ResearchOnline@ND

The University of Notre Dame Australia
ResearchOnline@ND

Medical Papers and Journal Articles

School of Medicine

2020

The power of collaborative planning: How a health and planning collaboration facilitated integration of health goals in the 30-Year Plan for Greater Adelaide

Michael McGreevy

Patrick Harris

Toni Delaney-Crowe

Matt Fisher

Peter Sainsbury
The University of Notre Dame Australia, peter.sainsbury@nd.edu.au

See next page for additional authors

Follow this and additional works at: https://researchonline.nd.edu.au/med_article

Part of the Medicine and Health Sciences Commons

This article was originally published as:
McGreevy, M., Harris, P., Delaney-Crowe, T., Fisher, M., Sainsbury, P., & Baum, F. (2020). The power of collaborative planning: How a health and planning collaboration facilitated integration of health goals in the 30-Year Plan for Greater Adelaide. *Urban Policy and Research, Early View, Online First*.

Original article available here:
https://doi.org/10.1080/08111146.2020.1776693

This article is posted on ResearchOnline@ND at
https://researchonline.nd.edu.au/med_article/1170. For more information, please contact researchonline@nd.edu.au.

Authors

Michael McGreevy, Patrick Harris, Toni Delaney-Crowe, Matt Fisher, Peter Sainsbury, and Fran Baum

This article is available at ResearchOnline@ND: https://researchonline.nd.edu.au/med_article/1170

This is an Author's Original Manuscript of an article published by Taylor & Francis Group in *Urban Policy and Research* on 22 June 2020**,** available online**:** https://doi.org/10.1080/08111146.2020.1776693

McGreevy, M., Harris, P., Delaney-Crowe, T., Fisher, M., Sainsbury, P., and Baum, F. (2020). The power of collaborative planning: How a health and planning collaboration facilitated integration of health goals in the 30-Year Plan for Greater Adelaide. *Urban Policy and Research,* https://doi.org/10.1080/08111146.2020.1776693

The power of collaborative planning: How a health and planning collaboration facilitated integration of health goals in the 30 Year Plan for Greater Adelaide (7976 words).

Introduction

This article provides an analysis of a collaborative spatial planning initiative that is viewed as a success by participants involved from both urban planning and health sectors. The notion that planning policy development processes benefit from multi-sectoral collaboration is routinely advanced in planning theory (Albrechts, 2016, Jessop, 1998, Nadin, 2007, Sørensen, 2013, Sehested, 2009). However, in planning practice collaborative processes are often characterised by power imbalances, conflict, tensions, and uncertainties. Therefore, successful collaborations are rare and non-market actors, particularly those from social sectors, are often sidelined (Sørensen, 2013, Potts et al., 2014, Innes and Booher, 1999, Friedmann, 2008). As such, the context and aspects of the process which led to this successful collaboration are worthy of analysis to inform both planning theory and practice.

In 2017 the State Government of South Australia released a comprehensive regional plan for metropolitan Adelaide, the capital and largest city in the state, entitled The Thirty Year Plan for Greater Adelaide (TYPGA). The 2017 edition was an updated version of a plan with the same title released in 2010.

Comprehensive regional plans such as the TYPGA are the highest level coordinating documents in comprehensive spatial planning systems. They attempt to coordinate the medium to long-term development of city regions. The intent of such plans is to steer spatial integration and coordination of the various aspects and actors involved in urban development and spatial change towards desired macro level goals (Albrechts, 2016, Healey, 2006, Hillier, 2008). In Australia, there has been a long history of relatively strong state government intervention to guide the development of metropolitan areas (Searle and Bunker,

25 2010). Therefore, the development of comprehensive spatial plans provides an important
26 platform from which non-planning sectors such as health can influence urban development in
27 order to advance their sector's interests.

28 The TYPGA was one of 108 urban planning related documents from all Australian state,
29 territory and federal jurisdictions analysed as part of an Australian Research Council (ARC)
30 funded project investigating the extent to which non health sector policies of Australian
31 governments take note of and are likely to lead to action addressing the social determinants of
32 health and health equity. These determinants are referred to as 'social' because their origins
33 lie not in biological factors but in factors that owe their existence, and importantly their
34 distribution within and between populations, to the decisions and actions that societies make
35 collectively; that is, they are societally created influences on health (for instance, levels of
36 income, housing conditions and access to education). Consequently, consideration of the
37 social determinants of health expands the search for the causes of health and illness beyond
38 purely 'downstream' personal influences (and associated pejorative 'blame the victim'
39 lifestyle theories) to 'upstream' factors, for instance conditions in the local environment and,
40 even further upstream, issues associated with culture, public policy and the dominant political
41 economic model. This has led to the development of theories focused on the social
42 production of disease and the political economy of health. Such approaches emphasise power
43 relations, societal decision-making (who determines the agenda and who decides?), human
44 rights, and social justice (who wins and who loses?). In the last 25 years, ecosocial theories
45 have sought to integrate biological, social and ecological factors into more complex,
46 dynamic, multi-level models of the generation of health and illness in individuals and
47 populations (Krieger, 2001).

48 The social determinants of health have been increasingly acknowledged as crucial to creating
49 healthy populations particularly since the work of the WHO's Commission on the Social

50 Determinants of Health and health equity (CSDH, 2008). This Commission conceptualised
51 the social determinants as the conditions of everyday life (including the quality of urban
52 environments) and the ways in which the distribution of power and resources in society shape
53 the distribution and nature of these conditions. Estimates are that the contribution of sectors
54 outside health to population health outcomes outstrips the contribution from the health sector
55 (McGinnis et al, 2002, Canadian Institute of Advanced Research, 2012, Kings Fund, 2020).
56 Consequently, there have been many efforts to encourage other sectors to take health into
57 account in their policies, plans and actions. A promising approach is the Health in All
58 Policies approach (WHO, 2013, Leppo et al., 2013). This approach has provided the
59 framework for cross sectoral work (including between health and planning) in South
60 Australia which has been shown to be promising in terms of improving population health
61 (Baum et al, 2017, Baum et al. 2019). Baum (2019a) argues that taking action to improve
62 population health requires a whole-of-system approach to governing for health and that
63 encouraging urban planners to create healthy urban infrastructure is a vital part of this
64 endeavour. Hence, the TYPGA is one potential means of taking action on the social
65 determinants of health.

66 The TYPGA includes three macro level goals:

67 • *Maintain and Improve Liveability*
68 • *Increase Competitiveness*
69 • *Drive Sustainability and Resilience to Climate Change* (DPTI 2017, 11).

70 Under these goals are six targets, all of which if realised would positively affect population
71 health.

72 **[Table 1 here]**

73 The plan is organised into 14 policy themes, one of which is *Health, Wellbeing and Inclusion*.
74 The effects that many of the other policy themes have on health is recognised and linked to
75 their contribution to macro goals particularly liveability and to their contribution to one or
76 more targets.

77 Based upon its goals, targets, and incorporation of multiple social determinants of health
78 within themes, the research team determined that the TYPGA was one of the best and most
79 comprehensive documents coded and analysed in a broader research project when it came to
80 advancing social determinants of health and health equity. As a result, stakeholders involved
81 in the formulation of both the 2010 and 2017 editions were interviewed in order to ascertain
82 the deliberations, processes and formulations that helped produce this outcome.

83 The interviews revealed that despite initial conflict, collaborators from all sectors were
84 pleased with both the outcome of the collaboration and the processes that formulated the plan
85 from the perspective of a participant. This is notable because literature in the area of
86 collaborative planning suggests that coalitions formed to advance collaboration are highly
87 effective when certain conditions are met but often break down or lose members along the
88 way because of intractable conflict within the process (Booher and Innes, 2002, Newman,
89 2008).

90 The goal of this article is an examination of the collaborative processes that developed the
91 TYPGA and the policies articulated within it from the vantage of urban planners organising
92 processes and non-urban planners attempting to influence the directions of the plan, in this
93 case engaged actors from the public health sector. The first section of the article provides an
94 overview of theories and previous research into collaboration processes with particular
95 reference to those that proved influential in the formulation of the TYPGA. The second
96 section provides details of the broader research project that this research was part of, and

97 elaborates the methods used to gather the data that informed the research. The third section
98 uses findings from the data to ascertain the contexts and circumstances that enabled health
99 advocates involved in the collaboration process to advocate successfully for the inclusion of
100 objectives related to the social determinants of health in the TYPGA. Selected quotes from
101 the interviews are used to highlight common themes from the interview data. The findings are
102 then analysed in light of pertinent planning and governance theories in order to explain the
103 circumstances, processes and interventions that helped bring about a successful outcome for
104 health advocates.

105 An overview of spatial planning theories and theories of collaboration

106 Comprehensive city based regional plans such as *The Thirty Year Plan for Greater Adelaide*
107 are commonly used in strategic spatial planning systems that are under the hegemony of neo-
108 liberalism to steer spatial integration and coordination of the various aspects and actors
109 involved in urban development and spatial change towards desired macro level goals
110 (Albrechts, 2016, Healey, 2006, Hillier, 2008). As such, they typically include one or more
111 overarching macro level normative social, environmental and/or economic goals as well as
112 objectives and projects that advance them (Hillier, 2008, Nadin, 2007). However, while plans
113 typically include goals such as liveable, vibrant, smart, competitive and sustainable that can
114 be made to fit within a neo-liberal paradigm, they rarely include goals such as equity and
115 social justice that cannot (Fainstein, 2014, Olesen, 2013).

116 Strategic spatial planning systems differ from previous modernist and post-modernist
117 approaches to metropolitan planning. They focus on spatial relationships and integration
118 rather than modernist planning's emphasis upon land uses, zoning, buffering and separation,
119 and look to planning as a means of guiding trajectories and realising goals and objectives
120 rather than designing for specific outcomes. They are also pluralist in outlook, and, therefore,

121 refer to acceptable expertise, research and evidence as mechanisms for directing policy
122 (Allmendinger and Haughton, 2010, Friedmann, 2008). In doing so they attempt to move
123 beyond the limitations of postmodern-inspired project-based collaborative planning or laissez
124 faire market determinism which, due to the absence of normative goals, often favour path
125 dependency and market power that is often invested in maintaining the status quo (Albrechts,
126 2016, Nadin, 2007, Allmendinger, 2002, Sager, 2009). Strategic spatial planning sees inter-
127 sectoral collaboration as central to effective urban planning (Sørensen, 2013). However,
128 unlike other notions of communicative, advocative or collaborative planning, the process is
129 not viewed as an end unto itself (Allmendinger, 2002, Sager, 2009). Instead, collaboration is
130 viewed as the most effective means of realising normative goals by coordinating and
131 integrating the complex political, cultural, economic, environmental and social agendas of
132 multiple autonomous agents from diverse sectors. These usually include sectors with
133 particular interests in the intersection of the built form with transport, hard and soft
134 infrastructure, society, the environment, and politics (Jessop, 1998, Sehested, 2009, Sørensen,
135 2013).

136 To this end, strategic spatial planning favours collaborative processes over linear draft,
137 consult and adapt approaches because of their ability to produce more holistic policy
138 outcomes and successfully coordinate the multiple actors operating within urban development
139 in pursuit of normative goals (Albrechts, 2016, Jessop, 1998, Sørensen, 2013). Collaborative
140 planning processes also align with theories of joined up governance or coalition governance
141 from public administration theory (Ferlie et al., 2011, Reff Pedersen et al., 2010, Jessop,
142 1998). Joined up governance advocates the overcoming of traditional compartmentalised
143 bureaucratic relationships competing for power and funding in favour of cooperation to tackle
144 holistically broad issues that traverse multiple sectors (Albrechts, 2016, Ferlie et al., 2011). It
145 encourages horizontal integration across traditionally vertical siloed professions, disciplines,

146 and administrations to produce holistic development and evaluation of programs, projects and
147 policies (Nadin, 2007, Ferlie et al., 2011). It looks to inter-sectoral collaboration as a means
148 of advancing better social cohesion, accessibility, economic competitiveness, and the
149 efficient expenditure of public funds, by preventing duplication, and fragmented and
150 contradictory activities, and encouraging partnerships, sharing, and synergies (Albrechts,
151 2016, Ferlie et al., 2011).

152 Ferlie et al. (2011) and Jessop (1998) argue that successful collaboration processes and
153 outcomes are best achieved via heterarchical governance networks. Within such networks
154 coordination is built upon formal and informal connections via relationships developed over
155 time linked by a combination of values (world views) and tasks (Sørensen, 2013).
156 Collaboration in these networks requires participants to use open dialogue as a means of
157 building consensus. Successful dialogue that leads to consensus requires a willingness to
158 learn, a willingness to question assumptions, an acceptance of difference and a willingness to
159 be persuaded by evidence (Ferlie et al., 2011, Booher and Innes, 2002). Heterachical
160 networks draw upon formal and informal relationships between agents to encourage flows of
161 ideas, values, interests and knowledge from diverse sources at multiple levels (Booher and
162 Innes, 2002, Sørensen, 2013).

163 Comprehensive regional plans such as the TYPGA are ultimately political documents in that
164 the ideological leanings of governments and agents with invested institutional and economic
165 power determine collaborators, macro level goals and subsequently degrees of
166 implementation commitment to objectives developed via collaborative processes
167 (Mossberger, 2009, Davies, 2005, Davies et al., 2018). Amongst those invited to collaborate
168 there are imbalances of power and influence and therefore it is not always the best evidence
169 or argument that necessarily holds sway (Mossberger, 2009, Sager, 2009). In particular,
170 under neo-liberal hegemony it is often the actors with the ability to advance economic goals

171 that have a far greater say than those looking for social or environmental results (Albrechts,
172 2015, Olsson, 2009, Reff Pedersen et al., 2010).

173 Therefore, for social and environmental advocates, participation in collaboration under the
174 hegemony of neo-liberalism requires submission to the primacy of global economic
175 competitiveness (Albrechts, 2016, Davies et al., 2018, Olesen, 2013). This inevitably restricts
176 the scope of interventions and the ability of collaborators to advance positions or submit
177 evidence which challenge the neo-liberal consensus (Allmendinger and Haughton, 2010,
178 Albrechts, 2015, Davies et al., 2018, Olesen, 2013, Smith and Katikireddi, 2013). Thus for
179 social, environmental or health advocates success is often not found by making claims in
180 their own right but instead by advancing them as contributors to global economic
181 competitiveness (Albrechts, 2015).

182 Nevertheless, even under hegemonic neo-liberalism strategic spatial planning can provide
183 arenas to advance normative social democratic and environmental goals given the right
184 political circumstances (Albrechts, 2015, Hillier, 2017, Reff Pedersen et al., 2010). The
185 remainder of this paper examines the extent to which the South Australian TYPGA was
186 successfully able to use collaborative planning process to encompass health and well-being
187 related objectives.

188 Method

189 *Document analysis*

190 The research used in this article was produced during a wider Australian Research Council
191 project to better understand how whole-of-government action can be progressed to promote
192 health while still addressing other sector-specific goals. Extensive details of the methods,
193 investigations, and ethics approvals used for this research are provided in the published
194 protocol paper for the broader research project (Author et al., 2018).

195 Following an analysis of the 108 urban planning related documents, the research team
196 identified the TYPGA as an example of good practice in urban planning policy addressing the
197 social determinants of health. Consequently, the process by which the document was
198 developed was chosen for further analysis as a potential guide for policy development in
199 other jurisdictions in Australia and internationally. This further analysis involved the
200 gathering and subsequent analysis of qualitative data gathered from interviews with 11 actors
201 directly involved in the processes which formulated the 2010 edition of the TYPGA and/or
202 the 2017 edition (Table 2).

203 [table 2 here]

204 **Findings**

205 ***The context***

206 We identified eight inter-locking processes that contributed to the relative success of the
207 collaboration in the development of the TYPGA: clarity of government roles, clear
208 governance networks, relationship building, the plan's shared goals, developing shared
209 knowledge, making compromises, weak interpersonal ties contributing to enduring
210 relationships, and the benefits of extended heterarchical networks. We discuss each of these
211 in turn.

212 ***The role of the State Government***

213 Newman (2008) argues that producing effective horizontal integration between actors
214 involved in urban planning is often problematic. A particular problem is that few
215 governments have the jurisdictional power and broad responsibility across city regions to
216 enforce the long term relationship building, dialogue, and interaction required for
217 collaboration and consensus building (Olsson, 2009, Allmendinger and Haughton, 2010,

218 Mossberger, 2009, Savitch and Vogel, 2009). Without the overarching organisation of an
219 empowered government, important agents involved in urban development may refuse to
220 participate fully and/or resist directions not perceived to be in their immediate interest
221 (Newman, 2008, Innes and Booher, 1999). In these circumstances the mediating and
222 consensus enabling role of urban planners to negate power and facilitate dialogue is unlikely
223 to be possible and market or institutional power prevails (Mossberger, 2009, Sager, 2009).

224 Against this theorising, the strength of the state government of South Australia was a major
225 factor in producing effective collaboration. Under the Australian Constitution, the state
226 government has principal responsibility for departments that directly affect urban
227 development such as urban planning, transport and infrastructure, as well as departments that
228 both affect and are affected by urban development such as education, health, justice, public
229 safety, housing, the environment, sport and recreation (Searle and Bunker, 2016).

230 In addition, the greater Adelaide region is the principal urban policy focus of the state
231 government and its constitutional and budgetary powers because, despite covering less than
232 1% of the state's territory, it contains over 80% of the state's population and economic
233 activity. Therefore, there is scope for the state government to facilitate and benefit from inter-
234 sectoral collaboration via joined up governance.

235 ***Establishing a governance framework***

236 In South Australia, the starting point for inter-sectoral collaboration came via the release of
237 the South Australian Strategic Plan (SASP) in 2004. The SASP was an initiative of a newly
238 elected state Labor government. It contained cross-sectoral goals and targets related to health,
239 environment, education, community, economics, and innovation, to which all departments
240 regardless of their specific jurisdictions needed to respond (Delany et al., 2014).

241 This SASP and other initiatives to advance joined up governance were seen as central to
242 launching inter-sectoral dialogue and collaboration, and subsequently bringing health into the
243 urban planning space. One respondent explained:

244 *I think that the overarching strategic settings initiating with SASP (South Australian*
245 *Strategic Plan 2004) were clearly recognising the – what is the word I am looking*
246 *for? The inter-relatedness of the drivers of the triple bottom line. So, you have got*
247 *that, kind of, overarching strategic framework that supported it to begin with. And*
248 *then, you have got [then State Premier] Jay's agenda which was elaborating and*
249 *playing to different elements of that, with the Premier's seven priorities. So, you had a*
250 *consistent narrative over nearly 15 years* (Public Servant, Health 5).

251 The SASP and subsequent long term initiatives to advance joined up governance and inter-
252 sectoral cooperation were crucial to the introduction of a *Health in All Policies* (HiAP)
253 approach in South Australia. This proved influential in the collaborative development of the
254 TYPGA. HiAP is not a theory of collaboration per se but rather an approach to stimulate
255 intersectoral collaboration to improve population health, wellbeing and equity while also
256 addressing the goals of other sectors (Exworthy and Hunter, 2011).

257 In line with notions of joined up governance, HiAP encourages public servants working in
258 the health sector to look for opportunities to be involved in policy development outside of its
259 core business (Lawless et al., 2012). It encourages health advocates to collaborate directly as
260 'norm entrepreneurs' in policy conception, development and implementation in sectors with
261 direct influence on the multiple social determinants of health and health equity.

262 The inter-sectoral acceptance of HiAP in the South Australian government gave the Health
263 Department a mandate to initiate collaboration in policy formulation beyond its core business
264 and made other departments more receptive to such collaboration (Delany et al., 2014). This

265 mandate was reinforced by the state government's *Thinker in Residence* initiative which
266 brought influential thinkers from overseas to South Australia to discuss and advocate for
267 innovative ideas. Several of the Thinkers in Residence addressed links between wellbeing
268 and planning directly (Baum et al., 2015). Based on the recommendations of one Thinker in
269 Residence, HiAP was formally introduced in South Australia in 2007 in the form of a
270 dedicated HiAP Unit funded by the Health Promotion Branch of SA Health. Via this unit, the
271 Health Department was able to collaborate on projects and policy development with multiple
272 departments, including two early projects that involved the Planning Department (Delany et
273 al., 2014).

274 Another related initiative commenced around the same time and coincided with development
275 of the first TYPGA in 2009-10. This collaboration called 'Health in Planning' involved the
276 Health Department funding two part time positions within the Planning Department to be
277 directly involved in the development of the TYPGA. Interviewees also noted that the health
278 focused collaboration that occurred as part of the HiAP initiative linked other agents into the
279 policy development process through the Healthy Living Coalition; a network that regularly
280 collaborated on projects and included the following government agencies and non-
281 government organisations:

282 Heart Foundation (SA Division)
283 Department for Health and Ageing
284 Department of Planning, Transport and Infrastructure (walking and cycling)
285 Renewal SA (state government agency)
286 Planning Institute of Australia, SA Division
287 Office of Recreation and Sport (state government agency)
288 Local Government Recreation Forum

289 A public servant from Health attributed some of the successes of TYPGA to the broad base of
290 the advocacy coalition.

291 *How did it come about? Because, we had multi-faceted governance with a multi D*
292 *(disciplinary) team with social planning strengths. Social planning and equity and*
293 *human rights strengths, so we brought health and we brought planning together. We*
294 *just went from there. (Public Servant, Health 5).*

295 The government's early efforts to advance joined up government facilitated multidisciplinary
296 involvement, and over time and multiple projects developed a coalition able to broaden the
297 issues canvased in the task of planning policy development.

298 ***Relationship building***

299 In line with theories of both joined up governance and strategic spatial planning, the original
300 2010 TYPGA was prepared via a governance coalition organised and facilitated by the state
301 government's urban planning agency (Ferlie et al., 2011, Reff Pedersen et al., 2010, Jessop,
302 1998). The formulation process for the first edition, but not the 2017 update, was undertaken
303 in conjunction with private consultants. Interviewees identified a number of collaborators on
304 the project: government departments and health, planning and transport agencies; business
305 representative groups such as the Urban Development Institute of Australia (UDIA), the
306 Housing Industry Association (HIA), and the Business Council of Australia (BCA); local
307 governments; and a range of non-government organisations.

308 Successful collaborative governance networks require consistent interaction, dialogue, open
309 flows of information, research support, a desire for success, acceptance of alternatives, and a
310 commitment to outcomes produced in collaboration (Olsson, 2009, Jessop, 1998, Talvitie,
311 2009). In particular, they benefit from agents collaborating routinely over long periods on
312 multiple shared tasks. This produces dense networks of informal and formal relationships that

313 facilitate the trust, reciprocity, knowledge sharing and open dialogue required for consensus
314 building (Booher and Innes, 2002, Davies, 2005, Newman, 2008).

315 A common theme amongst participants interviewed was the importance of developing
316 relationships and undertaking dialogue in good faith between departments and staff over time
317 and multiple projects. For example:

318 *This one was more about trying to say, "Let's get the settings right" and then people*
319 *can hopefully go on and design around that. Since then been involved in interagency*
320 *reference groups and things like that for planning as well. […] I think also from an*
321 *educative perspective as well you have planners talking to health folk and health folk*
322 *talking to planners on an ongoing basis and so we all started to come round to some*
323 *of the issues and say, "Well it's not health impact assessment, it's ongoing*
324 *relationships and negotiations." A very, very long game. (Senior Public Servant,*
325 *Health 1)*

326 While senior management of both the health and planning departments were enthusiastic
327 about HiAP-styled collaboration between health and planning, the perceptions of the
328 seconded health officers early in the process was that the planning staff charged with
329 initiating the TYPGA were less than enthusiastic:

330 *…when I started working within the department, when I started saying to people - My*
331 *job was there to be an influencer, and when I started to say to people, "I am here to*
332 *talk about health," the reaction from people who were well into their planning*
333 *careers was, "We don't do health. We are not about health," so there was a real*
334 *rejection of that agenda* (Public Servant, Health 3).

335 The reluctance of the planning officers to collaborate was also observed by a senior manager
336 in the Planning Department.

337 *I remember very early in the piece, the three or - I think there were only three or four*
338 *people working on the plan internally. And I remember we'd had a meeting with the*
339 *planning team. […]And our guys (government urban planning staff) had run down the*
340 *process and run down the chance of getting an actual plan, et cetera* (Senior Public
341 Servant, Planning 1).

342 Planning staff initially seemed unaware of and/or resistant to the central role planning theory
343 gives to multisector collaboration in the formulation of these plans (Sørensen, 2013). At first
344 they did not appear to see the virtues of expanding the knowledge base and collective
345 intelligence attached to the process. Potts et al. (2014) and Albrechts (2006) argue that this is
346 relatively common; many bureaucrats who have existed in silos for their careers often find
347 collaborative processes, where outsiders challenge their expertise, knowledge and
348 assumptions, threatening. In addition, participants in newly formed heterarchical networks
349 are likely to be used to positional bargaining rather than consensus building via dialogue.
350 Therefore, 'shadow' hierarchical structures headed by empowered facilitators such as senior
351 managers or politicians are often required to enforce inter-sectoral collaboration, dialogue
352 and consensus building in its early stages (Kjaer, 2009, Davies, 2005).

353 In the case of the TYPGA, the shadow hierarchy of management intervened to enforce
354 heterarchical governance and directed hesitant planning staff to make collaboration work:

355 *And it was very early in my role, and I just took them into another room and said,*
356 *'Not on my watch, guys. This is not going to happen. You are never to do that again.*
357 *We are actually going to get this thing up. We're going to work with these people […]*
358 *we're going to make this work. And you're going to have to find a way to make it*

359 *work, and you never run (the collaborative process and the new plan) down again.'*
360 (Senior Public Servant, Planning 1)

361 However, the public health officers were also unused to collaboration. Prior to the
362 introduction of HiAP, public health staff had become accustomed to 'draft and respond'
363 consultation processes. This type of process is common in Australian jurisdictions (Harris et
364 al., 2014). Consequently, Health's responses, via health impact and risk assessments within
365 Environmental Impact Assessment processes, could be unhelpful. A senior health public
366 servant from the Health Department described the process of previous EIA processes as:

367 *The health impact assessment stuff, as you're probably aware, tends to be you're*
368 *brought in at the very last minute when pretty much everything's decided and if you*
369 *say something nasty then everyone hates you [...] our mindset was very focused on,*
370 *"These are all the problems" and then we'd hand it back, "There you go, take care of*
371 *that will you" and some of them were insurmountable* (Senior Public Servant, Health
372 1).

373 The respondents quoted above were articulating a need for both planning and health staff to
374 significantly alter their previous approaches to collaboration for dialogue and collaboration to
375 succeed.

376 ***The goals of the plan***

377 From the start, there were two non-negotiable elements in the TYPGA for the state
378 government. First, the plan was a growth management strategy, and continued population and
379 economic growth were desired ends needing to be facilitated by it. Second, the plan was
380 required to work towards the three potentially conflicting normative goals of liveability,
381 competitiveness and sustainability. From a spatial perspective, sustainability and liveability in

382 the TYPGA are seen as being best advanced via ‘smart growth’ principles of transport and
383 land use integration, mixed use medium density neighbourhoods, and housing diversity as a
384 means of reining in urban sprawl. These goals needed to be acquiesced to as a condition of
385 entry into collaboration (Albrechts, 2015, Reff Pedersen et al., 2010).

386 ***Shared knowledge***

387 Newman (2008) argues that the forces acting in favour of open ended collaboration are often
388 much weaker than those against. Networks can suffer corporate memory loss because of
389 organisational instability, high turnover of staff, a lack of commitment by some participants,
390 and a revolving door of leadership (Mossberger, 2009). Consensus is particularly difficult
391 when participants are from different backgrounds and knowledge disciplines and have
392 different foci and experiences (Friedmann, 2008).

393 Between the health policy staff and planning staff there were different knowledge references
394 and assumptions. For example when it came to infill:

395 *Their (planning staff's) imperatives were to try and contain that [urban sprawl] in an*
396 *infill development type thing and I must admit even when we went into it, and there*
397 *were a few of us from health involved, we had that mindset of a tower block thing*
398 *almost, and all the social problems that come from that* (Senior Public Servant,
399 Health 1).

400 In addition, the DPTI's preferences for targeting new housing as infill along transit corridors
401 and around activity centres meant more people would be living in areas with higher than
402 average concentrations of air and noise pollution. This was viewed as a major problem by
403 health participants. Previous experience with Environmental Impact Assessment had attuned
404 health staff to making risk assessments to avoid potential hazards such as air and noise
405 pollution. However, such perspectives tend to favour traditional forms of land use planning

406 via separation, zoning and buffering rather than smart growth principles such as integration,
407 intensification, and the mixing of diverse uses (Newman and Kenworthy, 2015).

408 A senior public servant from DPTI observed:

> 409 *…when you write from a health impact assessment basis, you start with the*
> 410 *assumption that you've got a negative, and you have to mitigate the negative. And so*
> 411 *that everything about it is naturally negative. Whereas the planners were coming from*
> 412 *this assumption that building a TOD [Transport Oriented Development] was about*
> 413 *actually having a positive. So they literally were not speaking the same language*
> 414 (Senior Public Servant, Planning 1).

415 Consequently, the collaboration between health staff and planning staff began with some
416 tension:

> 417 *the collaboration between the town planners, health in all policy town planners, and*
> 418 *the health public policy people […] became completely intractable* (Senior Public
> 419 Servant, Planning 1).

> 420 *I think the experience was a little bit – not bruising, bruising's probably going a bit*
> 421 *far, but there was a lot of areas where we hit the wall in terms of language and so on*
> 422 (Senior Public Servant, Health 1).

423 In a traditional draft and respond submission process, the protestations from the public health
424 staff would have come late in the process and would likely have been ignored because they
425 were at odds with a major goal of the government and its planning department (Davies, 2005,
426 Kjaer, 2009). However, as the health staff were collaborators and the development of the plan
427 was only in its early stages, the conflict led to a standoff but not abandonment or withdrawal.
428 Albrechts (2015) argues that while collaborative planning cannot in itself overcome conflict it

429 can provide the processes, opportunity for dialogue and institutions where the claims of
430 conflicting parties are recognised as legitimate by those in opposition to them.

431

432 ***Making compromises to overcome conflict and reach consensus***

433 Olsson (2009) argues that conflicts based upon indivisible differences of values or ideology
434 can only lead to a breakdown of the process altogether or the ejection of dissident parties
435 from collaboration who then go on to be opponents of the outcome. On the other hand,
436 conflicts regarding processes, language and assumptions can be resolved by dialogue,
437 persuasion, and evidence (Sørensen, 2013, Kjaer, 2009).

438 The collaboration process between health and planning staff started from a position of
439 conflict and inability to understand the position of the other. A senior public servant from
440 DPTI articulated the problem as being about clashing approaches, assumed priorities, and a
441 lack of a shared terminology rather than a clash of irreconcilable values.

442 *It was extraordinary to see how much two groups of people, both coming from*
443 *essentially the same value base, were reaching completely different conclusions based*
444 *on their assumptions about - and their methodology about how they approached it*
445 (Senior Public Servant, Planning 1).

446 According to this interviewee, while the agents had the same task and similar values, there
447 was an absence of shared understandings, objectives and language. Kjaer (2009), and
448 Sørensen (2013) argue shared values are essential for effective collaboration because they can
449 help facilitate compromise and consensus through dialogue.

450 In addition, the direction from the ministerial level and management in the health department
451 was not to oppose but rather to be 'helpful'. Being helpful in this case meant not opposing
452 development goals but contributing to predetermined options in a positive way.

453 *...I think one of [my manager's] lines is, "Be helpful" which sounds highly wise and*
454 *fairly obvious, but again it was one of those things coming from a mindset, and I*
455 *totally believe in health impact assessment, don't get me wrong, but I just think the*
456 *way we were practising it was wrong* (Senior Public Servant, Health 1).

457 Conflict is often the result of action within a policy and knowledge silo producing
458 incompatible positions. Questioning assumptions based upon this knowledge can push
459 participants down paths they had not considered or were outside their normal terms of
460 reference (Ferlie et al., 2011, Sørensen, 2013). In this context, conflict can be good for the
461 collaborative process as it raises issues, initiates a search for evidence, provides a sounder
462 base for justification, and broadens the scope of policy (Sørensen, 2013).

463 Health staff proved willing to question their assumptions and change to operate successfully
464 within the governance structure and 'ride the wave' set by the planning goals. In particular,
465 they moved from a focus on risk assessment and hazard avoidance to policies that indirectly
466 advance the social determinants of health. This change came via dialogue in search of
467 consensus and the sharing of knowledge within the collaboration network.

468 *So again that was more a relationship or an engagement type thing that was fairly*
469 *difficult at the start, but I think we all started to come round a little bit and appreciate*
470 *what's going on. Because a lot of the same players are still involved in some of those*
471 *sorts of things we I think well me personally anyway, in understanding what planning*
472 *is trying to do and how difficult it actually is, particularly when you are looking to*

473 *change a mindset or a paradigm of how development is meant to be* (Senior Public
474 Servant, Health 1).

475 In addition, health officials found information sharing to advance their objectives with
476 planning staff useful.

477 *I think if you are looking to change or influence policy, coming in with a set of values*
478 *is one thing, but being able to come in armed with some clear data that can show*
479 *outcomes, is really important. Particularly, people who work in technical areas, they*
480 *are much more persuaded by facts and figures […]at the time we were quoting an*
481 *American controlled trial which did show that a walkable neighbourhood versus a*
482 *non-walkable neighbourhood, similar cohort, showed reduced levels of obesity. I*
483 *think that has now been replicated with better data. That kind of, just, clear evidence,*
484 *and I think that – evidence carries a lot of weight* (Public Servant, Health 3).

485 Booher and Innes (2002) argue that consensus building is not just about finding shared goals
486 but also creating language, meaning, and a shared narrative. Reff Pedersen et al. (2010) argue
487 joint sense making is reliant upon shared language and the exchange and synthesis of
488 meaning. The interviewees identified a lack of shared meaning as initially presenting a
489 significant obstacle to effective dialogue. Therefore, a major part of consensus building was
490 formulating a shared narrative and finding shared language and meaning. The health staff
491 came up with the narrative of density done well and the goal of liveability:

492 *I certainly wouldn't call them the social determinants of health to anyone within*
493 *Planning. I would call them the elements of the built environment which support*
494 *health and wellbeing. When you are talking with planners, it is important to talk*
495 *about built form, so the form of the built environment […] What we ended up doing*
496 *was trying to find a phrase that meant roughly the same thing [health] but which was*

497 *more palatable and more acceptable in the planning profession. Liveability was*
498 *starting to be used a bit, so we jumped on that and used that* (Public Servant, Health
499 3).

500 Thus, the term liveability was chosen because it was a term with virtuous connotations in
501 both planning and health related literature and in both sectors referred to similar spatial
502 attributes such as walkability, diversity, connectedness, and inclusiveness. It was an
503 important breakthrough as it enabled both departments to articulate ideas, objectives and
504 strategies which advanced this shared gaol.

505 ***Weak ties, enduring relationships and normalised collaboration***

506 Collaboration networks are continually evolving, adding new connections, and maturing over
507 time (Sørensen, 2013). A common result of collaborative planning and the relationships
508 forged in the process are weak or bridging ties built upon reciprocity, reputation and trust that
509 can be subsequently called upon in multiple contexts and projects (Olsson, 2009, Booher and
510 Innes, 2002, Davies, 2005). Once established these relationship ties make dialogue and
511 consensus building routine. For example, a health public servant noted:

512 *I mean at this point in time, our DPTI colleagues say to us "the argument's been won,*
513 *we know the importance of health and well-being, you don't need to keep telling us*
514 *that anymore."* (Public Servant, Health 4).

515 The networks established in preparing the first plan and subsequent projects meant the
516 relationships were in place for the 2017 update. This allowed the collaboration to continue
517 despite the loss of funding for HiAP-related activities and seconded staff. A health public
518 servant explained their role in relation to the 2017 update:

519 *We commented on drafts, and worked closely with two or three colleagues,*
520 *particularly two colleagues in the Department of Planning, Transport and*
521 *Infrastructure on providing comments on particular sections. Got to read and review*
522 *the whole document multiple times. We would rewrite bits, sent it back, and there was*
523 *a bit of a toing and a froing that – So, yes, we were hands on, I think, quite - I mean,*
524 *(a health colleague) did a lot of writing, and I think because we had done the*
525 *planning* (Public Servant, Health 2).

526 A collaborator from the Active Living Coalition explained their role:

527 *…this new version came about and we were involved with the workshops in the lead*
528 *up to that. I was involved with an Open Space workshop, we had a Healthy*
529 *Neighbourhoods workshop* (Active Living Coalition 1).

530 The continued association also meant that health staff and the active living coalition were
531 more able to influence objectives in the 2017 update. In particular, they wanted a more direct
532 reference to health than was articulated in the 2010 edition:

533 *I think the earlier version (2010) of the 30-Year Plan, there had been some references*
534 *to health that were quite narrow, but I think the word 'health' had been in there, and*
535 *we really wanted to see the word 'health' back. But, of course, our Planning*
536 *colleagues wanted health to be very strongly connected to place, because they think*
537 *differently to us. We think about people, they think about spatial things. So, healthy*
538 *neighbourhoods just seemed to, kind of, resonate, and when they – I think they came*
539 *up with that, not us […] We wanted more than liveability. We wanted health in there,*
540 *and we kept saying that, really, there should be health […] That was a really big shift.*
541 *In the beginning it was all about liveability, and they really increased the health focus*
542 (Public Servant, Health 2).

543 This supports the notion that policy change in collaborative processes tends to advance
544 incrementally rather than via major breakthroughs (Katikireddi et al., 2013).

545 ***Expanded heterarchical networks and their wider benefits***

546 Urbanisation under the hegemony of neo-liberalism creates power predominantly via access
547 to investing capital. In particular, in the sphere of urban development neoliberalism
548 preferences stakeholders such as private property developers, financiers, chain retailers and
549 transport departments who have the financial resources and positional power to determine
550 whether a project or urban activity proceeds. As such they can be the most difficult to obtain
551 consensual agreements from because of the power they wield (Mossberger, 2009, Rydin,
552 2007).

553 Within government, transport departments can become particularly focused upon key
554 performance indicators such as reducing travel times and increasing passenger numbers,
555 which can interfere with liveability and the integration of land uses with public transport
556 (Mees, 2009). In the first edition of the TYPGA there was a sense amongst both planning and
557 health staff that transport planners were not as committed to the objectives of land use-
558 transport integration and the social aspects such as liveability and health and wellbeing as
559 other members of the coalition. A senior public servant from planning, who worked on the
560 first plan but not the update, found transport planners particularly difficult to deal with
561 because of their singular focus:

562 *Transport planners really do totally and only privilege transport corridors: cars and*
563 *trains and trams. And there's some appalling examples of that in Adelaide. They talk*
564 *about the health of the road network, not the health of the people [...]. I thought the*
565 *transport planners were actually going to break me* (Senior Public Servant, Planning)
566 1).

567 Therefore, for liveability and health to be advanced as a goal in collaborative determinations,
568 a check needed to be placed upon the power of the transport department officials. In
569 collaborative planning, one of the roles of government planners and shadow hierarchies is to
570 intervene and attempt to rebalance power within the coalition (Sørensen, 2013, Davies,
571 2005). In this case, control over both planning and transport gave the state government power
572 to place spatial planning and the planning department at the fore of urban development:

573 *When the former Premier created the Department for Planning, Transport and*
574 *Industry, he intentionally put - even though planning was the smallest bit being*
575 *amalgamated in, he put planning at the beginning of the name to try to send a signal*
576 *that planning rather than transport was important. But the money is what makes the*
577 *difference. Transport has all the money* (Senior Public Servant, Planning 1).

578 In this case, the support of the elected government was nominated as vital for elevating urban
579 planning and design over traditional transport department imperatives.

580 **Impacts of HiAP collaboration**

581 There were notable impacts from the HiAP collaboration that were identified by informants.
582 The priority of planning over transport was not noticeable in the first edition of the TYPGA.
583 However, five years later, the release of the state's transport plan signified the rebalancing of
584 power toward planning that included an identifiable shift to HiAP influenced priorities. In the
585 *Integrated Land Use and Transport Plan* (DPTI, 2015) there is an emphasis on the
586 importance of land use and transport integration and a major focus on liveability and
587 responding to the goals and objectives of the TYPGA:

588 *Well I think the development of that Integrated Transport and Land Use Plan and*
589 *that's a fairly – relatively recent development within DPTI but that certainly I think*

590 *has been a driver to connect people together and get them to focus on the people*
591 *rather than the bridge or the railway line or the whatever it is (Public Servant,*
592 *Transport 1).*

593 After the release of *Integrated Transport and Land Use Plan (2015)* and the 2017 update of
594 the TYPGA, a senior public servant from planning also observed a noticeable shift of
595 thinking within the transport agency:

596 *It's your public places, it's the work we're doing with our transport colleagues at the*
597 *moment around the tram extension and a very different dialogue with our colleagues*
598 *than we would have had two years ago, which would have been about, well how*
599 *quickly can we move people and how many bums can we get on seats? The actual*
600 *place making has actually almost outstripped the importance of the efficiency of the*
601 *network* (Senior Public Servant, Planning 2).

602 Furthermore, the impact of HiAP and the on-going collaboration of the health sector in the
603 planning space since 2010 on planning practice was referred to by a number of informants. In
604 particular, they mentioned that designing for health related liveability had been integral to the
605 master planning of a number of developments initiated post 2010. For instance, Public
606 Servant (Transport 1) noted:

607 *…some of the renewal SA work that's been happening…looking at designing Bowden*
608 *or Lightsview or whatever you know certainly all of those principles about healthy*
609 *living and connectedness and those sorts of things have been a component of that so I*
610 *think that's really influenced people's work in general.*

611 Finally, Olsson, (2009) argues coalitions, via weak ties and relationships at multiple levels,
612 can produce information networks, where participants become direct suppliers and

intermediaries of knowledge. The effects of dense multi-level networks drawing upon knowledge from a diversity of sources was evident in the preparation of the 2017 update. Prior to the 2017 update health staff had been collaborating with the Environment Department on another project, from which they gained knowledge they were able to transfer to the TYPGA update project:

> *…because we were doing this other work, the Healthy Parks Healthy People, around mental health and the literature was emerging that, basically, looking at a tree can drop your blood pressure. […] we want the planning system to understand the benefits are more than just cycling and walking, because they are a bit blasé about it* (Public Servant, Health 2).

Thus, the addition of an objective to increase the green canopy in metropolitan Adelaide by 25% in the 2017 update was a significant breakthrough for health collaboration (DPTI, 2017). This demonstrated a case of multi-sector collaboration producing information networks. In this case, one department became a supplier and intermediary of knowledge to another department, which led to a practical policy outcome in another.

The scope of this research was the how collaborative processes in the planning system can be used by no-planning sectors, in this case health, to advance their sectorial concerns. A natural follow up to this research is the extent to which these policy influences effect outcomes in tangible developments. We recommend this as an area for further research.

Conclusion

The contentment of public health advocates with the process that developed the TYPGA and its outcomes in tackling multiple social determinants of health revealed in the data is illuminating for both planning theorists and practitioners. The success of the TYPGA in tackling multiple social determinants of health was, in the eyes of both the research team and

participants interviewed, in large part due to the long-term engagement of public health staff in the collaborative processes that developed it. This engagement was made possible in part by the Health Department's adoption and commitment to HiAP principles. A plank of this continued engagement was a willingness on behalf of public health officials to work within the neo-liberal inspired primacy of economic competitiveness and growth and the economic and environmental motives behind urban containment. The goal of urban consolidation initially created considerable tensions between planning and health participants. However, these were eventually overcome by health official's acceptance of 'liveable' infill over the alternative of extensive growth on the urban fringe.

The health sectors~~ir~~ involvement in the planning process was ~~also~~ facilitated by the state government's long-term commitment to the principles of interdepartmental coordination and joined up governance. Furthermore, the relative power of the state government in both health and urban development, and the importance of the metropolitan Adelaide region to the state, meant this commitment to joined-up governance had considerable policy effect. It provided the health department with the opportunity and mandate to pursue a HiAP model and send policy entrepreneurs into other government departments and agencies including those associated with urban planning.

The commitment of health staff to the collaborative process and the occasional hierarchical intervention of Planning and Health Department management and government ministers in the first turbulent stages of collaboration ensured the process survived and a collaborative network based upon formal and informal relationships was formed, expanded, and normalised over time and multiple projects. In addition, the relationships, dialogue, knowledge sharing, trust and commitment to consensus building formed during these ongoing collaborations meant that the health staff were able to achieve a superior health and well-being outcome in the 2017 update compared to the original 2010 edition. There is also

662 some evidence that collaboration with other departments on other projects is dispersing
663 knowledge more broadly through networks and forming alliances to tackle the social
664 determinants of health from a greater number of directions.

665

666 References

667 ALBRECHTS, L. 2015. Ingredients for a More Radical Strategic Spatial Planning.
668 *Environment and Planning B: Planning and Design,* 42**,** 510-525.

669 ALBRECHTS, L. 2016. Shifts in Strategic Spatial Planning? Some Evidence from Europe
670 and Australia. *Environment and Planning A,* 38**,** 1149-1170.

671 ALLMENDINGER, P. 2002. Towards a Post-Positivist Typology of Planning Theory.
672 *Planning Theory,* 1**,** 77-99.

673 ALLMENDINGER, P. & HAUGHTON, G. 2010. Spatial Planning, Devolution, and New
674 Planning Spaces. *Environment and Planning C: Government and Policy,* 28**,** 803-818.

675 BAUM, F., DELANY-CROWE, T., MACDOUGALL, C., VAN EYK, H., LAWLESS, A.,
676 WILLIAMS, C. and Marmot, M., 2019. To what extent can the activities of the South
677 Australian Health in All Policies initiative be linked to population health outcomes using a
678 program theory-based evaluation?. *BMC public health*, *19*(1), p.88.

679 BAUM, F. 2019a *Governing for Health: Advancing Health and Equity through Policy and*
680 *Advocacy*. New York: Oxford University Press.

681 BAUM F, DELANY-CROWE T, MACDOUGALL C, LAWLESS A, VAN EYK H,
682 WILLIAMS C. 2017. Ideas, actors and institutions: lessons from South Australian Health in
683 All Policies on what encourages other sectors' involvement. *BMC Public Health*.;17:811.

684 BAUM, F., LAWLESS, A., MACDOUGALL, C., DELANY, T., MCDERMOTT, D.,
685 HARRIS, E. & WILLIAMS, C. 2015. New norms new policies: Did the Adelaide Thinkers in
686 Residence scheme encourage new thinking about promoting well-being and Health in All
687 Policies? *Social Science & Medicine,* 147**,** 1-9.

688 BOOHER, D. E. & INNES, J. E. 2002. Network power in collaborative planning. *Journal of*
689 *planning education and research,* 21**,** 221-236.

690 CANADIAN INSTITUTE OF ADVANCED RESEARCH, Health Canada, Population and
691 Public Health Branch. AB/NWT 2002, quoted in Kuznetsova, D. 2012. *Healthy places:*
692 *Councils leading on public health. London: New Local Government Network*. Available
693 from New Local Government Network website.

694 CDSH (Commission on the Social Determinants of Health). 2008. Closing the Gap in a
695 Generation, Geneva: WHO.

696 DAVIES, J. S., BUA, A., ORIOL, M. C. & THOMPSON, E. 2018. Why is austerity
697 governable? A Gramscian urban regime analysis of Leicester, UK. *Journal of Urban Affairs***,**
698 1-19.

699 DAVIES, J. S. 2005. Local governance and the dialectics of hierarchy, market and network.
700 *Policy studies,* 26**,** 311-335.

701 DELANY, T., HARRIS, P., WILLIAMS, C., HARRIS, E., BAUM, F., LAWLESS, A.,
702 WILDGOOSE, D., HAIGH, F., MACDOUGALL, C., BRODERICK, D. & KICKBUSCH, I.
703 2014. Health Impact Assessment in New South Wales & Health in All Policies in South
704 Australia: Differences, similarities and connections. *BMC Public Health,* 14.

705 DPTI, 2017. T*he 30 Year Plan for Greater Adelaide (2017 update).* Department of Planning,
706 Transport and Infrastructure. Adelaide: Government of South Australia.

707 DPTI, 2015. T*he Integrated Transport and Land Use Plan.* Department of Planning,
708 Transport and Infrastructure. Adelaide: Government of South Australia.

709 EXWORTHY, M. & HUNTER, D. 2011. The challenge of joined-up government in tackling
710 health inequalities. *International Journal of Public Administration,* 34**,** 201-212.

711 FAINSTEIN, S. 2014. The just city. *International Journal of Urban Sciences,* 18**,** 1-18.

712 FERLIE, E., FITZGERALD, L., MCGIVERN, G., DOPSON, S. U. E. & BENNETT, C.
713 2011. Public Policy Networks and 'Wicked Problems': A Nascent Solution? *Public*
714 *Administration,* 89**,** 307-324.

715 FRIEDMANN, J. 2008. The uses of planning theory: A bibliographic essay. *Journal of*
716 *Planning Education and Research,* 28**,** 247-257.

717 HEALEY, P. 2006. *Urban complexity and spatial strategies: Towards a relational planning*
718 *for our times*, London: Routledge.

719 HILLIER, J. 2008. Plan (e) speaking: A multiplanar theory of spatial planning. *Planning*
720 *Theory,* 7**,** 24-50.

721 HILLIER, J. 2017. *Stretching beyond the horizon: a multiplanar theory of spatial planning*
722 *and governance*, London: Routledge.

723 INNES, J. E. & BOOHER, D. E. 1999. Consensus Building as Role Playing and Bricolage.
724 *Journal of the American Planning Association,* 65**,** 9-26.

725 JESSOP, B. 1998. The rise of governance and the risks of failure: the case of economic
726 development. *International social science journal,* 50**,** 29-45.

727 KATIKIREDDI, S., HIGGINS, M., SMITH, K. E. & WILLIAMS, G. 2013. Health
728 inequalities: the need to move beyond bad behaviours. *Journal of Epidemiology and*
729 *Community Health*.

730 KINGS FUND, 2020. Kings Fund https://www.kingsfund.org.uk/projects/time-think-
731 differently/trends-broader-determinants-health. Accessed 12/2/20.

732 KJAER, A. M. 2009. Governance and the urban bureaucracy. In, Judge, D., Stoker, G., and
733 Wolman, H., (eds.) *Theories of Urban Politics.* USA: SAGE, 137-152.

734 KRIEGER, N. 2001. Theories for social epidemiology in the 21st century: an ecosocial
735 perspective. *International Journal of Epidemiology*, 30668-677.

736 LAWLESS, A. P., WILLIAMS, C., HURLEY, C., WILDGOOSE, D., SAWFORD, A. &
737 KICKBUSCH, I. 2012. Health in All Policies: evaluating the South Australian approach to
738 intersectoral action for health. *Canadian journal of public health = Revue canadienne de*
739 *santé publique,* 103**,** eS15-19.

740 LEPPO, K., OLLILA, E., PEÑA, S., WISMAR, M. & S COOK (eds.). 2013. *Health in All*
741 *Policies, Seizing Opportunities, Implementing Policies* (pp.25-43). Helsinki: Ministry of
742 Social Affairs and Health.

743 MCGINNIS, J.M., WILLIAMS-RUSSO, P. AND KNICKMAN, J.R. 2002. The case for
744 more active policy attention to health promotion. *Health Affairs* 21 (2) pp.78-93.

745 MEES, P. 2009. *Transport for suburbia: beyond the automobile age*, London: Routledge.

746 MOSSBERGER, K. 2009. Urban regime analysis. *Theories of urban politics,* 2**,** 40-54.

747 NADIN, V. 2007. The emergence of the spatial planning approach in England. *Planning*
748 *Practice and Research,* 22**,** 43-62.

749 NEWMAN, P. 2008. Strategic Spatial Planning: Collective Action and Moments of
750 Opportunity. *European Planning Studies,* 16**,** 1371-1383.

751 OLESEN, K. 2013. The neoliberalisation of strategic spatial planning. *Planning Theory,* 13**,**
752 288-303.

753 OLSSON, A. R. 2009. Relational rewards and communicative planning: Understanding actor
754 motivation. *Planning Theory,* 8**,** 263-281.

755 POTTS, R., VELLA, K., DALE, A. & SIPE, N. 2014. Exploring the usefulness of structural–
756 functional approaches to analyse governance of planning systems. *Planning Theory,* 15**,** 162-
757 189.

758 REFF PEDERSEN, A., SEHESTED, K. & SØRENSEN, E. 2010. Emerging Theoretical
759 Understanding of Pluricentric Coordination in Public Governance. *The American Review of*
760 *Public Administration,* 41**,** 375-394.

761 RYDIN, Y. 2007. Re-Examining the Role of Knowledge Within Planning Theory. *Planning*
762 *Theory,* 6**,** 52-68.

763 SAGER, T. 2009. Responsibilities of theorists: The case of communicative planning theory.
764 *Progress in Planning,* 72**,** 1-51.

765 SAVITCH, H. & VOGEL, R. K. 2009. Regionalism and urban politics. *Theories of urban*
766 *politics,* 2**,** 106-124.

767 SEARLE, G. & BUNKER, R. 2016. Metropolitan strategic planning: An Australian
768 paradigm? *Planning Theory,* 9**,** 163-180.

769 SEHESTED, K. 2009. Urban Planners as Network Managers and Metagovernors. *Planning*
770 *Theory & Practice,* 10**,** 245-263.

771 SMITH, K. E. & KATIKIREDDI, S. V. 2013. A glossary of theories for understanding
772 policymaking. *J Epidemiol Community Health,* 67**,** 198-202.

773 SØRENSEN, E. 2013. Conflict as driver of pluricentric coordination. *Planning Theory,* 13**,**
774 152-169.

775 TALVITIE, A. 2009. Theoryless Planning. *Planning Theory,* 8**,** 166-190.

776 WHO (World Health Organization). 2013. *The Helsinki Statement on Health in All Policies.*
777 The 8th Global Conference on Health Promotion, 10-14 June. World Health Organization and
778 Finland Ministry of Social Affairs and Health.

779

780

781

782