1	0	0	0	0	54	3.04
		2	0	0	7	0.12	71	4.67
	B	**0**	3	-	3	-	4	-
		1	0	0	0	0	0	0
		2	0	0	3	0.02	0	0
	C	**0**	3	-	3	-	4	-
		1	0	0	0	0	0	0
		2	0	0	0	0	0	0
	D	**0**	0	0	1	0.09	1	0.07
	Total	**1**	49	1.28	72	2.92	15	0.63
	Transport*		2	0.11	35	1.67	0	0
	Leisure		3	0.08	1	0.02	0	0
	Crime		1	0.02	1	0.04	2	0.05
	Housing		1	0.01	0	0	3	0.18
	Education		2	0.05	0	0	0	0
	Emplmt		5	0.11	4	0.12	0	0
	Food		2	0.05	0	0	0	0
	Social		22	0.84	15	0.48	2	0.11
	Enviro		5	0.15	13	0.87	0	0
	POS		3	0.06	0	0	0	0
	Health		3	0.06	2	2.07	2	0.09
		2	0	0	0	0	0	0
Integrated planning	**E**	**0**	0	0	0	0	0	0
		1	29	1.70	73	4.69	81	7.38
		2	191	12.66	124	10.73	71	9.55
	F	**0**	0	-	0	-	0	-
		1	0	0	0	0	0	0
		2	0	0	0	0	0	0
	G	**0**	0	-	0	-	0	-
		1	16	0.59	53	3.65	10	0.86
		2	0	0	0	0	0	0
	H	**0**	0	0	0	0	0	0
		1	6	0.2	17	0.82	6	0.39
		2	0	0	0	0	0	0
	I	**0**	0	0	0	0	0	0
		1	0	0	0	0	0	0
		2	0	0	0	0	0	0
Commitment to implementation	**J**	**0**	0	0	2	0.08	3	0.24
		1	3	0.25	1	0.03	3	0.33
		2	464	47.08	355	49.91	255	40.53
	K	**0**	3	-	3	-	4	-
		1	0	0	0	0	0	0
		2	0	0	0	0	0	0
Community and stakeholder participation	**L**	**0**	0	0	0	0	0	0
		1	0	0	0	0	0	0
		2	0	0	0	0	0	0
	M	**0**	0	0	0	0	0	0
		1	0	0	0	0	0	0
		2	0	0	0	0	0	0

*Key	Relevant to particular social determinants of health:	
	Transport = Transport	Food = Food and other goods
	Leisure = Leisure and culture	Social = Social cohesion and local democracy
	Crime = Crime and safety	Enviro = Natural environment
	Housing = Housing	POS = Public open space
	Education = Education	Health = Health and social services
	Emplmt = Employment and income	

Overall goals in relation to the social determinants of health

The content analysis showed that the *Planning and Environment Act 1987* does not explicitly promote human health or wellbeing (Criterion A) (Victorian Government, 1987a). This finding is consistent with the parliamentary *Inquiry into Environmental Design and Public Health in Victoria* final report, which noted that the *Planning and Environment Act 1987* "does not directly engage with considerations of health" (Legislative Council Environment and Planning References Committee, 2012, p.vii).

In contrast to planning legislation, 'health' is identified as a clear goal on seven occasions in the *Transport Integration Act 2010*. In addition, the *Transport Integration Act 2010* is the only Act that explicitly mentions community liveability (a term that is closely related to social determinants of health), when setting out the objectives of the Public Transport Development Authority, the Roads Corporation and the Linking Melbourne Authority (Criterion B) (Victorian Government, 2010). As expected, health is mentioned as a desirable goal on 71 occasions within the *Public Health and Wellbeing Act 2008*.

None of the Acts explicitly aim to promote the social determinants of health (Criterion C), yet they all include content that is supportive of various social determinants of healthy communities (Criterion D). In all three Acts, statements that are supportive of the social determinants of health largely refer to aspirational goals, such as "enabling efficient and effective access for persons and goods to places of employment, markets and services" (Victorian Government, 2010, section 9(a)), without mentioning specific strategies for achieving these goals.

The *Transport Integration Act 2010* has the largest number of statements that partly meet Criterion D (72). However, whilst some objectives of this Act promote walking, cycling and public transport over car use, this is undermined by section 26, which allows transport bodies to determine the weight given to each transport objective (Victorian Government, 2010). The *Planning and Environment Act 1987* has 49 statements that are supportive of health determinants, with the majority being enabling provisions for community involvement in land use planning. Surprisingly, the *Public Health and Wellbeing Act 2008* includes just 15 statements that specifically support the social determinants of health. Many sections of this Act are about secondary prevention and responding to infectious disease outbreaks, rather than primary prevention of chronic disease through the creation of healthy environments (Victorian Government, 2008).

Integrated planning

All three Acts explicitly state how they work with other relevant policies, regulations and Acts (Criterion E). For this reason, no text was coded in any of the Acts as implicitly complementary of other policies (Criterion I). In terms of the three Acts considered, the *Transport Integration Act 2010* and the *Planning and Environment Act 1987* refer to each other, but neither refers to the *Public Health and Wellbeing Act 2008*. The *Public Health and Wellbeing Act 2008* refers to the *Planning and Environment Act 1987* (Victorian Government, 1987a, 2008, 2010) but has not been amended to mention the *Transport Integration Act 2010*.

In keeping with the nature of legislation, all three Acts explicitly direct the development and content of subordinate state and local government policies. However, the *Planning and Environment Act 1987* and the *Public Health and Wellbeing Act 2008* provide inconsistent directives in relation to planning for health at the local government level. The *Public Health and Wellbeing Act 2008* directs local governments to develop Municipal Public Health Plans that are consistent with their Municipal Strategic Statement prepared under the *Planning and Environment Act 1987*. On the other hand, the planning act does not require Municipal Strategic Statements to be informed by Municipal Public Health Plans.

Whilst none of the Acts provide any indication about collaboration between different departments or levels of government during development of the legislation (Criterion F), all outline circumstances in which different departments or levels of government are required to work together when implementing

the legislation (Criterion G)(Victorian Government, 1987a, 2008, 2010). However, none of the Acts fully meet this criterion, as they either do not require a high level of collaboration, or provide no indication of the extent of collaboration. Of the three Acts, the *Transport Integration Act 2010* requires the highest level of consultation and collaboration, particularly between different state government Departments and Ministers (Victorian Government, 2010).

The *Transport Integration Act 2010* most explicitly promotes integrated planning (Criterion H). While all of the Acts only partly meet this criterion, as ways of achieving policy integration are not fully explained, the *Transport Integration Act 2010* has the most frequent mentions of 'integrating' transport and land use, and integrated transport planning. Indeed, integrated decision-making is one of the principles outlined at the beginning of this Act (Victorian Government, 2010). This focus on integrating transport and land use is not reciprocated by the much older *Planning and Environment Act 1987*. The *Public Health and Wellbeing Act 2008* is the only Act that explicitly promotes integration across levels of government for the expressed purpose of improving health and wellbeing (Victorian Government, 2008).

Commitment to implementation

As Table 2 shows, a large proportion of each document (between 40 and 50 per cent) is taken up with allocating roles and responsibilities to individuals (such as Ministers) or organisations (such as local governments or advisory committees) established under the Acts (Criterion J). This is in keeping with the role and procedural nature of legislation. However, while it is usually clear who is responsible, the frequent use of the word 'may' as opposed to 'should' or 'must' indicates that many actions, including procedures that would promote health, are discretionary rather than mandatory. Furthermore, in lists of aims or objectives, no clear or measurable targets are identified for any of the Acts (Criteria K) (Victorian Government, 1987a, 2008, 2010).

Community and stakeholder participation

All of the Acts facilitate community participation in the implementation of the legislation, with the *Planning and Environment Act 1987* being the most supportive of community involvement in policy activities (Criterion D – social cohesion and local democracy). However, none of the Acts mention the extent of community or stakeholder participation in the process of developing the legislation (Criteria L and M) (Victorian Government, 1987a, 2008, 2010). This finding is not surprising given the nature of legislation. These criteria were primarily designed for the next phase of the research where policies and plans will be analysed, as these documents often include information related to community and stakeholder engagement.

Discussion

The results demonstrate that the Victorian *Transport Integration Act 2010* has the greatest capacity of the three Acts reviewed to facilitate integrated planning that promotes health. Despite being a non-health sector Act, improving health and wellbeing is one of its key objectives and it is also the most supportive of the social determinants of health. Moreover, it performs best against the integrated planning criteria, in terms of facilitating inter-sectoral collaboration and explicitly promoting integrated planning (Victorian Government, 2010). As the most recent Act, it highlights the growing interest in integrated planning.

Other possible facilitators of integrated planning for health were identified. Firstly, the *Planning and Environment Act 1987* and the *Transport Integration Act 2010* refer to each other, suggesting a degree of integration. Secondly, the *Public Health and Wellbeing Act 2008* (section 53) gives the Health Minister the power to commission health impact assessments (HIA) (Victorian Government, 2008). HIA facilitates integrated planning for health (Gardner, 2008; Ison, 2009) by assisting policymakers to accept, reject or amend policies or plans in any sector based upon their potential or current effects on population health (Forsyth, Slotterback, & Krizek, 2010; Health in All Policies Unit, 2011; Hensgen, 2009; World Health Organization, 2011b). Whilst HIAs are not compulsory, or routinely conducted in Victoria, the inclusion of HIA in this Act provides the option of conducting HIAs.

The results also highlight potential barriers to integrated planning for health in Victoria. Whilst integrated planning for health necessitates that all relevant legislation be aligned in a health promoting direction, the *Planning and Environment Act 1987* is arguably the most pivotal legislation for the spatial planning of healthy communities. This Act has some key weaknesses in relation to integrated planning that promotes health. Importantly, the *Planning and Environment Act 1987* does not reciprocate the transport act's emphasis on transport and land-use integration, creating inconsistency within the legislative framework.

In addition, there is no direct consideration of health and wellbeing in the *Planning and Environment Act 1987*, which is an omission considering the growing understanding of the links between planning and health outcomes. This means that there is currently no legal obligation for planners to prioritise health (Cancer Council Victoria et al., 2011). With recent amendments to sections 12(2)(c) and 60(1) of the Act, it is now compulsory for planning authorities to consider potential social and economic effects when preparing a planning scheme and deciding whether to approve a planning application. Previously this was optional (Victorian Government, 2013). Sections 12(2)(c) and 60(1) could be further amended to ensure that potential health impacts are also considered. It has been suggested that section 12A(4) should be amended to align local government Municipal Strategic Statements with Municipal Public Health Plans (Cancer Council Victoria et al., 2011; Legislative Council Environment and Planning References Committee, 2012). Creating environments that support public health could be made one of the explicit objectives of the Act in section 4(1) (Legislative Council Environment and Planning References Committee, 2012). The *Planning and Environment Act 1987* could also legislate that planning authorities must conduct formal HIAs for key planning decisions (Legislative Council Environment and Planning References Committee, 2012). Similar changes regarding HIAs could be made to the *Transport Integration Act 2010*.

The *Public Health and Wellbeing Act 2008* also presents challenges for creating healthy communities through integrated planning. Considering that this is the primary legislation for the protection and promotion of public health, this Act has little focus on preventing chronic disease through healthy environments. Rather it focuses on secondary prevention and responding to infectious disease outbreaks. Changing this Act so that it promotes the conditions to prevent chronic diseases as well as infectious diseases, and incorporating requirements for closer collaboration across departments and sectors may facilitate integrated planning for health.

Furthermore, none of the Acts mandate key actions to support social determinants of health, nor are specific strategies for achieving progress on the social determinants of health or integrated planning outlined. Being more specific and mandating health-promoting actions and procedures could assist in the achievement of these important objectives. The *Tobacco Act 1987* is an example of legislation that has produced public health benefits over time by mandating very specific health-promoting interventions (Victorian Government, 1987b).

With continuing development of urban environments with potential negative impacts on health, particularly on Melbourne's fringe, the real challenge is integrating concern for promoting health into everyday planning practice in Victoria (Whitzman, 2007). The limitations of the three Acts analysed may hamper health-promoting integrated planning. However, content analysis provides limited information about how particular sections of the Acts are used in decision-making and interpreted in case law. The regulations and policies that operate under the Acts are key mechanisms through which the legislation is implemented. For this reason, relevant state regulations and policy documents will be analysed in the next stage of this research. As this paper shows, legislation does not typically set outcome targets. This creates flexibility for state and local government policies to respond to changing circumstances. It is essential that policies relevant to planning healthy communities not only support the social determinants of health, but also have strong implementation plans, with designated funding, clear targets and a commitment to evaluation.

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