

Are Metropolitan Planning Frameworks Healthy? The case of Melbourne 2030.

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ABSTRACT

This paper presents preliminary findings of a project investigating the integration and application of ecological public health principles in Melbourne 2030, the Victorian Government's urban planning blueprint for Melbourne for the next 30 years. The study examines the political, organisational, social, and inter-personal factors that impact on the integration and application of broad health considerations into urban planning policy in Victoria. We are testing the premise that achieving integrated planning requires a systematic integration of government activity across sectors. Using discourse analysis and key informant interviews, we examined relevant government policy and legislation and its implementation against world's best practice. Preliminary findings show that the degree of leadership in relation to deploying the mission, and implementation processes sustain or impede integrated planning at a whole-of-government and intersectoral level

These findings may inform a much-needed national agenda on promoting health through integrated planning. Findings will identify future research directions and action to bridge the gap between urban planning and health planning systems

INTRODUCTION

As part of its 1947 Constitution, the World Health Organisation defined 'health' as "the state of complete physical, mental and social well-being and not the merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief or economic and social condition". For decades, Public Health professionals have appreciated that many of the factors that affect people's health lie outside their personal control, and instead can be found in the complex environments in which people live. Within the Social Model of Health framework, improvements in health and well-being are achieved by addressing the many social, cultural, environmental, biological, political and economic determinants of health. Therefore, to promote wellbeing, this more 'ecological' understanding of health needs to become the core business not just of health professionals, but of all professions and agencies whose work impacts on the health and wellbeing of individuals and whole communities.

Urban planning is crucial in terms of building opportunities for people to experience health 'into' the environments in which they live. Many facets of urban design are core 'upstream' social determinants of health, in terms of amenity, social support, planning for physical activity, and better material resources (Department of Human Services, 2001; Wilkinson & Marmot, 2003). Yet as the world's human population becomes primarily urban (Hinrichsen, 2005), many cities are expanding faster than governments can plan for them, resulting in piecemeal and overloaded infrastructure, a decline in social norms and social support, increased social disorganisation and stress, and associated physical and mental health problems (McMichael, 1993).

As part of the rush to globalisation, Australian cities – including Melbourne – are also experiencing the challenges faced in other Western cities. These include suburban sprawl, loss of habitat and biodiversity, car dependency, gentrification of inner urban areas, privatisation of public space, social and geographical marginalisation of lower income populations, poor infrastructure planning and provision to promote physical activity and social interaction, and associated public health issues of social isolation, depression, obesity, and loss of social capital (Butterworth, 2000; Langton, 2001; McMichael, 1993; Victorian Department of Sustainability and the Environment, 2005). “Meeting the new urban health challenges depends upon reuniting public health and urban planning in the academic world, in the professional arena, in community development and in government” (Duhl & Sanchez, 1999, p. 2).

Healthy Cities

The Healthy Cities approach developed by the World Health Organization has been paramount in the growing acceptance of a systemic, ecological approach to addressing social inequalities in health, and the link between urban planning and wellbeing (Duhl & Sanchez, 1999). Healthy Cities is a long-term development project that seeks to place health on the agenda of cities around the world, and build a constituency of support for public health at the local level (Tsouros, 1995). The Healthy Cities approach is based on the recognition that city and urban environments affect citizens’ health, and that healthy municipal public policy is needed to effect change (Ashton, 1993). Linking the seminal Ottawa Charter for Health Promotion (WHO, 1986) with evidence on the social determinants of health (Wilkinson & Marmot, 2003), Healthy Cities projects are characterised by broad-based, intersectoral political commitment to health and wellbeing in its deepest ecological sense; commitment to innovation; an embrace of democratic community participation; and a resultant healthy public policy that addresses health inequalities (WHO, 1995; 1997). Since the concept was embraced by WHO in 1986, the movement has inspired over 7000 projects worldwide. The concept is evolving to encompass healthy villages, islands and municipalities (National Civic League, 1998). Considerable evidence has been gathered around the world on the positive impacts of Healthy Cities initiatives that have sought to address urban environments (De Leeuw, 2001). This includes neighbourhood and community beautification, facilities construction, expansion and renovation, public utilities and public safety, enhanced public transport and enabling public policy (Kegler, Norton & Aronson, 2003).

Since the late 1980s, WHO-endorsed Healthy Cities programs have been established in only three locations: Nourlanga in South Australia, Canberra, and Illawarra Shire (New South Wales). According to Healthy Cities researcher Brian Dunn, little early emphasis was given to urban design issues or policy (Dunn, personal communication, 2 & 6 December 1999). In Victoria, a ‘Healthy Localities’ pilot project implemented six projects using the Healthy Cities approach (Garrard, Hawe, & Graham, 1995a, b, c), but failed to advance Healthy Cities principles into Victorian state urban planning policy. Nevertheless, during the last five years, significant advances have been made to integrate international Healthy Cities concepts and best practice into some Victorian policy.

The Political Context in Victoria

During the last five years, a strong awareness has developed across the Victorian state, local and non-government sectors about the ways in which consideration for health and wellbeing are the core business of many departments and policy areas outside the traditional health realm. Such systems herald a paradigm shift towards a systemic, ecological approach to health for many, in areas that have not been traditionally concerned with health and well-being. Such areas include transport, neighbourhood renewal, community building, infrastructure and urban planning (see National Heart Foundation, 2004). Through Environments for Health, the municipal public health planning framework, the Department of Human Services has strongly encouraged local governments to make use of Healthy Cities literature, and to integrate urban planning and health planning as a core business priority (DHS, 2001; Hay, Frew & Butterworth, 2001). A current review of the Victorian

Health Act 1958 (DHS, 2004) has created much discussion about the ecological approaches to health planning, raising the prospect of health impact assessment being applied to urban planning. Health impact assessment (HIA) can be a useful tool for assessing the effects of plans and policies of different sectors on health. It can contribute to the evidence base on health determinants, and help raise awareness regarding the determinants of health among different sectors at the local and national level (WHO, 2002). Currently, the Victorian government is exploring ways to integrate HIA into their core business (Mahoney, 2003).

While the health sector has clearly identified the connection with urban planning, the reverse cannot yet be said generally of the urban planning sector's understanding of its role in promoting the notion of health envisioned by the World Health Organisation. The Planning Institute of Australia's Victorian Chapter has become increasingly aware of the synergies that exist between planning decisions and the impact these decisions have on the health of communities (PIA, 2005). However, in urban planning decisions, the social dimensions of health and wellbeing are still frequently overlooked (see Read, 1996; 1997). Conceptual, political, ideological and organisational barriers remain. The connection to ecological public health principles and Healthy Cities has not been so transparent in Melbourne 2030.

Melbourne 2030

Melbourne 2030 is the State government's blueprint for how Melbourne will grow and consolidate physically over the next 30 years. It encompasses infrastructure, housing, transport, suburban development, amenities, services and open space, and the city's relationship with the surrounding region. The Strategy calls for 600,000 projected new dwellings to be incorporated over the next 30 years into Melbourne's existing geographical area. Numerous 'activity centres' have been identified as locations in which high density housing can be incorporated through urban infill (Department of Sustainability and Environment, 2002).

Melbourne 2030 was developed through an extensive process of scoping across government departments and consultation with community and industry. Hundreds of citizens across Melbourne took part in its development. The plan is anchored in the stated principles of: sustainability; innovation; adaptability; inclusiveness; equity; leadership; and partnership. Drawing on these principles, nine broad directions are outlined in Melbourne 2030. These are (i) a more compact city; (ii) better management of metropolitan growth; (iii) networks with the regional cities; (iv) a more prosperous city; (v) a great place to be; (vi) a fairer city; (vii) a greener city; (viii) better transport links; (ix) better planning decisions and careful management (DSE, 2002).

As a rhetorical document, Melbourne 2030's concern for the social determinants is implied in its principles and directions. Elements of the Ottawa Charter for Health Promotion, which advocates for healthy public policy, supportive environments, strengthening community actions, developing personal skills and reorienting health services (WHO, 1986), can also be discerned. However, the challenge for Melbourne 2030 is in its realisation.

Implementation of the Strategy has direct implications for social justice and the very social determinants of health that it is intended to enhance. For example, the Strategy is not clear about how urban infill would proceed, how the community would be engaged in the process, what building regulations would be enforced to preserve and enhance urban character, and what the resulting urban fabric might look like. As a result, many 'activity centres', identified in places of high local heritage value (if not legislated urban heritage), have been targeted by developers keen to use the rhetoric of Melbourne 2030 to extract maximum financial return from their site (Smith Street Collingwood Action Group, 2005). Furthermore, a high-level advisory group recently warned that without a dramatic increase in transport spending, Melbourne 2030 is "doomed" (Millar, 2005). Similarly, Ellingson (2003) commented on the demise of Melbourne's green wedges, "the city's lungs which, despite new laws meant to ensure their survival, are still being eroded". Davidson (2002) described Melbourne 2030 as "a dream come true for VicRoads" (the government's road

administration). He asked: “What are we trying to achieve? Most people agree, it is a liveable city. But for whom?”

Whilst Melbourne 2030 calls for a ‘joined up government’ approach to implementation, it is apparent from social commentators that at present its rhetoric has not yet been matched by reality. The Strategy notes that all Government departments and agencies will assess the relationship between their infrastructure investment plans and Melbourne 2030 as part of their budget process (DSE, 2002, p. 175). Key policies and initiatives to be taken into account include housing, activity centres, transport, environmental management and regional development. Interestingly, the document does not identify that government departments will need to consider the health impacts of their policies, or that Melbourne 2030 implementation plans will be audited for their health impacts. In other words, Melbourne 2030 currently appears to provide limited detail of how cross-sectoral and whole-of-government approaches will be developed, especially in relation to identifying health outcomes.

THE CURRENT STUDY

This study explored the relationship between the social determinants of health, Melbourne 2030, and other core state- and community-level planning systems. We explored the integration and application of ecological public health principles into Melbourne 2030. We speculated that the current lack of integrated planning is a consequence of a failure to integrate government activity across sectors. We sought to test this premise and identify the characteristics of barriers and enablers to planning health into cities. Specifically our study aimed to:

1. Examine government policy in Victoria for evidence of an ecological, integrated approach – as exemplified by the Ottawa Charter, Social Determinants of Health and Healthy Cities – that links health and the built environment within Melbourne 2030, and
2. Identify the factors that sustain or present barriers for integrated planning and its application in relation to current urban/ social planning frameworks within state and federal legislative contexts.

METHOD

Our study involved two methodological components:

1. Discourse analysis of Melbourne 2030 and other relevant policy documents
2. Key informant interviews were conducted with stakeholders involved in the development and application of planning (urban and health) legislation and policies. Data collection comprised semi-structured interviews (face to face and telephone) and focus groups.

A key aim of the proposed research was to gain insight into the prevailing world view driving the development of Melbourne 2030, and to determine the extent to which the ecological approach of Healthy Cities has been embedded in them. Therefore, discourse analysis was used to examine the rhetoric of these documents, and their stated principles, goals and accompanying implementation plans.

According to Stubbs (1983), discourse Analysis is most appropriate in the application of critical thought to social situations and the unveiling of hidden (or not so hidden) politics within the socially dominant as well as all other discourses (interpretations of the world, belief systems, etc.). Government legislation, policies and planning frameworks are mandated frameworks that guide action. They, and the accompanying reports, correspondence, media and other material on the public record, serve to encapsulate a culture's prevailing ideology, belief systems and values at any particular time. As a product of a particular world view, the rhetoric, stated values, goals and

strategies, and opinions expressed in all these public documents contain clues as to the currency of particular modes of thought and ways of seeing and interpreting the world. Discourse analysis can help expose the assumptions behind the definitions of social problems and goals and the ideologies and motivations behind decisions made by the dominant social elite. Reflecting the growing acceptance of a systemic, ecological approach to addressing social inequalities in health the (Kickbusch, 1989), Healthy Cities literature contains rhetoric that espouses a style of planning and action that results in a whole of government approach (indeed, a whole-of-community approach) to addressing the social and environmental determinants of health.

A Research Network was established, comprising six key stakeholders from the Victorian state government, representatives from the Planning Institute of Australia, and other experts. This Network was used to inform the research process and help locate key informants and documents. Potential participants were sourced through contacts available to the Research Network, with additional snowball sampling techniques used to fill cohort quotas.

Key informant interviews with stakeholders involved in the development and application of planning (urban and health) legislation and policies, were conducted to provide insights into the extent to which the rhetoric of these documents has been matched with action, in terms of:

- The political decision-making frameworks established to develop these plans and frameworks - to what extent have they embraced the ecological public health philosophy of empowerment, participation, inclusion and intersectoral collaboration?
- Comparing the stated priorities with the funds and resources attached to them, and the time allocated to their implementation
- The gaps in these plans, from the perspective of Healthy Cities/ecological public health.

A sample of 30 key informants were derived from a larger pool of key informants including:

- State govt (ministers / officers) (n = 10)
- Industry reps (n = 6)
- Local government planners (health and urban design) (n = 10)
- Local government senior management (n = 10)
- PIA members (n = 6)
 - Community advisory group members (n = 15)
 - Elected councillors (n = 10)

Participants were asked the following questions:

- How participants felt they had influenced the policy and how it influenced them (in regards to their job description).
- Identify the key stakeholders in the development of Melbourne 2030.
- How do stakeholders work together and how well do they work together/Suggestions for improved collaboration.
- How important is health to Melbourne 2030?
- In your understanding does Melbourne 2030 define health?
- Were health promotion strategies used within the planning process?
- Are there improvements that can be made in terms of health?
- What action can be taken to put health on the agenda for Melbourne 2030? Who are the key stakeholders to do this?
- How does Melbourne 2030 integrate with other policies in state government?
- How much do you know about the implementation of the Melbourne 2030 policy?
- What would be the ideal outcomes for the Melbourne 2030 policy?
- Are there measures in place to assess the effectiveness of the Melbourne 2030 policy?

PRELIMINARY FINDINGS

Deploying the Vision of Melbourne 2030

Participants perceived that Melbourne 2030 is ‘asking a lot of local government’ – and also of developers – to take leadership on this policy and drive the vision. Many participants commented that there did not appear to be significant leadership from government. Participants argued that state government needs to provide more resources to local government to implement the policy.

Some participants identified that there has been a lack of promotion of Melbourne 2030 from state government. They argued that the policy has not been marketed to its full potential, especially in relation to its potential as a healthy policy for the community. It was felt that the health benefits of Melbourne 2030 could be marketed as an integral component.

Many of the participants perceived language to be a barrier within Melbourne 2030, and that the language used by the health sector can contribute to this barrier. Key stakeholders need to be mindful of the language they use in relation to Melbourne 2030, because sometimes within different disciplines one word can have a completely different meaning. As collaboration is a significant part of the policy, it is important to clarify understandings and expectations across all sectors. Disciplines commonly identified by participants included health planners, land use planners and engineers. More work is needed to ensure further understanding between these professions before progressing healthier urban planning. A common understanding of health promotion principles is needed before they can be realised in practice. Interestingly, one participant commented on how town planning was created to foster public health, however the profession has evolved away from public health to such an extent that health is no longer within their job description.

Participants were asked to identify key stakeholders for Melbourne 2030. They identified a wide range of Key Stakeholders ; these are listed in Table 1 below.

Table 1: Range of stakeholders identified by research participants

Aged Services	Building	Business Sector	Community Groups
Community Health	Community Safety	Crime Prevention	DHS
DOI	DSE	DVC	Environmental Planners
Federal Government	Health	Hospitals	Local Government
MAV	Non – government agencies	Other Living Organisms (trees, animals)	Planning Institute of Australia
Private Developers	Public Open Space Planners	Schools	Social Planners
Save Our Suburbs	State Government	Strategic Planners	Town Planners
Traffic Engineer	Transport – DOI	Transport Planners	Universities
VicHealth	VicRoads	Youth services	

All participants identified many opportunities for improving collaboration among key stakeholders. It was agreed that Melbourne 2030's vision is intrinsically collaborative, and that there is a need for continuing relationships that create trust and build understanding. One participant noted because of high staff turnover, achieving collaboration is often difficult in today's workplace. It is often difficult to form relationships and vision within and across departments.

Embedding Health into Melbourne 2030

All participants agreed that it is important to put health on the agenda within Melbourne 2030, as health was seen as a key policy driver. In particular, social health was seen as fundamental to the policy. A challenge was identified in moving beyond thinking of health merely in terms of hospitals, and looking at health in a broader context. Those participants involved in social and health planning indicated that advocating the health and wellbeing of the population was “a constant battle”. Participants viewed it as essential that Melbourne 2030 stakeholders recognise prevention as integral to health, and that this be demonstrated in all areas of the policy. More than half of the participants stated that each sector had a role to play in doing this; however participants argued, as stated earlier, that State government should take a leadership role.

Despite the centrality of health to Melbourne 2030, many participants from a senior level, in state and local government perceived that it was not a requirement for the policy to incorporate health explicitly, nor attempt to define health. A comment from one participant was that stakeholders ‘won’t look at the same definition because of an understanding of health each department has’. Despite this, most participants commented that health is one of the underlying principles within the directions and initiatives of the policy. When looking at the policy through a health lens, most could see where health lay. The problem with this approach, however, is that each of the key stakeholders may see and interpret ‘health’ differently. As an example, one participant explained that land use planners do not always have the research to underpin the objectives of health, although they know that good outcomes are important. However, ‘good outcomes’ are often not articulated as health outcomes. Land planners do not seem to understand the ‘hard’ data surrounding health e.g. cardiovascular, depression, isolation and building communities. Therefore, more focus is needed on ensuring that developers incorporate consideration of these health outcomes into their projects.

According to interviewees, health promotion strategies such as: Ottawa Charter (WHO 1986); Social Determinants of Health (Wilkinson & Marmot 2003), were not overtly used in planning Melbourne 2030. Some participants commented that these might be expressed within the practice and implementation of the policy. However, other informants believed that health promotion strategies were not used in planning and may struggle to be realised through implementation. It was felt that health promotion could be embedded within the principles of Melbourne 2030, and could have been highlighted more.

Transport

Because of its obvious and well-documented health implications, participants identified transport as an issue. Interviewees identified the need to coordinate and integrate provision of bus, train and tram services, and also making it possible to increase frequency of bus services across all areas of Melbourne. While bus services are given a large emphasis in Melbourne 2030, some participants identified that they would prefer rail and light rail to ensure prosperity and a more sustainable city. VicRoads will receive significant funding through Melbourne 2030. However this was seen as an unhealthy outcome for the policy. Concern was raised over the Vic Roads’ emphasis on producing more roads and tunnels when Melbourne 2030 aims to move toward a more walkable and environmentally sustainable city with fewer cars. This was particularly germane to the perceived need to protect Green Wedges – maintaining these areas for access for community connection, health and wellbeing. The issues of roads and public transport were seen as difficult area for health advocates, as roads and public transport appear to be pitched against each other, with cars still given preference in government policy.

What do People want to see in Terms of Implementation /Desired Outcomes

Interviewees had limited knowledge about Melbourne 2030’s implementation strategy. It was suggested by participants that stakeholders need further guidance on how to implement the policy.

Most participants agreed that they would like to see the continuation of Melbourne 2030. Goals expressed for the implementation of Melbourne 2030 included:

- Community involvement in their communities – continual engagement and consultation;
- Health becoming an integral part and elevated within the framework;
- Ensuring provision of infrastructure for adequate services (e.g. transport);
- A community that can thrive and be happy;
- Well planned communities – looking carefully at social assessment;
- Ensuring a vibrant city and a positive vision of how the city might look in the future.

Monitoring and Evaluating Melbourne 2030

No participant could identify any measures for monitoring the implementation or impact of the policy. Participants saw it as a requirement for the policy to identify a vision for all sectors of the policy (inclusive of community) to aid in the visionary process. Furthermore, participants were unaware of whether any targets or strategic plans or performance plans had been established to realise what the policy aims to achieve. It was unknown which stakeholders would evaluate the policy, although it was anticipated that key stakeholders would include DSE and local government. However, some participants felt that evaluation should be conducted by an independent source (i.e. Academic sector or an inter-state evaluation team) independent from the stakeholders involved in implementing the policy. It was suggested that Health Impact Assessment could be incorporated to ensure that Melbourne 2030 deliver the best possible health outcomes.

DISCUSSION

This study aimed to investigate prevailing world views driving the development of Melbourne 2030, and to determine the extent to which the ecological approach of Healthy Cities has been embedded in them.

In viewing preliminary findings through a Healthy Cities lens one can determine the extent to which the policy is meeting its objectives against world best practice. It can highlight exemplary practice as well deficiencies and can ultimately produce recommendations for improving the implementation of Melbourne 2030 towards improved health outcomes for all. Healthy Cities are characterised by:

- **Broad-based, intersectoral political commitment to health and wellbeing in its deepest ecological sense;**

Preliminary findings show that there is such a commitment amongst some stakeholders but that communication about the links to health outcomes are required in order to assist wider commitment, and improve the implementation of the policy. Participants understand the intersectoral responsibilities here, however bemoan a lack of leadership and coordination from the 'top'. They suggest that further work is required in communicating the vision of Melbourne 2030, and that while this message may not necessarily emphasise health as an over-arching policy platform, that nonetheless embedding health outcomes in these messages may serve to clarify the vision for many stakeholders.

There may be a role for leadership or coordination in relation to the evidence base (as discussed in more detail below) required for Melbourne 2030. In a local government planning environment experiencing significant churn of planning professionals due to work pressures, the planning system is currently vulnerable to experiencing a loss of systematic accountability. Development of indicators and monitoring systems to track the implementation and impacts of Melbourne 2030 across the entire metropolitan area must take account of these organisation pressures impacting on the local collection of valid, reliable data. Indeed, data collection might need to be coordinated and led at the state level.

- **Commitment to innovation; an embrace of democratic community participation;**

Whilst community participation and civil society appear to be policy platforms as understood by stakeholders, participants saw the lack of guidance in relation to implementing the policy as a barrier to accessing the policy for many stakeholders. It was suggested that processes for implementing the policy, and evaluating these interventions was required. Taking the issue of transport for example, stakeholder interests are often in conflict in relation to public transport providers and Vicroads. Yet the policy does not appear to provide processes for breaking through these nexus points towards a solution that is aligned with policy objectives, that is, a more walkable and environmentally sustainable city with fewer cars. Preliminary findings seem to suggest that innovation in conflict resolution and maximising collaboration to enable win-win situations are required.

The use of Health Impact Assessment (HIA) may be an important innovation for moving forward on critical implementation projects. HIA provides a practical tool for considering the health and social impacts of planning proposals (Mahoney & Potter, 2005). It provides a systematic means of including evidence about potential impacts of the policy, strategy or project during the decision making process, therefore providing an opportunity to achieve the ‘best scenario’ outcome across competing interests. The Greater Christchurch Urban Development Strategy in New Zealand is currently performing HIA on the development of its urban planning framework (GCUDS, 2005).

- **A resultant healthy public policy that addresses health inequalities**

Although still preliminary, findings suggest action on developing performance indicators that can be utilised in the measurement of implementation strategies and programs to address health inequalities. For this, tools are required to enable data to be collected easily that has obvious policy relevance and commitment by decision makers for its application (Innes & Booher, 1999).

MONITORING AND EVALUATION: BUILDING THE EVIDENCE BASE

Given the complexity of the implementation of Melbourne 2030 and its health, social and environmental impacts a range of measures need to be developed to map progress towards and attainment of the nine directions of Melbourne 2030. Many of these directions could best be monitored through processes measures that map progress towards intersectoral collaboration, such as the five-level framework for mapping community capacity developed by Kegler, Norton and Aronson (2003) as part of their evaluation of Californian Healthy Cities and Communities initiatives. Their framework is presented in Figure 1 below.



Figure 1 Community capacity framework (Keler, Norton & Aronson, 2003, p. 3)

Such a monitoring and evaluation approach could also be used to map progress towards addressing the upstream social determinants of health, which include addressing the need to prevent long-term disadvantage; the effects of the social and psychological environments; the importance of a good childhood environment; the impact of work on health; problems of unemployment and job insecurity; the role of friendship and social cohesion; the dangers of social exclusion; the effects of alcohol and other drugs; the need to ensure access to healthy food; and the need for healthier transport systems (Wilkinson & Marmot, 2003).

We note from our interviews that Melbourne 2030's nine broad directions still do not appear to have measures developed, or key responsibilities identified for their collection. Indeed, in the spirit of intersectoral collaboration, workable partnerships between health and urban planners at the state, local and private sectors to ensure the adequate collection, interpretation, dissemination and utilisation of process and outcome measures. It is worth noting, however, that substantive initiatives are underway to develop a range of indicators across levels of government, including the discrete and combined efforts of the Department of Victorian Communities, Department of Human Services, the Victorian Health Promotion Foundation, universities, some community health centres, and many local governments. Also note by research participants are the efforts of the Department of Victorian Communities to broker an entirely new way of working across government (DVC, 2005). However informants were unsure as to how this process was progressing.

In relation to Melbourne 2030, however, it was suggested during interviews that the State Government needs to identify and resource indicators for use in Melbourne 2030 in a way that can be sustained over five-yearly reviews during the next 25 years. Attributions of causality would also need to be carefully considered, for example as to whether changes in local measures of indicators could be attributed to a local planning scheme or to Melbourne 2030 in general – or, of course, a combination of these levels of policy. Reporting requirements and incentives would need to be established to ensure adequate return of usable data.

Opportunities also exist in this policy environment to integrate indicators developed by WHO for use in Healthy Cities monitoring and evaluation (see de Leeuw, 2001; Doyle et al, 1999). The comprehensive list of indicators did include measures of the built environment; many of these indicators were collected by urban planners (Barton & Tsourou, 2000). Not all social determinants of health were covered; indeed, most indicators were germane mostly to physical health. The research team also encountered significant challenges in accessing usable data. Doyle et al (1999) concluded that “barriers to uniformity of reporting at the city level are as formidable as at the

national level” (p. 298). Nevertheless, this experience points to the concerted international effort to investigate and document the health impacts of urban planning. Combined with efforts to map intersectoral efforts designed to enhance community capacity (Kegler et al, 2003), Melbourne 2030 implementation managers could be linking their work with international best practice.

CONCLUDING REMARKS

Our study data, although preliminary, has nevertheless identified some key issues and concerns from across the health, urban planning and other sectors. At the very least, it would appear that the Department of Sustainability and Environment needs to take a lead role to ensure that Melbourne 2030 is well understood and embraced by practitioners, policy makers and stakeholders in the public and private sectors. Furthermore, efforts need to be made swiftly to link quickly the indicator work being developed across Victoria to the implementation efforts at state and local government levels. Finally, combined with innovative participatory processes such as HIA, the implementation of Melbourne 2030 could not only become a tool to build community capacity, but also generate sustainable planning outcomes that will foster health, wellbeing and quality of life up to 2030 and beyond.

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