Improving integrated planning in Melbourne: Exploring barriers and enablers of health-promoting policy integration

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Abstract: Integrated planning across multiple sectors is essential for creating healthy communities, where jobs, shops and services are accessible from homes via walking, cycling or public transport. This paper explores barriers and enablers of health-promoting integrated planning in Melbourne, focussing on horizontal integration across Victorian state government departments and agencies. Content analysis was undertaken of Victorian state government policy documents that shape the health of urban environments. The planning strategy for Portland, Oregon, USA was also analysed, to identify lessons that might be drawn from the City of Portland, which is widely regarded as a leading example of integrated planning. In addition, in-depth semi-structured interviews were conducted with senior policymakers from the Victorian state government and the City of Portland. Walt and Gilson's (1994) policy analysis framework was used to assess and categorise barriers and enablers of integrated planning into actor, process, content and context factors. Despite clear aspirations and efforts at health-promoting integrated planning in Victoria, this research suggests that key challenges remain, such as the disconnection between land use planning and infrastructure and service delivery. Recommendations for improving governance arrangements, policy processes and policy content are outlined, to assist in the creation of healthier communities through integrated planning.

Introduction

There is a growing understanding of the ways in which city planning determines the health and wellbeing of urban populations. Chronic diseases, such as cardiovascular disease, cancer, type 2 diabetes and mental health problems, are now the leading cause of death and disability globally (Kent *et al.* 2012; World Health Organization 2011a). This is the case amongst city populations in both low-to-middle income countries and high income countries such as Australia. Melbourne, the capital of Victoria, Australia, has been rated the world's most liveable city according to a limited set of indicators (Economist Intelligence Unit 2012), yet has one of the largest ecological footprints globally (Newton 2012), and faces significant planning and public health challenges.

Melbourne's population is rapidly expanding, with the fastest growth occurring in low-density greenfield developments in the outer north and west (Australian Bureau of Statistics 2011; Outer Suburban/Interface Services and Development Committee 2012). These growth areas are typically low-density developments, with significant delays in the provision of local jobs, shops and essential infrastructure and services, such as public transport, parks, schools and health and community services. Insufficient nearby destinations and inadequate walking, cycling and public transport infrastructure discourages physical activity and fosters car dependence (Essential Economics 2012; Legislative Council Environment and Planning References Committee 2012; Perkins 2012). Compared with more established inner city areas, growth area communities may also have 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 *et al.* 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). Along with socioeconomic and demographic variables, urban planning and design factors may be contributing to the higher rates of chronic diseases observed amongst outer suburban residents compared with Melbourne and Victorian averages (Essential Economics 2012; Outer Suburban/Interface Services and Development Committee 2012).

Under Victorian legislation, local governments are responsible for most land use and development decisions and must prepare municipal public health and wellbeing plans (de Leeuw *et al.* 2006; Williams and Maginn 2012). However, the state government maintains a leadership role in spatial planning, by approving local planning schemes, and producing metropolitan planning strategies, such as the current *Plan Melbourne* (Department of Transport, Planning and Local Infrastructure 2014; Municipal Association of Victoria 2009). The state government also provides major infrastructure and services such as roads, public transport, and government schools and hospitals, with the responsibility

for planning and delivery of these services spread across many different state departments (Australian Social and Recreation Research 2009; Williams and Maginn 2012). The state Metropolitan Planning Authority coordinates planning and infrastructure in key strategic areas (Metropolitan Planning Authority 2015), but there is a lack of strong metropolitan governance in Melbourne and other Australian cities (Gleeson et al. 2012).

In this governance environment, integrated planning across state government departments and agencies is critical for supporting the creation of healthy communities. Integrated planning or policy integration refers to the "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). Integration can be either vertical between different organisations and/or levels of government, or horizontal across policy domains within the same organisation or level of government, such as across state government departments (Holden 2012; Kidd 2007).

While there are multiple interpretations in the literature about what integrated planning involves (Canoquena 2013; McQueen et al. 2012), these can be distilled into processes (i.e. how policies are developed, implemented and evaluated), policy content (i.e. the objectives, strategies and regulatory instruments put in place) and the outcomes sought (Nilsson and Persson 2003). The aims of these three main components of integrated planning in relation to creating healthy communities are outlined in Figure 1. The overall goal is to create healthy, 'complete' communities where jobs, services and infrastructure can be conveniently accessed from most homes, by walking, cycling or public transport. To achieve this, there needs to be inter-sectoral governance that supports effective partnerships and collaboration between different sectors and stakeholders (Holden 2012; Keast et al. 2007), resulting in coherent and consistent policies (Nilsson and Persson 2003; Rayner and Howlett 2009) that support the social determinants of health (i.e. physical, political, social and economic factors that shape health outcomes (World Health Organization 2012)). The literature on integrated planning also emphasises the role of policy actors (i.e. individuals, organisations and government) and the broader context (i.e. political, structural and cultural factors) in shaping policy development and implementation (Exworthy 2008; Marsh and Smith 2000).
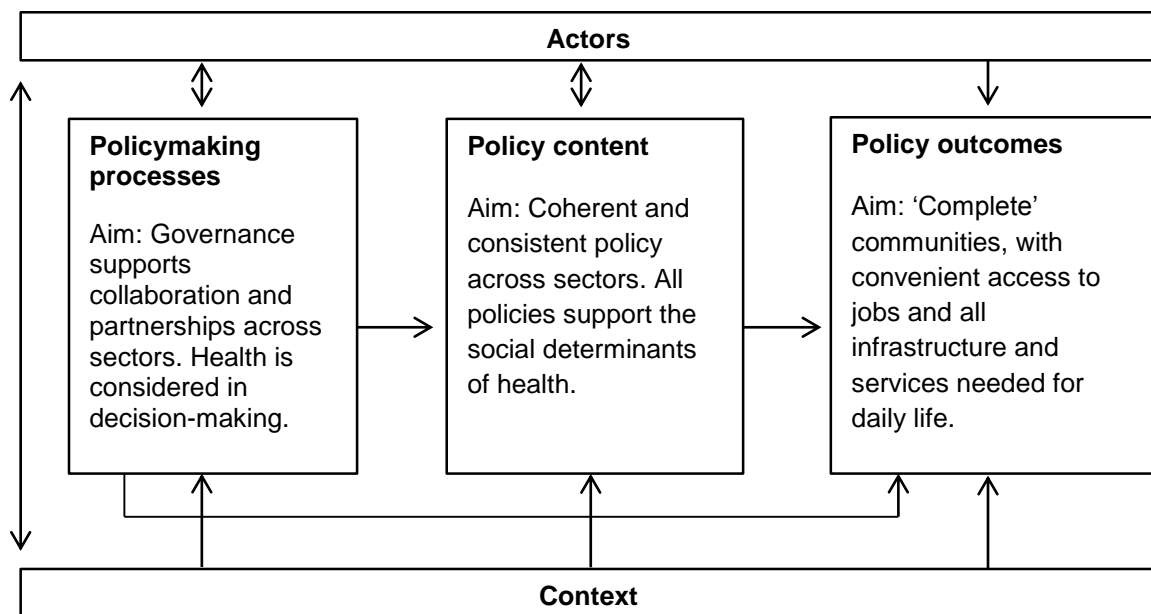

Figure 1: Model of health-promoting integrated planning (adapted from Buse et al. (2001), Nilsson and Persson (2003), and Walt and Gilson (1994)).

Closely related to these ideas, Walt and Gilson's (1994) health policy framework identifies four elements of policymaking – actors, context, processes, and content. For these authors, policymaking is the result of the complex interrelationships and interactions between these components. They argue that all four components need to be analysed to understand how to reform policy and improve implementation and outcomes. The model of health-promoting integrated planning outlined in Figure 1

is therefore developed out of both Walt and Gilson's (1994) policy framework and the literature on integrated planning.

Internationally, there is a growing interest in using integrated planning to address health holistically or through improving one or more social determinants of health (e.g. transport planning). Efforts to improve health through integrated planning have included 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. It does so by engaging local governments in a process of political commitment, institutional change, capacity-building, partnership-based planning and innovative projects (Rydin *et al.* 2012; World Health Organization Regional Office for Europe 2012). Health Impact Assessment is increasingly being used in Australia and internationally as an approach to promoting health across sectors (Gardner 2008; Ison 2009). This methodology assists policymakers to accept, reject or amend policies or plans in any sector based upon their potential or current effects on population health, often with a particular focus on health inequities (Forsyth *et al.* 2010; Harris *et al.* 2007; Health in All Policies Unit 2011; Hensgen 2009; World Health Organization 2011b).

Portland, Oregon, USA is often cited as a leading example of integrated strategic planning and growth management, resulting in health benefits (Abbott 2000; Mayer and Provo 2004). Portland's long-term strategic land-use, transport and infrastructure planning within a defined urban growth boundary, has created a city that supports walking and cycling and ranks highly on quality of life (Mayer and Provo 2004). The current planning strategy, the *Portland Plan,* has a strong focus on health, equity, inter-sectoral collaboration, and implementation planning (City of Portland 2012), and can provide insights into optimal policy design for integrated planning.

Previous research into integrated planning efforts in Victoria has identified shortcomings in both policy processes and policy content. Victoria's *Environments for Health* state-wide framework for municipal public health and wellbeing plans, launched in 2001, was designed to provide a framework for horizontal integrated planning at the local government level (de Leeuw *et al.* 2006). An evaluation of *Environments for Health* in 2006 found that there was limited integration of public health plans with other local government plans (de Leeuw *et al.* 2006). Barriers to integrating public health plans with council and land use plans included a lack of collaboration across sectors, workforce capacity issues, and the complexity of council planning requirements (de Leeuw *et al.* 2006). Melbourne's previous metropolitan planning strategy, *Melbourne 2030*, attempted to promote integrated planning, but an evaluation of this strategy found that it was limited by insufficient funding and attention to implementation (Mees 2011; Moodie *et al.* 2008). In addition, a recent parliamentary *Inquiry into Environmental Design and Public Health in Victoria* noted a lack of consideration of health in state planning legislation and policies (Legislative Council Environment and Planning References Committee 2012). Moreover, an extensive analysis of the capacity of state and local government policies to deliver land use and transport integration by Curtis *et al.* (2010) found that Melbourne only had a basic level of integration between levels of government.

This paper aims to extend this area of research, by examining determinants of the extent of integrated planning across Victorian state government departments and agencies that deliver infrastructure to support healthy communities. The main question guiding this research was: *What are the main barriers and enablers of health-promoting integrated planning across state government departments in Victoria?* The secondary research question was: *What lessons can be learned from the process of developing and implementing the planning strategy for Portland, Oregon?* The paper begins by outlining the methods used to critique policymaking at the state government level in Victoria. Results are then discussed in terms of barriers and enablers of integrated planning. Finally, recommendations for strengthening integrated planning in Victoria are outlined, drawing on lessons from Portland.

Methods
This paper uses the framework of health-promoting integrated planning outlined in Figure 1 to structure the analysis of policymaking at the state government level in Victoria. Specifically, it focusses on policy content, policymaking processes, the actors involved, and the broader context (Buse *et al.* 2001; Walt and Gilson 1994).

Policy document analysis
This policy analysis study involved two methods. The first was *content* analysis of Victorian state government policies as well as the *Portland Plan*. The aim was to analyse Victorian policies that had a direct, high-level role in governing the key social determinants of health in Melbourne's growth areas

- transport, housing, education, employment, and health and social infrastructure (Department of Health 2012a, 2012b). There are no overarching state government policy documents specifically dedicated to transport, education, housing or social infrastructure planning. Hence the policy analysis included the following Victorian documents:

- *Planning and Environment Act 1987* (Victorian Government 1987)
- *Victorian Planning Provisions* (Department of Planning and Community Development 2012)
- *Public Health and Wellbeing Act 2008* (Victorian Government 2008)
- *Transport Integration Act 2010* (Victorian Government 2010)
- *Plan Melbourne* (Department of Transport, Planning and Local Infrastructure 2014)
- *Victorian Public Health and Wellbeing Plan 2011-2015* (Department of Health 2011a)
- *Victorian Health Priorities Framework 2012-2022* (Department of Health 2011b)
- *Services Connect* (Department of Human Services 2013)

Content analysis criteria were developed to reflect best-practice principles for health-promoting integrated planning, as described in the literature (see for example, McQueen *et al.* 2012; WHO Centre for Health Development 2014). There were four categories of criteria, which examined: the documents' overall goals in relation to the social determinants of health; the extent to which they support integrated planning across sectors; evidence of commitment to implementation; and reported levels of community and non-government stakeholder participation. The Victorian policies and the *Portland Plan* were all analysed against these criteria.

Key informant interviews
In addition, in-depth semi-structured interviews were conducted with a purposive sample of current and former senior policymakers, between January and June 2014. The 20 Victorian participants had experience in a variety of senior roles in a broad range of departments and agencies. At the time of the interviews, the names of the relevant departments were Health, Human Services, Transport Planning and Local Infrastructure, Education and Early Childhood Development, State Development Business and Innovation, Premier and Cabinet, Places Victoria (Victoria's state development agency) and the Metropolitan Planning Authority. In addition, two senior planners were interviewed from the City of Portland, who had been involved in developing and implementing the *Portland Plan*. The aim of the interviews was to explore participants' perspective and experiences of policymaking, in order to interrogate the *processes*, *actors* involved, and the political *context* in which policies were developed and implemented. The interviews were audio-recorded, transcribed and analysed thematically, to identify key barriers and enablers of integrated planning.

Barriers and enablers of health-promoting integrated planning
This section outlines and discusses the key results on barriers and enablers of health-promoting integrated planning in Victoria. The policy document analysis results are presented first, followed by the findings from the key informant interviews, which are divided into context, actor and process factors.

Policy content
The content analysis first examined how strongly the documents supported health, wellbeing and the social determinants of health. All of the Victorian policies analysed explicitly promote health and/or wellbeing as a policy goal, with the exception of the *Planning and Environment Act 1987,* which does not directly engage with the link between planning and health outcomes. The *Planning and Environment Act 1987* is the pivotal legislation for the spatial planning of communities, so currently there is no legal obligation for planners to prioritise health.

All of the Victorian documents reviewed contained statements that supported the social determinants of health, with generally good coverage of the main determinants when all of the Victorian policies are taken together. However, while action on the social determinants of health could be led by public health legislation, notably the *Public Health and Wellbeing Act 2008* provides little guidance on preventing chronic disease through the creation of healthy environments. Furthermore, across all the Victorian documents reviewed, the majority of statements that support the social determinants of health refer to aspirational goals without outlining specific strategies and actions for achieving progress. This provides limited direction to those charged with implementing the policies.

The lack of spatial guidance for the provision of key infrastructure and services in the Victorian context could also be a barrier to promoting health through integrated planning. *Services Connect*, the

Victorian Public Health and Wellbeing Plan, the *Victorian Health Priorities Framework,* the *Public Health and Wellbeing Act 2008*, the *Transport Integration Act 2010* and the *Planning and Environment Act 1987* were all found to have a limited spatial focus. There is also a lack of detailed metropolitan-wide policy for spatial provision of housing, education, active transport and social infrastructure, and land use planning policy appears to be quite disconnected from infrastructure and service delivery processes.

Victoria's main spatial planning documents, *Plan Melbourne* and the *Victorian Planning Provisions,* had the highest number of statements supporting health determinants. *Plan Melbourne* promotes 20-minute neighbourhoods, where jobs, shops and services are located within a 20-minute journey of most homes. However, this policy emphasises car transport projects, failing to prioritise public transport, cycling and walking infrastructure within the 20-minute neighbourhood concept. The *Victorian Planning Provisions* include many statements that support health determinants, yet continue to promote low-density development in suburban growth areas.

In contrast, the *Portland Plan* is a strategic land use planning document that strongly and consistently supports the determinants of healthy communities. Promotion of health and equity are guiding principles of the document, and this follows through into key health-promoting actions. Notably, the equity focus is not shared by any of the Victorian documents analysed. The *Portland Plan* also advocates for the creation of 'complete' 20-minute neighbourhoods, and consistently prioritises active transport over car use.

The second group of criteria analysed policy integration. All of the Victorian documents explicitly state how they work with a range of other policies, regulations and Acts. However, there are a number of discrepancies and missing links in the Victorian policy framework. Notably, 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. Municipal public health and wellbeing plans prepared under the *Public Health and Wellbeing Act 2008* must be consistent with councils' Municipal Strategic Statements prepared under the *Planning and Environment Act 1987*, but not vice versa. Also, *Services Connect* does not refer to policies outside of the human services sector, suggesting that this policy is not well integrated with other sectors. Likewise, the *Victorian Health Priorities Framework* is very internally focused on the health sector.

All of the Victorian documents analysed explicitly promote integrated planning across sectors and/or levels of government. However, across all of the Victorian documents, few of the references to integrated planning are accompanied by specific strategies for achieving policy integration. Importantly, the planning act does not to reciprocate the transport act's emphasis on transport and land-use integration, creating inconsistency within the legislative framework. The health sector documents, *Plan Melbourne* and the *Victorian Planning Provisions* all promote health through integrated planning, indicating that this is a shared goal across the planning and health sectors. However, compared with the non-health policies in Victoria, the *Portland Plan* more strongly promotes health through integrated planning, by having a consistent focus on both health and inter-sectoral collaboration.

While all of the Victorian documents analysed support partnerships between departments/agencies to some extent, the majority of relevant statements across the documents either indicate a low level of collaboration between departments, or provide no indication of the extent of collaboration. By contrast, each action outlined in *Portland Plan* is accompanied by a list of partners (different departments and levels of government) who are *collectively* responsible for implementation.

In terms of the commitment to implementation criteria, five of the eight Victorian policies clearly outline who is responsible for implementation of the various actions contained within them. The *Victorian Public Health and Wellbeing Plan*, the *Victorian Health Priorities Framework* and *Services Connect* do not clearly allocate roles and responsibilities. A key strength of *Plan Melbourne* is that at least one department/agency is identified as responsible for each action listed. In addition, while it is usually clear who is responsible for implementing the Acts, many of the legislated powers given to decision-makers are discretionary, missing the opportunity to mandate specific strategies or procedures that would support the social determinants of health or integrated planning.

All of the Victorian policies analysed have a low rate of inclusion of clear targets, measures and timeframes, by which to monitor progress towards implementing the policies or achieving desirable change. In particular, no measures or targets are identified for any of the Acts or for *Services Connect*. On the other hand, the *Portland Plan* outlines clear and measurable inter-sectoral performance

targets, supporting transparency and accountability for implementation. Notably, the *Portland Plan* includes both health and 20-minute neighbourhood measures and targets, the attainment of which requires health-promoting integrated planning.

The documents were also analysed for information about community and non-government stakeholder participation during policy development and implementation. The Victorian policies and statutory laws provide limited insight into this. Meanwhile, the *Portland Plan* clearly identifies the role of non-government stakeholders such as the private and community sectors in policy development and implementation.

Policy context

This section and the two that follow outline results of the interviews. In terms of contextual factors, the Victorian interview participants identified the historical lack of bipartisanship in the state political system between the two major political parties as a key barrier to integrated planning. According to participants, the politicised nature of the planning system means that the ability to undertake long-term planning for Melbourne is limited by election cycles, as a change of government usually results in the previous government's policies becoming redundant, and the development of new policies or plans. In recent times for example,

> You look at the *Victorian Transport Plan*, so much work went into that, and then it's just in the bin as soon as the new government comes on board. The same with *Melbourne 2030*; it's in the bin (former transport bureaucrat).

In contrast, the Portland participants spoke about having broad political support for strategic plans, including the current *Portland Plan*. This means that planning strategies have stayed reasonably consistent over the long-term, despite changes in political leadership.

Departmental silos, resulting from traditional sectoral divisions of responsibility, were discussed by both Victorian and Portland participants as an ingrained contextual barrier to integrated planning. They identified the role of inter-sectoral governance structures such as cabinet and inter-departmental committees in helping to break down these silos, by providing a forum for people from different sectors to meet formally and collaborate on addressing particular issues. Victoria's Regional Management Forums were specifically mentioned as a way of fostering collaboration at the regional level, by bringing together representatives from local government and state government departments. The regional structure of government departments was also identified as an important facilitator of integrated planning. Participants reported that regional offices are more in touch with the needs of their local community, and more aware of the activities of other government and non-government service providers in their region.

Policy actors

In terms of policy actors, the Victorian and Portland participants spoke about how leadership can be a vital facilitator of integrated planning. As a former Victorian health bureaucrat put it, "Leadership, leadership, leadership, leadership. Probably <u>the</u> most important thing". The interviews with Portland planners also highlighted the positive impact of leadership, as the Mayor and bureaucratic leadership from the planning department were driving forces behind the inter-sectoral collaborative approach to developing and implementing the *Portland Plan*. In contrast, many Victorian participants spoke about the current lack of leadership for integrated planning, particularly from senior public servants and politicians. This was seen to be creating barriers for more junior public servants working towards integrated outcomes. Some participants were optimistic that the Metropolitan Planning Authority (newly-formed at the time of the interviews) could potentially take a leadership role on integrated planning.

Another theme that emerged from the Victorian interviews was the importance of having informal networks of people across departments and agencies that can facilitate collaboration across sectors. These people do not necessarily need to be in senior leadership roles, and their work can complement more formal governance structures. As one health bureaucrat put it,

> If you know someone and you have a respectful working relationship, then it makes it much easier to pick up the phone or meet around something. And where you have those networks across government working pretty well, then I think you do get some quite good synergies.

These networks take time to build up, and can be disrupted by changes in the workforce. For this reason, the Victorian participants identified recent job losses under the previous state government (2010-2014) and the resulting insecure employment environment, as barriers to integrated planning.

Policy processes

In Victoria, recent efforts at precinct and place-based approaches to planning were thought to be beneficial. Six participants specifically talked about the Precinct Structure Planning Guidelines introduced by the former Growth Areas Authority (now superseded by the Metropolitan Planning Authority) as a facilitator of strategic planning. However, there was widespread recognition of an overall lack of strategic long-term, metropolitan-wide planning in Melbourne. A major contributor is the lack of bipartisanship and senior leadership for policy integration, as discussed above. The resulting *ad hoc* approach to planning, often led by the private sector, means that "We've got a growing population…[and] the infrastructure lags behind it a long way, and further and further every year" (member of parliament). This contrasts with Portland where consistent strategy over the long-term has been their hallmark planning approach, made possible through political leadership, bipartisanship and consensus-building.

Budgetary processes in Victoria were also frequently identified as a barrier to integrated planning. One of the main issues relates to budgetary competition. As a former transport bureaucrat said,

> …all the departments fight for the one piece of budget pie, so everybody is still at some point a competitor for the budget pie….transport projects are up against hospital projects, they're up against local government projects, they're up against…urban renewal projects.

This competition for funding is a barrier to partnerships and collaboration, and was heightened during the previous state government's budget cuts.

On the other hand, the referral system between departments was reported as a key facilitator of inter-sectoral collaboration in Victoria. There are two different referral processes whereby other state government departments and agencies can be involved in land use planning decisions:

> One is the statutory referral process [set out in the *Planning and Environment Act 1987*], where different agencies are listed for mandatory referral, and then there's another pathway where, at the discretion of the responsible authority, they can seek input (urban planning bureaucrat).

The Portland participants identified extensive and open consultation with the community and government and non-government agencies as another process that facilitates integrated planning. This was undertaken very early in the process of developing the *Portland Plan*, and was reported to have helped with reaching agreement between sectors and securing shared commitment for implementation.

Discussion

Given the complexity of the policymaking environment, there are a broad range of factors that shape how planning manifests in Victoria. The results indicate that health-promoting integrated planning is a clear aspiration in Victoria, and that some significant efforts have been made to achieve this in Melbourne. These facilitators include: inter-departmental governance structures and processes, the collaborative skills of many policymakers, place-based planning approaches and the content of legislation and policies supporting many health determinants and aspiring to promote integrated planning. However, it is clear that key challenges remain, with a range of opportunities to enhance health-promoting integrated planning at the state government level, as outlined below.

Recommendations

Addressing ingrained contextual factors such as departmental silos and lack of bipartisanship could potentially have the most widespread benefits, but these challenges are difficult to address directly. For this reason, most of the suggested strategies for strengthening integrated planning focus on actor, process and content factors. However, many of these approaches could indirectly help to overcome contextual barriers.

The interviews highlighted a number of recommendations in relation to policy *actors*. It was clear that there is a need for stronger political (World Health Organization and United Nations Human Settlements Programme 2010) and bureaucratic leadership for integrated planning, to help break down departmental silos. As demonstrated by Portland, leadership from the 'top' can create an environment where collaborations and partnerships across sectors are expected and supported. Some Victorian interview participants spoke about the need to realise the potential of the Metropolitan Planning Authority to be an autonomous leader and coordinator of planning activities. This could help to strengthen metropolitan governance and de-politicise planning in Melbourne (Gleeson *et al.* 2012).

The results also highlighted a number of ways to enhance integrated planning by addressing policy *processes*. Firstly, there is a need to improve budgetary processes and funding arrangements. To help break down competition between departments, joint budget submissions could be prepared by one or more departments. Joint budgeting was suggested by interviewees, but is also recommended in the literature as an important governance mechanism for inter-sectoral action on health (McQueen *et al.* 2012; WHO Centre for Health Development 2014). Indeed, this can be an impetus for identifying and working towards co-benefits across sectors. In order to realise integrated land use outcomes, the Ministerial Advisory Committee for *Plan Melbourne* (2012) proposed the use of innovative funding approaches to address the under-investment in infrastructure and services on the urban fringe. The current revision of *Plan Melbourne* under the guidance of the Ministerial Advisory Committee provides an opportunity to explore and introduce these funding mechanisms, such as value capture (Department of Environment, Land, Water and Planning 2015; Fensham and Gleeson 2003). Secondly, interview participants suggested the need to reward public servants for collaboration, through performance measures and criteria for promotion. Thirdly, to formalise consideration of health in decision-making, it was suggested that Health Impact Assessment could be used more extensively in Victoria, particularly for major developments and infrastructure projects. Health Impact Assessment is also supported by the literature on inter-sectoral action for health (WHO Centre for Health Development 2014). Finally, engagement of the community and non-government stakeholders in policymaking could be strengthened in Victoria, following the example of the *Portland Plan*. Incorporating the public's perspectives, needs and values is increasingly recognised as an important ingredient in successful inter-sectoral governance initiatives (McQueen *et al.* 2012; WHO Centre for Health Development 2014) and for strengthening local partnerships (Aboelata *et al.* 2011).

The document analysis results indicated a number of ways to support integrated planning by strengthening the *content* of Victoria's policies and statutory laws. First, there is a need to fill in gaps in the policy framework to provide more guidance on where and how to deliver key infrastructure and services. For example, comprehensive plans for the location of new schools could be developed. Second, to support health as a planning priority, the *Planning and Environment Act 1987* requires amendment to make health one of its objectives, and to mandate the consideration of health impacts in planning decisions (Cancer Council Victoria *et al.* 2011; Legislative Council Environment and Planning References Committee 2012). In addition, all non-health policies in Victoria could follow the example of the *Portland Plan*, and more strongly and consistently promote health and equity, from the guiding principles through to including health targets. Third, for all Victorian documents, there is a need to be more specific and prescriptive about actions to achieve progress on the social determinants of health and integrated planning, to shift policies from being broad aspiration statements into implementable strategies for change. Fourth, clearer implementation and evaluation plans need to be prepared (Althaus *et al.* 2007). Specifically, all of the documents could more clearly direct different departments and levels of government to collaborate on implementing the policies. There is also a need to include measurable targets in all Victorian policies, and the health and human services policies should more clearly allocate roles and responsibilities to support implementation (Planning Institute of Australia *et al.* 2009). Finally, following the example of the *Portland Plan*, the Victorian policies could provide more information about the extent of community and non-government stakeholder involvement during policy development and implementation. Such reforms could assist in the creation of healthier communities in Melbourne.

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