Master of Community and Regional Planning
Capstone Report

LEGAL ANALYSIS OF HEALTH PLANNING LAW IN BRITISH COLUMBIA

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I. Executive Summary

Over the past half century, North American cities have moved towards single use zoning, which has increased automobile dependence and decreased density. This has resulted in a built environment which harms public health by reducing daily physical activity and increasing sedentary lifestyles. Health issues associated with this include obesity, diabetes, heart disease, depression, and anxiety. While we can mitigate some of these negative externalities through dedicated exercise and healthcare, this creates equity issues as these mitigation measures require capital and free time.

One solution which has the potential to be more equitable and effective is the implementation of health-based planning initiatives aimed at developing walkable neighbourhoods, which facilitate and emphasize active transportation and physical exercise. This paper examines the major components of planning law in BC with a focus on local government's ability to enact zoning and other regulatory bylaws focused on core components of walkability; including mixed use, density, connectivity, and attractiveness. This examination includes municipal authority to enact zoning, regulatory bylaws designed to support zoning bylaws, and the use of Official Community Plans.

The report's key finds include:

- The authority to zone is a core tool of local governments and in BC the enabling legislation is worded to allow for broad authority on the part of local governments. Zoning authority includes control over density limits and types of use. Further, courts have upheld the power of local governments to use their zoning power in such a manner that creates a high threshold for arguments of *de facto* expropriation on the part of local governments.
- Regulatory bylaws can provide substantial support to health planning initiatives when they work in tandem with zoning regulations. These powers must be utilised carefully, as the enabling legislation has strict rules for bylaw adoption, depending on the authority being used. A new development for health planning is the adoption of "public health" as a fundamental power of local governments in the *Community Charter*, meaning that local governments may adopt bylaws specific to public health, provided they adhere to protocols set out by the provincial government.

- Official Community Plans can be a useful tool to allow local governments to adopt long term, comprehensive strategies to promote public health, and they are a way that the provincial government could emphasize public health planning in communities across BC. However, the adoption of these documents is not mandatory and depending on their content, they may not provide the strong guidance or enforceability to be effective.

Overall, this report concludes that the current planning legislation in BC provides sufficient tools and authority for local government to enact many types of health planning initiatives, focused on the core principles of mixed use, density, connectivity, and attractiveness. This can be achieved through the coordinated use of zoning regulations, regulatory bylaws, and provincial government initiatives. A gap identified in the legislation is the mandate to enact such initiatives. As such, it will require political will by politicians, local organisations, and/or residents to see health planning initiatives enacted and sustained.

II. Introduction

The cities, towns, and settlements we live in affect our health in a myriad of ways. Of particular significance is the design and composition of these places and communities, as this affects the way we move through and live in our environment. The physical composition of where we live is known as the 'built environment' and refers to the various components that comprise the urban landscape of communities (Frank, 2003, 6, 99-116). The built environment includes the physical elements of an area, such as transportation networks, buildings, and open spaces, but it refers to much more than just what can be found in an urban environment. It also includes how these elements are composed, including their proximity to one another, their physical dimensions, and the ways in which they are arranged and interact with one another. The built environment can be thought of as all of the physical features of a space, their individual designs, and how those components relate to impact the people occupying that space.

Since the end of World War II, there has been a growing trend in ordering the built environment towards low density, single use zoning, and auto-centric designs (Valiante, 2016, 138-139). This has resulted in the current built environment, known widely as 'urban sprawl'. Research indicates that this form of built environment contributes to a number of public health issues, such as obesity, diabetes, heart disease, depression, and anxiety (Frank, 2003; Frank, 2006; Black, 2008; King 2011). New initiatives have been proposed to reimagine our urban spaces, focused on improving walkability and reducing auto-dependency to create environments where people can be more physically active, which contributes to healthier populations (Frank, 2003, 38-54; Saelens, 2003; WHO, 2007). Although a growing number of research studies have substantiated the link between physical activity and improved health, questions persist regarding how to practically implement this research in the context of planning initiatives. One such question is, do our local government have the legal tools to implement these proposals? With mounting research emerging regarding the potential for these new planning initiatives to improve public health, I will examine in this paper the legal framework in which these initiatives can be implemented. Given the scope of this paper, and because my research centres on a legal analysis of planning laws, I have chosen to focus this analysis on British Columbian planning law. While the specifics of this paper pertain to British Columbia, my expectation is that there will be insights applicable to all provinces, such that the findings will be of use throughout Canada.

In addition to reviewing the legal foundation of planning law in Canada generally, and British Columbia specifically, I will also seek to understand the challenges and opportunities that health planning initiatives face within the legal realm. This paper is organised into three sections; first a review how zoning and planning created cities which in turn created and are fueling public health issues related to sedentary lifestyles; second an exploration of proposed remedies to this planning and public health issue, with a focus on active living; and finally an examination of the legal issues surrounding the implementation of these new initiatives, focusing on the legal mechanisms at play and what challenges and opportunities can be identified within.

III. Zoning and Sprawl

Zoning is a planning tool used to regulate the division of land into permitted and prohibited uses. It began, in part, as an attempt to make cities healthier by responding to what was a revolution in urban environments. As a result of the industrial revolution, cities were urbanising and growing at an incredible rate. Industries, located in cities, were also developing that had not previously existed, thus using technology that created industrial hazards and endangered people and property (Schilling 2005). This combination of increasing density, new technology, and rapid growth led to dangerous living conditions for urban residents. New industries created dangerous by-products, and the proximity of these new industries to residential space meant that residents were being exposed to a myriad of risks on a regular basis (Talen, 2011). These risks included pollution and industrial accidents such as fires and explosions. In addition to the proximity to industry that endangered human life, proximity to one another as a result of densification carried its own risks. At this time of rapid urbanisation, general understanding of sanitation and public health was poor. As such, the increased density carried significant dangers of infectious disease such as tuberculosis and cholera, which spread quickly in dense urban areas (Schilling, 2005).

Early measures to improve public health and quality of life focused on separating people from these harmful elements (Schilling, 2005). This separation led to a significant change in how communities were organised, with entire areas separated into single land uses. This practice became known as single use zoning and relied upon putting physical distance between residents and anything considered undesirable, such as heavy industry. In addition to separating residential uses from all other uses, lower density was considered desirable as there was a belief at the time that illness was

caused, or at least associated with, bad air. Buildings in dense neighbourhoods often lacked ventilation and windows for light, creating unpleasant living conditions. Density itself was also associated with impoverished neighbourhoods populated primarily by immigrants (Rosen, 1958). These neighbourhoods suffered from inferior infrastructure and limited access to healthcare, as compared to wealthier neighbourhoods, which exasperated perceptions of the unhealthy attributes of density.

To address the perceived ills of density, planners and health officials believed that sunlight and fresh air would eliminate the bad air common in dense urban centres (Schilling 2005). While reducing density and moving people away from industrial sites did prove to be somewhat effective, we know now that it was not the air itself that cause illness; rather, microscopic life forms such as bacteria and viruses that cause infections. With deeper understanding of infectious disease, proper sanitation, better hygiene, and technological innovations such as vaccines we have been able to effectively address and, in some cases, eliminate these illnesses (Rosen, 1958). In a similar manner, understanding of industrial hazards has improved allowing for technological innovations that have led to reduced levels of pollution and improving work safety practices which reduce the hazards of industrial operations.

As urban planning in the first half of the twentieth century focused on physically separating land usage, and therefore spaces, transportation problems arose as the distance a person could reasonably travel was generally limited by how far they could walk. While a number of solutions arose, such as streetcars and trolleys, it was the invention and mass production of the automobile that would allow the new form of urban composition to excel into what we understand today as sprawl (Valiante, 2016). Through the mid-twentieth century, as the automobile became more prevalent in North American life, it also began to change the way North American cities were shaped and conceived. For example, automobiles necessitated storage space and dedicated lanes to move safely and quickly through urban spaces. In this way, roadways became the domain of the automobile, businesses and homes required space for parking, and over time cities began to appear more as if they were designed for automobiles than they were for the people living in them (Frank, 2003, 11-37). Ultimately, automobiles allowed for more regular travel across greater distances between destinations, and for entire neighbourhoods to be dedicated to single land uses, with people travelling out of their immediate community each day to work and play. The ways in which cities and towns developed in North America post-World War II can be described by three key themes: increasing reliance upon single use zoning; decreasing levels of density; and increasing reliance on automotive use (Valiante, 2016).

Although improving public health may have been the original goal of zoning, this practice of controlling and shaping the urban form to separate spaces and reduce density has had many consequences. One of the most significant consequences is the expansion of urban sprawl; characterised by low density urban development, wide and pervasive roadways, large areas of single use zoning, and a heavy focus on automobile usage. The focus on automotive transportation is so high that other means of transportation, such as walking or cycling, become dangerous and/or unreasonable to perform amidst such high automotive usage (Jacobsen, 2009). Perhaps the most significant health related side effect of sprawl has been an increase in sedentary lifestyles and the corresponding reliance on automobiles. Sedentary lifestyles are directly correlated with increases in obesity, overweight, associated illnesses such as diabetes, certain forms of cancer, heart disease, depression, anxiety (Frank, 2003, 38-54; King, 2011). While innovations in the field of medicine have allowed us to live longer, these sprawl-related illnesses reduce quality of life and place immense strain on the healthcare system (Anis, 2010; Canadian Obesity Network, 2017). Moreover, illnesses and health conditions associated with sedentary lifestyles do not just cost millions of dollars to treat each year, they also create huge costs for the economy in lost productivity as workers must take time off for treatment or are unable to regularly work due to reduced physical or emotional capacity (Katzmarzyk ,2004). The intangible and tangible costs associated with sprawl are significant.

While the negative health effects associated with sprawl can be mitigated by individuals through dedicated physical activity[1] and innovations in medical treatment,[2] these options only treat the symptoms rather than address the problems created by sedentary lifestyles. Further, these measures can be expensive and often take up significant time, meaning that their effectiveness relies heavily on the financial capital and free time of individuals. Reliance upon such mitigation strategies thus creates significant equity issues, as the ability for someone to avoid or undo the physical and mental harm associated with sprawl becomes linked to their economic and political means. These problems are further compounded by the fact that marginalised communities are the most likely to be exposed to

[1] Exercise and physical sports, such as jogging, weight training, hockey, or lacrosse to name just a few.
[2] Innovations such as stents, medications to control blood pressure, cholesterol, and insulin, as well as implants such as pacemakers.

areas with poor walkability, have minimal community amenities, and have the highest proximity to land uses that produce harmful externalities such as pollution (Adkins, 2017).

IV. Health Planning

The sprawl-related negative health outcomes outlined in this paper primarily stem from sedentary lifestyles, brought on by single use zoning, low density, and automotive dependency. In order to combat these health issues, various initiatives have been proposed which focus on changing the built environment through planning policy. Given the aforementioned negative health outcomes stemming from sedentary lifestyles, the forms of health planning this paper focuses on can be described broadly as 'active living planning' or 'health planning'. Planning measures associated with these ideas focus on integrating physical activity into daily life to reduce the amount of time people spend being sedentary.

Planning initiatives that have been linked to improving health often focus on increasing opportunities for physical exercise without requiring significant disruption to the fundamental tasks of the average person's life or, put another way, physical exercise that can be seamlessly integrated into the average day. The reason planners have sought such seamless integration is for two major reasons. First, as has already been addressed, finding time to exercise has an equity component whereby if people are expected to take time out of their day for exercise, then those with limited free time will be unable to afford such a luxury. Second, while a limited amount of research has shown that proximity to fitness facilities has some beneficial effects on health, it is important to acknowledge that not everyone has the desire, ability, or time to participate in sports or traditional exercise (Kaczynski, 2014). By creating opportunities to engage in low impact physical activity such as walking to destinations that people visit regardless, physical activity can be achieved on a regular basis while completing the tasks of daily life.

Transportation methods that require physical excretion are generally referred to as 'active transportation', and they include walking, biking, and even taking transit as each trip begins and ends with some walking. As noted, active transportation is attractive to those involved in health planning as it allows people to exercise without needing to take extra time out of their day to do so. However, in order to be effective, there needs to be an understanding of how active transportation can be best

facilitated and encouraged by the built environment. An indicator of how easily active transportation can be undertaken is known as walkability. The precise definition of walkability is complex, and it deserves to be broken down into its core components as there is more to walkability than just active transportation. The core components of walkability include mixed uses, connectivity, healthy density, and attractiveness (Frank, 2003; Lo, 2009; Adkins 2017). When an area has high walkability, it has multiple destinations within it, these destinations are of interest to those making the trips, the area is easy to navigate and traverse, and it is a safe and inviting place to occupy. Having multiple destinations to which one can travel, which can be a product of mixed use zoning, is important so that residents are able to rely upon active transportation to fulfil their daily needs, such as going to work or completing everyday errands. Being able to fulfil these needs within walking or biking distance means less reliance on automobiles, and therefore less time spent being sedentary.

Connectivity is important as it relates to the transportation networks used to traverse an area. High connectivity means routes are easy to navigate and provide ample options/routes so that users can move between multiple destinations in a straightforward manner (Frank, 2003, 115-136). Connectivity can also refer to the quality of the infrastructure in an area, such as sidewalks, ramps, and bicycle lanes. High quality infrastructure that adheres to the principles of universal design means that a greater number of users can have equal access to each pathway. Equal access to active transportation is especially important as many health concerns associated with sedentary lifestyles tend to have feedback loops where the illness reduces mobility, leading to increased difficulty exercising, and thus exacerbating the problem (Frank, 2003, 87-88). By implementing universal design standards, transportation networks are made more accessible to everyone with a priority on those with the lowest mobility. This results in greater accessibility, regardless of what condition may reduce mobility, be it chronic or temporary (British Columbia, 2019).

Having density higher than those levels observed in traditional, low density suburban developments is important to walkability as it increases the number of possible destinations in an area, and provides the population required to support a large and interesting mix of commercial destinations. The level of density required to sustain this is referred to here as 'healthy density', as opposed to simply high density, because having a dense neighbourhood alone will not provide these benefits and may be viewed as an unattractive feature to a neighbourhood. Rather, healthy density refers to the level of density required to support a desirable level and mix of destinations and

transportation networks. This heightened density is also important because these destinations, be they for shopping, work, or social engagements need to be within a distance where active transportation is a reasonable method for a majority of the population to use. If an area has too low a density there may be an insufficient variety of destinations to visit, the destinations may be too far to use active transportation to get to, or the population may be too small to support the types of destinations or the types of transportations networks present in the area. The relationship between density and the types of transportation networks that can thusly be supported is a common consideration when assessing the efficiency of public transportation systems such as light rail which have high operating costs and require large ridership to be financially viable.

The final component of walkability mentioned here is attractiveness. This is perhaps the most complex component as it includes largely subjective measures, and touches on all three of the other components. Attractiveness of an area can refer to the quality of the transportation networks, the ease of navigation, and the variety or types of destinations, as discussed above. It can also refer to the experience and perception of users, and while any of the components of walkability can be influenced by socio-economic factors, this one in particular is subject to such considerations (Adkins, 2017). For example, areas with high crime rates, or the perception of high crime rates, can be undesirable to occupy, even when the physical attributes of the area might be considered walkable by other standards. Studies have also found that neighbourhoods that are considered socio-economically disadvantaged are more likely to be located close to land uses that produce high levels of harmful pollutants, such as highways and heavy industry (Adkins, 2017). These negative externalities not only make the act of being outdoors, such as walking beside a highway, undesirable, they can also result in exposure to dangerous pollutants which in turn can damage health, undoing the intended good of making a neighbourhood more walkable (Marshall, 2009).

Heavy automotive use also reduces how 'attractive' or 'desirable' an area is in terms of active transportation. With heavy automotive use there is reduced air quality and increased danger of being seriously injured in an automobile accident. As such, in order to improve walkability, not only must active transportation be encouraged, but automotive use needs to be actively discouraged in favour of active transportation. Attractiveness is therefore critical to the overall walkability of a neighbourhood and to ensuring that investments in infrastructure and changes to planning laws are made in a meaningful and useful way.

At the time of writing this paper, the world is battling the COVID-19 pandemic, which has drawn into question how close is too close in terms of containing the spread of a novel virus. While the current situation has changed the landscape for public health by raising old fears of infectious disease spreading in dense neighbourhoods, it is too early to say with certainty what will be the long term effects and impacts of this pandemic. While initial measures to limit the spread of this virus have included physical distancing, it is my opinion that this will not mean the end of urban living; rather, I would argue that cities should continue to seek healthy density. Preliminary observations suggest that the efficacy of a government's response is more important to reducing the number of infections than the density of an area (Conference Board of Canada, 2020). Government response includes measures such as active testing, public education, proper hygiene, and quarantines when necessarily. As mentioned above, some of the earliest zoning measures were designed to combat infectious diseases and while these were implemented with some effect, significant improvement in controlling infectious disease came with the discovery of vaccines and better sanitation. It seems reasonable that society should see a similar pattern with the current pandemic. Initial measures may focus on the simple and immediately actionable initiatives such as physical distancing, but as our understanding of the virus improves there will be more effective measures society can take that will allow for a return to increases in healthy density in urban areas.

V. Legal Analysis of Health Planning

As described above, there is a growing understanding among planners of how built and social environments can promote healthy activity, but a thorough analysis of the legal frameworks which underpin the creation of such environments remains an area with limited research. This paper began with a discussion of how zoning and auto-centric planning negatively impacts public health. As the root causes of this damage are based in the legal framework that supports the designing and planning of communities, future efforts to undo the damage wrought by tools such as single use zoning will also need to be rooted in this legal framework. This work of 'undoing' includes approaches such as moving away from single use, low density zoning and towards zoning that promotes healthy density. In order to begin this work, planners, lawyers, and city officials must ask and answer questions such as, can we legally undertake the types of changes that are being proposed, what challenges will be faced in pursuing such changes, and how best can these initiatives be implemented? Another way of asking

this is, do local governments in British Columbia have the tools and authority to legally implement these proposed changes, and if so, what opportunities and challenges await?

In the pursuit of answers to these questions, this paper will focus on the legal jurisdiction of British Columbia. It is important to note, however, that the contents of this paper will also provide some guidance to the larger Canadian context as there is overlap between provincial planning legislation across Canada. To begin this analysis, I will examine the foundations of planning law in British Columbia, including an examination of the power of the state to regulate land use and the broader constitutionality of zoning in Canada. I will also determine under what contexts land use regulation can be performed, as well as how the provincial government delegates planning power to local government. This legal analysis will also review additional planning powers delegated to local governments that are used to complement zoning regulations, such as the authority to pass bylaws for the purposes of protecting public health, and the restrictions around this new authority. Finally, I will discuss the use of official community plans as a method of creating comprehensive zoning plans which have been proposed as a way to encourage more holistic and inclusive planning.

A. Constitutionality of Zoning

Perhaps the broadest, and most powerful, planning tool of the local government is zoning authority. Through zoning, a local government may establish where the many components of a city can be located, and stipulate where and what uses may and may not be undertaken within the municipality's limits. At its most fundamental, the power of zoning is about balancing public and private interests, realized through the limitations placed on the enjoyment of private property. Zoning operates to limit what potential uses can be undertaken on property in a manner intended to reduce conflicting uses. In this way, zoning balances public and private interests by limiting some private uses in the name of public interest, while also providing benefits to private property owners by giving some assurance towards consistency of use around their property.

The authority for zoning in Canada originates from the provincial governments via the *Constitution Act, 1867*, 30 & 31 Vict, c 3. which governs the division of power between the provincial and federal governments. The power to zone is derived from the provincial authority over municipalities, which the provincial government is able to delegate to local government through legislation. Local

governments are themselves created through legislation adopted by the provincial government, making local governments creatures of statute. Because their power and authority are set out by provincial statutes, local governments may only exercise that authority as set out in their enabling legislation. This is similar to the United States, where the power to zone has been delegated to local governments by the individual States. The power of zoning was given legal confirmation in the US in the 1924 case of *Village of Euclid v. Ambler Realty Co* (1926), 272 US 365 ("*Euclid*"). In this case the US Supreme Court upheld the use of zoning to exclude uses deemed undesirable to the local government.[3] This was significant as the US constitution protects the right to property, and zoning presented a conflict as it regulates and therefore limits possible uses of land. *Euclid* confirmed that despite this conflict, the state has the authority to regulate land use in certain cases. In its decision, the US Supreme Court referenced the law of nuisance as having a similar purpose to zoning. It is from this case that the term *Euclidean zoning* originates, referencing what is known now as single use, traditional zoning regulation.

While the US Supreme Court's support of zoning in *Euclid* was instrumental to legitimizing planning in the United States, Canada does not have a *Euclid* style case to confirm the constitutionality of zoning powers, and rather this power has been largely taken as a given by Canadian courts (Valiante, 2016). This may be in part because the Canadian constitution does not offer the same guarantee to private property that the American constitution does. In this respect, Canada is unlike other large common law jurisdictions around the world, such as the United Kingdom and the United States, which have formally adopted the right to property in their constitutions. The right to property was adopted in the *Canadian Bill of Rights*, SC 1960, c 44, but this document is only a statute, meaning it can be changed by Parliament and does not have the stature or authority of an official constitution. While other rights have been read into the *Charter*, Canadian courts have thus far refused to do so for property rights, which some researchers have interpreted as meaning there is a significant legal tolerance for the state's power over property in Canada (Valiante, 2016).

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[3] The 'undesirable' use was the construction of an apartment building in a low density residential suburban neighbourhood. Sadly, the first major confirmation of the state's power to zone was to be associated with the exclusion of people on the basis of socio-economic class. A sign of the damage zoning would come to inflict on urban landscapes in the next 70 years.

Despite Canadian courts having thus far refused to include the right to property within Canada's constitution, the courts have recognized property rights, which has had effects on the state's zoning authority. Expropriation, or the taking of private property by the state, is an example of such state authority in Canada and is regulated by statute and the common law. In addition to strict expropriation, the concept of the state taking private property has been extended to also include the practice of taking potential uses away from property, which is known as *de facto* expropriation or *de facto* taking. In the United States, where it is more commonly referred to as the 'law of taking', courts have used this principle in conjunction with their constitutional right to property to restrict the state's authority to limit potential uses, and therefore objections based on taking arguments almost always have some potential of success against zoning bylaw, since all acts of zoning involve the limitation of use (Bauman, 2019). This is significant as it poses an ongoing check on the authority of the American state to zone and could potentially limit future innovation in health planning law.

The courts in Canada, unlike those in the United States, have imposed a high legal burden to prove claims of *de facto* expropriation, which can in part be attributed to the absence of the right to property in the Canadian constitution. The case of *Canadian Pacific Railway Co. v. Vancouver (City)*, 2006 SCC 5 (CanLII), [2006] 1 SCR 227 ("*CPR v. Vancouver*") is the most recent Supreme Court of Canada case to address this issue. In this case, lands were owned by Canadian Pacific Railways (CPR) and used as a rail corridor within the City of Vancouver. As time passed, this rail corridor was used less and less for train operations and CPR made plans for commercial and residential development along the corridor. Around this time, the City of Vancouver passed a new Official Development Plan (ODP) which designated the rail corridor a public thoroughfare, negating the development plans by CPR. In response, CPR claimed *de facto* expropriation had occurred and sought to have the ODP declared *ultra vires*.[4] When the Supreme Court of Canada examined the issue of *de facto* expropriation it set out a two part test: there must be; 1) an acquisition of a beneficial interest in the property or flowing from it, to the expropriating authority and 2) removal of all reasonable uses of the property by the current owner. Applying this test to the facts in *CPR v. Vancouver*, the court held at paragraph 33 that the City of Vancouver had gained no beneficial interest in the property, as "[t]he City has gained nothing more than some assurance that the land will be used or developed in accordance with its vision" and CPR

[4] *Ultra vires* refers to a declaration by a court that means a law, in this case a bylaw, is beyond the authority of Council to adopt, and therefore not a valid law.

was still able to use the land as a transportation corridor, something the court noted was the only use it had ever had in the history of the city. This ruling by the Supreme Court set a very high standard in Canada for successful claims of *de facto* expropriation and signaled that as an act of government power, zoning was to be understood as a broad authority to direct possible use of land, so long as it was done within the confines of the authority set out by the enabling legislation.

Setting aside the lack of constitutional restrictions on zoning authority in Canada, local governments must still adhere to a number of restrictions when utilizing zoning authority. The most relevant area of restrictions comes from the enabling legislation itself. As mentioned above, in Canada local government enabling legislation is adopted by the provincial governments and therefore planning law will be practiced in slightly different ways in each province, depending on how the law in each province is adopted. In British Columbia the legislation creating, and empowering local governments is largely contained within the *Local Government Act,* RSBC 2015, c.1 ("*LGA*"), and the *Community Charter,* SBC 2003, c.26 ("*Community Charter*"). Additional legislation contributes and augments the powers of local governments, such as the *Vancouver Charte*r, SBC, 1953, c.55 which replaces the *Community Charter* for the City of Vancouver. For the purpose of conciseness, this paper will focus on the *LGA* and the *Community Charter*.

In British Columbia, the authority to create zoning bylaws comes from the *LGA,* Part 14. Beginning at s.479, the authority is laid out:

> **479** (1) A local government may, by bylaw, do one or more of the following:
> (a) divide the whole or part of the municipality or regional district into zones, name each zone and establish the boundaries of the zones;
> (b) limit the vertical extent of a zone and provide other zones above or below it;
> (c) regulate the following within a zone:
> (i) the use of land, buildings and other structures;
> (ii) the density of the use of land, buildings and other structures;
> (iii) the siting, size and dimensions of
> (A) buildings and other structures, and
> (B) uses that are permitted on the land;
> (iv) the location of uses on the land and within buildings and other structures;
> (c.1) limit the form of tenure in accordance with section 481.1;
> (d) regulate the shape, dimensions and area, including the establishment of minimum and maximum sizes, of all parcels of land that may be created by subdivision.

As one can see in the text of the law, the powers conferred here are broad, using largely neutral language such as 'regulate' and 'may'. The broad nature of this power is made further so with text in the *Community Charter* at s.4, which directs that "[t]he powers conferred on municipalities and their councils under this Act or the Local Government Act must be interpreted broadly in accordance with the purposes of those Acts and in accordance with municipal purposes".

Given this, it would seem that on its face, the current legislation is sufficient to allow for many of the proposed innovations envisioned in health planning. Zones created through this legislation can be mixed use, of any dimensions a council chooses, and may designate the density for which land can be built up to. In broad strokes, this covers some of the simplest descriptions of health planning initiatives, such as allowing for mixed use properties and increased density. As such, it can be concluded that with respect to creating mixed use areas that allow for higher density, local governments do have the legislative tools they require. These zoning powers, however, lack some depth as they do not directly address other issues of walkability such as transportation/connectivity and attractiveness/design.

In addition to zoning's limited reach in this regard, these zoning laws are also restricted to the regulation of 'use', with regulation of 'users' existing in other, additional powers of local governments.[5] The distinction here is 'use' refers to what the land may be used for, while 'users' refers to regulating the individuals using the land. For example, zoning may restrict the land use of a piece of property to certain permitted uses (gas station, hair salon, grocery store, etc.), while a business licensing bylaw regulates the users of the land as to how they may operate the business (operational hours, building capacity, collection of employee's names, etc.). This distinction is intentional as the procedural and substantive requirements for bylaws regulating use are different compared to other bylaws and resolutions which a local government may adopt. An example of this intentional division is s.8(7)(c) of the *Community Charter*, which states that the 'fundamental powers' of local government, which include the power to regulate, prohibit, and impose requirements on things such as municipal services

[5] The one exception is the recent addition of s.479(c.1) which limits the form of tenure in accordance with section 481.1. This is the only example of zoning authority under s.497 which allows the government to regulate who uses property, rather than how the property may be used.

and public places, "may not be used to do anything that a council is specifically authorized to do under Part 14 *[Planning and Land Use Management]* or Part 15 *[Heritage Conservation]* of the *Local Government Act*". Here, the power to regulate, prohibit, and impose requirements related to the fundamental powers of local government, are specifically restricted from being used to effect zoning regulations, as set out in Part 14, which includes s.479 reference above.

The difference between these types of bylaws relate to the efforts that a local government must undertake to properly adopt each type of bylaw. Within the *LGA,* a bylaw related to land use and zoning must have a public hearing, where the public can be advised of the intended bylaw and allowed to make representations. This public hearing is in addition to three readings at council. The *Community Charter* on the other hand, allows for other types of bylaws to be adopted without the public hearing, relying on the three readings, as well as a day of consideration after the third reading before the bylaw may be adopted. The legislature in British Columbia has therefore placed a higher procedural requirement for land use bylaws, requiring a local government to give the public an opportunity to learn about the zoning bylaw and be heard regarding its adoption. This is important as it indicates the higher degree of transparency that the provincial government requires of local governments with regard to land use bylaws, and also creates a more onerous process for local governments.

B. Regulating for Public Health in BC

As discussed above, the text of British Columbia's zoning legislation is seemingly sufficient to address some aspects of improved walkability, specifically increasing density and creating mixed use zones, but it is in and of itself insufficient to embody a comprehensive planning tool to implement all health planning initiatives. In order to achieve the goals of health planning, additional powers of the state will play a crucial role. These additional powers include other types of bylaw regulations, which will be required to work in tandem with zoning bylaws to complement one another in order to complete the picture of a healthy community.

Found within the *Community Charter* at s.8 is a list of several substantial regulatory powers referred to as 'fundamental powers', which include the power to regulate, prohibit, and impose requirements related to several areas including municipal services and public places, as well as the power to regulate

businesses.[6] Of the fundamental powers provided to local governments in s.8, one in particular stands out as having significant potential in the effort to create healthier communities. This power is under s.8(3)(i) 'the power to regulate, prohibit, and impose requirements in relation to public health'. With the coming into effect of the *Community Charter* in 2004, the provincial government of British Columbia chose to explicitly list public health as a fundamental power of local governments, which allows local governments to adopt bylaws specifically intended to address public health issues. This identification of public health as a fundamental power of local government has significant implications for planners, local governments, and all others concerned with health planning as it has the potential to be a useful tool to empower local governments to act directly in the interest of public health.

It should be noted though that this specific power has some strict limitations. While historically public health was foundational in planning authority and understood as a natural power of local governments,[7] the provincial government has included public health in a list of fundamental powers which are considered 'concurrent spheres of authority'[8]. These concurrent spheres are listed in s. 9 of the *Community Charter* and are subject to limitations by the provincial government not applicable to other fundamental powers set out in s.8. These limitations constitute potential opportunities and significant challenges for implementing public health-based planning initiatives.

The legislation dealing with concurrent spheres of authority sets out that those areas of power which have been delegated to local governments, being public health, the environment, animals, and removal and deposit of soil and other material, are areas in which local governments shall not adopt bylaws without the cooperation and approval of the provincial government. This approval can be achieved in accordance with a regulation set out by the provincial government, an agreement between the responsible minister and one or more local governments, or by the approval of the responsible

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[6] The *Community Charter* specifically restricts a local government's power to the regulation of business, as opposed to the power to 'regulate, prohibit, and impose requirements' which applies to most of the other fundamental powers listed in s.8. Local governments may though prohibit certain types of land uses under their zoning authority, which could in effect prohibit certain types of business.

[7] See section II "Zoning and Sprawl" of this paper.

[8] The designation of public health as a concurrent sphere of power suggests that the provincial government is interested in retaining certain authority within its control, despite the fact that public health has historically been a municipal concern. This historical perspective includes the addition of 'health' as a rationale for action by local government in the previous *Town Planning Act*, S.B.C. 1925, c. 55 at s.9(3)(a) and *Municipal Act*, RSBC 1979, c.290 at s.513(1), which were the legislation predating the *Local Government Act*.

minister. The responsible minister in each case is set out by the legislation and generally refers to the minister whose portfolio contains the area concerned. In the case of public health, it is the minister responsible for the administration of the *Public Health Act*, SBC 2008, c 28.

While this regulation gives the provincial government final say on local government initiatives, there is great potential as it allows for coordinated efforts between local governments and the provincial government. This power does not provide for the provincial government to mandate that local governments implement public health initiatives, there are other laws for doing that, but it does create an opportunity for collaboration. It also creates an opportunity for guidance and support from senior levels of government, which are more likely to have access to greater resources than most local governments. This assistance could include large scale studies, collaboration with health authorities, or coordination of funding for cross-ministries initiatives. This creates an opportunity for the province to lead in the creation of public health schemes and create regulations which allow local governments to adopt public health regulations. Performed in a collaborative manner, these public health schemes can be created in consultation with local governments, ideally allowing for bylaws that are effective while also being adaptable to fit local needs.

In a similar fashion, this new legislation has created the opportunity for local governments and the provincial government to come to a specific agreement for the creation of public health regulation. This is similar to the above path but does not require the creation of a regulation by the provincial government, which is easier to create and modify than a statute but remains a potentially resource heavy endeavor. Simply having an agreement allows for a very locally focused public health initiative, which could work as a test run for future regulatory schemes by the province for other local governments in British Columbia.

The most obvious challenge that this arrangement creates is that local governments may <u>only</u> enact public health-based bylaws when given permission by the provincial government. This means that local governments are inherently limited in what they may do on their own, which if not properly administered by the provincial and local governments could limit innovations or local solutions. This also creates another issue for the exercise of the public health powers. Local governments have a number of powers, and as set out in s.8 of the *Community Charter,* there are 16 fundamental powers, 12 of which are not considered concurrent spheres of authority and therefore can be exercised without

provincial approval. These powers are worded in a broad manner, like the ability to regulate business or public places, and allow for broad areas of influence. These areas of influence are so broad that they overlap in places, such as public places and protection of the environment. A bylaw regulating garbage collection in parks could relate to public places, protection of the environment, and even municipal services. In a situation where a local government can regulate any of these areas fully on its own there is no conflict, since regardless of the source of the authority, it is entirely within the local government's power to exercise that authority. But what happens if a bylaw is enacted by a local government, but it can be described as falling under more than one area of power and one of those is a concurrent sphere of authority? Does the provincial government need to give its approval, or can it be understood as an exercise of local government power not requiring provincial approval? In creating concurrent spheres of authority, the legislation has produced an interesting legal question; at what point does a bylaw, which can reasonably be considered to fall within separate spheres of authority, require provincial approval?

This question arose in the case of *Plastic Bags v. Victoria*, 2019 BCCA 254. In this case, the City of Victoria adopted a bylaw banning the use of plastic bags by businesses. The bylaw was brought under the city's business regulation power, which does not require provincial approval, but the bylaw was understood as an effort to ban plastic bags to protect the environment. The bylaw was challenged on the basis that this was a bylaw rightfully under the s.8(3)(j) protection of the natural environment which required provincial approval, something which it has not received. In this case, approval was not sought because the city characterised the bylaw as a business regulation, which was within the fundamental powers of a local government not requiring provincial approval. When this case was initially heard the city successfully argued that the legislation allows for bylaws to be lawfully adopted, without provincial approval, if they could be properly attributed to one of the fundamental powers which does not require approval from the minister. In other words, the city argued the plastic bag ban was related to business regulation, and even though it could have the effect of protecting the environment, it is also about regulation of business and therefore does not require provincial approval. This was based upon s.9(2)(a) of the Community Charter which reads:

> For certainty, this section <u>does not apply</u> to
>
> > (a) a bylaw under section 8 *[fundamental powers]* that is under a provision not referred to in subsection (1) or is in respect of a matter to which subsection (1) does not apply,

> even if the bylaw could have been made under an authority to which this section does apply. (emphasis added)

On appeal at the British Columbia Court of Appeal, the court interpreted these words as requiring a pith and substance test to determine the true intention behind the bylaw in question. A pith and substance test is a legal test used in Canada to assess the dominant purpose behind a law. It was initially used to make determinations in cases of conflicting authority on constitutional issues. In this case, the idea was similar as the bylaw's effect resulted in a potential conflict, as powers had been divided between levels of government. The court concluded that in pith and substance, the bylaw was adopted to protect the environment and therefore was *ultra vires*, or beyond the power of the City of Victoria, as the bylaw lacked ministerial approval.

This decision raises a significant issue for the use of the public health power as it creates uncertainty for local governments. On a plain reading of s.9(2) if the local government can use another power, it may. That is relatively straightforward and gives local governments clear authority to regulate in certain spheres. With a pith and substance review the courts can undo this, and therefore local governments may be unwilling to regulate areas which could potentially be in conflict. It can also sow uncertainty where the underlying conflict has not been anticipated. In either case, when the provincial government does not provide approval, which could be for many reasons unrelated to the quality or desirability of a bylaw, there is the potential for bylaws which in some way benefit or address public health to be found *ultra vires*.

This decision by the Court of Appeal is especially troubling as it creates uncertainty regarding the role of public health which has long been a foundational purpose of planning initiatives. Many municipal services such as sewage and garbage collection are at their core public health concerns. How the court will address this consideration is yet to be seen but given the growing interest in planning for healthier cities it seems all the more important for the provincial government to work with municipalities to create and coordinate initiatives, so that applicable bylaws are not found to be *ultra vires*. Co-operation between levels of government has already been called for by some experts and academics as a way to meaningfully improve the health of urban residents, and in British Columbia with this court decision it is now all the more important that these levels of government work together (Valiante, 2016).

While the above discussion outlines a significant area of possible conflict between local government authority and provincial authority, it is worth noting that the provincial government has adopted a regulation governing adoption of public health bylaws that has the potential to be especially accommodating to local governments. The *Public Health Bylaws Regulation*, BC Reg 42/2004 sets out that any bylaw adopted by a local government under the public health power, relating to the 'protection, promotion or preservation of the health of individuals' must fulfill two requirements to be properly adopted; a copy of the bylaw must be submitted to the responsible minister, and before adopting the bylaw, council must consult with the regional health board, or the medical health officer.

While as of yet, there are no reported cases of litigation on this issue, a plain reading of this regulation suggests that consultation with the health authority does not need to result in approval by the health authority, only that it needs to occur. The purpose of requiring consideration but not necessarily requiring approval is likely to ensure that a council can be advised of the health implications and consider that advice, but not have its decision-making power usurped by the health authority. That establishes a low bar for approval of public health bylaws, and while the regulation includes other areas of public health which require additional consultation with the province, any proposed bylaw that can be properly confined to the 'protection, promotion, preservation of an individual's health' need only satisfy those two requirements.

In addition to the powers found within s.8 of the *Community Charter*, local governments have a number of other regulatory powers which they may utilise to shape the built environment and improve public health. Found within the *LGA* at s.525 are the off-street parking and loading space requirements, which grants local governments the ability to adopt bylaws regulating the provision of and requirements surrounding off-street parking. These regulatory powers have the ability to influence the design of a community as it relates to auto-dependency. As noted above, auto-dependency is a key pillar in the development of sprawl and the shaping of North American communities over the past 70 years. As automobiles became commonplace, they required cities to be reshaped to accommodate their use. This included wider streets, which excluded all non-automotive road users, and large amounts of space dedicated to parking. These changes negatively affect walkability, and so to improve walkability automotive use needs to be de-emphasized. This can lead to improved air quality, road safety, and can encourage people to seek out alternative forms of

transportation. By restricting the availability of off-street parking, local governments are able to affect the ease of use of automobiles, and through this de-emphasize their use.

The wording of the off-street parking legislation is as follow:

> **525** (1) A local government may, by bylaw, do the following:
> (a) require owners or occupiers of any land, or of any building or other structure, to provide off-street parking and loading spaces, including spaces for use by disabled persons,
> (i) for the building or other structure, or
> (ii) for the use of the land, building or other structure;
> (b) establish design standards for spaces required under paragraph (a), including standards respecting the size, surfacing, lighting and numbering of the spaces;
> (c) permit off-street parking spaces required under paragraph (a) to be provided, other than on the site of the building or other structure or use, under conditions that are specified in the bylaw;
> (d) as an alternative to complying with a requirement to provide off-street parking spaces under paragraph (a), permit, at the option of the owner or occupier of the land or the building or other structure, the payment to the municipality or regional district of an amount of money specified in the bylaw.

A review of the language of s.525 reveals an interesting component of the legislation. While the *LGA*'s zoning powers use neutral language, which gives local governments a significant amount of freedom to design zones as they choose, the *LGA*'s language in s.525 only provides affirmative language to require off-street parking in some form or pay the local government to not have the parking requirements. While it remains an option for local governments to not require off-street parking and allow the market to direct the availability of parking, this language is a departure from the broad powers in other sections of the *LGA*, as it does not grant the explicit authority to prohibit off-street parking.

The option under s.525(1)(d) to make payments in lieu of parking creates an opportunity for local governments to build non-automotive transportation infrastructure, as s.525 goes on to mandate that monies collected in this manner must be spent on either off-street parking elsewhere or be used to develop alternative transportation infrastructure, such as public transit or bike lanes. This method to raise funds though remains optional for developers and property owners, which means that the only way to raise the funds requires local governments to require off-street parking in the first place. This

underscores the inherent bias automotive use has developed in North American society and is an example of where legislative change could improve planners' ability to advance health planning.

C. Official Community Plans

Health planning is a complex endeavor, that requires significant coordination of parties and resources to be effective. Concepts such as walkability have been identified as a planning goal to improve public health, but as discussed, it is a route that has multiple components such as physical and social considerations and therefore requires a comprehensive plan to be effectively implemented. Even when the physical components are present, such as sidewalks and parks, if the area is perceived as dangerous or unsafe due to crime or high automotive traffic then the area cannot truly be considered walkable (Adkins, 2017). The same can be seen along transit networks such as bike paths and public transit networks. Completeness of a transportation network is a key feature, to ensure users are able to access the entire network and encourage use (British Columbia, 2019, B.2). The implication for health planning is that those responsible for design and implementation must consider how the various zoning, bylaw regulations, and other planning initiatives can be used to complement one another and support the larger goal of improved public health.

A tool of governments which can help achieve this holistic approach is the implementation of a comprehensive plan. In British Columbia, local governments are able to adopt comprehensive plans, which are known Official Community Plans (OCP), as set out in the *Local Government Act,* RSBC 2015, c.1 ("*LGA*").[9] The purpose of an OCP is to act as a high-level policy outline meant to provide a regulatory framework for development (Steven, 2013). This document then guides future development, providing a sense of cohesion to community planning, as well as long range predictability for residents, businesses, and developers. Crucial to the effectiveness of a comprehensive plan is broad engagement by the community, so that the final document reflects the needs of all community members. In this way OCPs must be substantially and procedurally

[9] There is also a federal program used to work with First Nations communities to create comprehensive plans which extend beyond the scope of this report, as they focus on many areas outside of land use.

comprehensive, so they can provide meaningful guidance that is both comprehensive in a jurisdictional and social scope.

The *LGA* is the enabling legislation for adopting OCPs and describes them at s.471(1) as "a statement of objectives and policies to guide decisions on planning and land use management, within the area covered by the plan, respecting the purposes of local government". OCPs are not mandated by the provincial government, but rather are an optional planning tool that a local government may adopt. When a local government chooses to adopt an OCP it must fulfill certain procedural and substantive requirements which are set out in the *LGA*. Procedurally, the adoption of an OCP is by bylaw, requiring three readings which are broken up to allow for mandated consideration of separate plans, such as the financial and housing plans, and to provide for a public hearing after the first reading. In addition to the public hearing held after the first reading, the local government must "provide one or more opportunities it considers appropriate for consultation with persons, organizations and authorities it considers will be affected" as per s.471(1) of the *LGA*. This consultation process is meant to be flexible to suit each local government's situation, but as I will discuss below, it presents a potential challenge for effective health planning.

Substantively, an OCP is designed to include a number of components, some of which are optional for local government and others which are mandatory. An OCP's mandatory requirements are numerous, but some of the requirements that are more relevant to health planning include the approximate location, amount, type and density of residential developments required to meet anticipated housing needs over a period of at least five years, and the approximate location, amount and type of present and proposed commercial, industrial, institutional, agricultural, recreational and public utility land uses. These required components relate directly to the potential for mixed use and higher density (healthy density) neighbourhoods.

There are other mandatory components, such as affordable housing policies and targets and policies for reducing greenhouse gas emissions. While these are certainly important objectives for local governments, none of them directly relate to public health and health planning. The *LGA* also sets out numerous topics that local governments may include in an OCP, which range from protection of farmland to social development policies. While none of these directly relate to health planning, the *LGA* does set out a list of purposes and goals at s.471(2) which an OCP should work towards. Of

note, the first two are avoiding urban sprawl, and minimizing the use of automobiles in favour of active transportation. This indicates that while the provincial government did not view these endeavours as appropriate for mandatory inclusion, at a minimum they were considered important enough to be listed first amongst recommended goals for urban development.

Although the *LGA* describes an OCP as "a statement of objectives and policies to guide decisions on planning and land use management", once an OCP has been completed it becomes more than just the guiding document for the community's development, as it also creates requirements for all future bylaws the local government adopts. Set out a s.478 of the *LGA*, the effect of an OCP is to require that all bylaws enacted or works undertaken by a council, after the adoption of an OCP, must be consistent with that plan. While the *LGA* is explicit in stating that the OCP does not commit or authorize a local government to proceed with any plan set out in the OCP, it does create an onus on the local government to ensure that any municipal works undertaken in the future are consistent with this plan.

Official community plans present a significant opportunity as a tool for comprehensive change. It is an opportunity to bring together the community to set a long-term vision and objectives, rather than piecemeal planning which can lead to ineffective or even conflicting measures and initiatives. In order for an OCP to fulfill this potential though, it needs to be executed in a meaningful and thorough manner. In evaluations of comprehensive plans generally, research has found that they require several components to be effective, including public participation to capture a large part of the public's priorities and interest (Stevens, 2010). As noted above, this is essentially to establish meaningful walkability, which addresses the needs and concerns of those who occupy the land. Further, given the provincial government's ability to mandate what content is required within an OCP, these documents present an opportunity for the provincial government to prioritise health planning in the same way that they have prioritised reduction of greenhouse gas emissions[10]. By mandating that local governments include a plan to prioritise active transportation/walkability, the provincial government could play a leading role in encouraging health planning within British Columbia.

[10] S.473(3) states that an official community plan must include targets for the reduction of greenhouse gas emissions in the area covered by the plan, and policies and actions of the local government proposed with respect to achieving those targets.

Despite the potential to support health planning, OCPs present a number of challenges as well. These challenges relate not to the failure of the legislation to provide sufficient powers for local governments to implement health planning, but rather to the legislation's deference to local governments in creating an OCP. This deference manifests in the consultation requirement for local governments when adopting or amending an OCP, and the substantive requirements for the OCP.

When an OCP is being drafted, s.475 of the *LGA* requires that one more opportunities be provided for consultation with 'persons, organizations and authorities the local government considers will be affected'. It also mandates that the local government consider whether consultation be early and ongoing, and whether certain authorities such as school boards or First Nations need to be consulted. The requirements around consultation leave the details of how and to what extent consultation needs to be undertaken at the discretion of the local government. The purpose would appear to be an effort to allow local governments to tailor their consultation process to the needs of the situation. This consultation requirement applies to adoption, amendments, and repeal of an OCP, and so it is reasonable to assume that an amendment might not require the same level of consultation as the adoption of an OCP, but the fact remains there is no minimum standard or guiding mandate to ensure that consultation is thorough or meaningful.

The deference set out in this section was upheld by the British Columbia Court of Appeal in *Gardner v. Williams Lake,* 2006 BCCA 307 where the court noted that the legislation was explicit that consultation was to be conducted as the local government determined was appropriate. Given the wording, the challenge this presents to health planning is not related to the ability of a local government to act, but the potential that it will fail to act in a meaningful manner. Potential deficiencies in the process of drafting an OCP could be the result of a local government's failure to appreciate the importance of meaningful engagement, or it could be as a result of inadequate funding to complete such engagement, but regardless the threat still exists. Local governments do not receive funding from the provincial government to draft OCPs, so inadequate funding is a threat most acutely experienced by smaller municipalities (Stevens, 2013).

The second significant challenge to health planning associated with an OCP is related to the effectiveness of an OCP to guide future bylaws and works by the local government. As set out in

s.478 of the *LGA*, once an OCP has been adopted, the local government is under no obligation to undertake the plans therein, but it is required to ensure that all future bylaws and work are in accordance with the OCP. What this means is that the OCP has no official teeth to ensure that the priorities and goals set out in the OCP are fulfilled, but it does have a passive mechanism to guide future development in certain directions. From the perspective of comprehensive plan analysis, the lack of enforcement mechanisms means that OCPs in British Columbia tend to lack implementation and monitoring methods, which undermines their overall effectiveness (Stevens, 2013).

In addition to generally lacking implementation and monitoring components, OCPs also suffer from policy wording and guidance that may lack sufficient specificity to ensure subsequent actions by local governments adhere to the intent of the OCP policy statements. This is because there is an incentive for the drafters of an OCP to word the policy statements in such a manner so as to allow for sufficient flexibility to avoid potential conflicts between the various interests within the OCP. As an OCP is comprehensive in its scope, there is a reasonable likelihood that the OCP will address community interests that may not be aligned. Given the purpose of politics, and the work of government, is to balance competing interests, this is completely reasonable. But, as the *LGA* mandates that all bylaws and works of a local government must be consistent with the OCP, it means that the policy statements within an OCP must allow for sufficient flexibility so that bylaws advancing one policy goal do not directly conflict with another policy goal.

This conflict was addressed by the courts in British Columbia in the *Rogers v. Saanich (District),* 1983 CanLII 321 (BC SC) case at the Supreme Court and the *Residents and Ratepayers of Central Saanich Society v. Saanich,* 2011 BCCA 484 at the BC Court of Appeal. In those cases, the courts confirmed that the policy statements in an OCP should not be interpreted in the same strict way as a statute and only when there is a direct and clear conflict would a bylaw be struck down. The result of these rulings is that OCPs tend to use softer, visionary wording, rather than clear rules, to avoid potential conflicts with subsequent bylaws. That manner of wording OCPs means that there is flexibility in its interpretation and therefore it can be difficult to use the OCP as a strong policy document to enact potentially politically decisive measures.

VI. Conclusion

Current research into planning and public health has established a link between the built environment and the growing public health issues related to sedentary lifestyles. The composition of communities across North America, focusing on single use zoning, low densities, and automotive dependency are not only facilitating sedentary lifestyles, but at times making active living difficult for residents. These factors contribute to obesity, heart disease, depression, and a myriad of other public health issues. While this research has identified causes of these issues, and recommended solutions, how those solutions will be implemented remains an active question. The purpose of this paper was to examine the legal landscape on which these health planning initiatives would be built.

From a review of the major statutes governing planning law in British Columbia, it would appear that local and provincial governments in British Columbia have the basic tools to enact these health planning initiatives and have the broad authority to make zoning and land use restrictions, but the legislation lacks a mandate or enforcement component to ensure that health planning is implemented. The *Local Government Act* and the *Community Charter* provide the authority to zone for mixed use, and to increase the allowable density of a given zone, which are two major pillars in walkability and health planning. It also provides local governments the explicit authority to regulate in the interest of public health, but this explicit authority comes with the caveat that these efforts must be approved by the provincial government. This mandates a need for coordination and creates the possibility that health initiatives could be inadvertently *ultra vires*. Additionally, the *Local Government Act* provides the provincial government and local governments with the power to create comprehensive guides to planning and development, which offers great potential for holistic approaches to health planning but lacks the mechanisms to ensure strong policies or implementation.

What this means is that while governments in British Columbia largely have the tools they require, health planning at this time requires the political will to be implemented. While a complete review and consideration of what changes could be implemented is beyond the scope of this legal analysis, future research should focus on what regulatory changes could encourage health planning, and the potential for public health to be understood as a fundamental requirement of planning so as to view planning that undermines public health as illegal or unreasonable uses of public planning law. For now, it remains that the basic tools exist, which places healthier communities within our reach.

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