Local public health planning as a form of social action to achieve better health outcomes

What can be learned from the Victorian experience?

Submitted by

Diane Edwards,
Dip Teaching Primary, GDip Special Education, Master Pub Pol (Melb)

A thesis submitted in partial fulfilment of
the requirements for the degree of
Doctor of Public Health

School of Public Health
Faculty of Health Sciences

La Trobe University
Bundoora, Victoria 3086
Australia

June 2012

ACKNOWLEDGMENTS

I wish to acknowledge and thank Professor Hal Swerissen for his valuable guidance and suggestions during the course of this study.

My heartfelt thanks to my wonderful mother Evelyn Edwards, my sister Robyn Mills and my niece Lisa Mills. My inspirations.

I would like to thank Guy Campbell for his valuable comments on the draft, Susan Gilheany, Kerry Monterro, Lesley Hyde, Mary Natoli, Jude Quinn, Brett Mills, Karene Fairbairn and Estelle O'Callaghan for their care, support and encouragement over many years.

I would also like to thank Lorraine Richards for her guidance, and Sevi, Winnie and Nell for sharing their boundless energy and joy with me.

My thanks to my employer, the Department of Health for providing study leave and to the women and men who participated in this research.

I would also like to thank Gill Gartlan, Red Dog Productions, for editing this thesis.

In fondest memory of my wonderful father Lindsay Edwards.

TABLE OF CONTENTS

Tables

Figures

SUMMARY

The focus of this research is on local public health planning as a form of social action to achieve better health outcomes within the context of Municipal Public Health Plans (MPHPs).

Drawing on existing research and the framework developed by Swerissen and Crisp (2004) it is argued in this thesis that an effective MPHP is one that is embedded into the council organisation, responds to the social and environmental conditions affecting health and drives changes to the rules and norms that lead to and sustain individual behaviour. When this occurs a MPHP will be effective in driving long-term change to the social and environmental conditions that affect health. It will lead to the creation of environments that promote health and to the establishment of "rules" and norms that support behaviour change, and the local council will have delivered an effective MPHP. Action to achieve this requires coordinated planning to reduce institutional, organisational and individual risk factors affecting population health outcomes. Local public health planning provides the means through which this can be achieved and through which local institutions and organisations manage the change process. However, this kind of enterprise is complex and subject to a range of processes and factors that limit effective planning.

The research for this thesis was conducted using case study design. Data was collected from three case study sites in two studies. Study 1 aimed to assess whether the key elements of effective and sustainable change were evident in MPHPs from three local government areas. MPHPs from each site were analysed to assess the extent to which they incorporated each of the eight planning elements that this thesis argues are indicative of an effective MPHP. Plans were categorised into one of three levels of change. Study 2 involved semi-structured in-depth interviews with key stakeholders from each case study site. Participants' views about the factors and processes affecting the successful development and implementation of the MPHPs were explored. The barriers and facilitating factors identified by participants were checked for consistency with the analytical framework for the thesis.

The findings show that the analytical framework for this thesis and criteria for assessing the plans according to a perspective of change provide a useful tool to inform the development of future MPHPs. For MPHPs to be an effective strategy for governments

in achieving improved health outcomes, coordinated action is needed by the state government, local councils and community agencies. Underlying this is the need for clear criteria and definition for what constitutes an effective MPHP that is based on a perspective of achieving sustainable change.

This thesis addresses this gap and provides a tool that can be utilised by state and local governments alike to both review existing plans and inform the development of future plans.

STATEMENT OF AUTHORSHIP

Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis submitted for the award of any other degree or diploma.

No other person's work has been used without due acknowledgement in the main text for this thesis.

This thesis has not been submitted for the award of an degree or diploma in any other tertiary institution.

All research procedures reported in the thesis were approved by the relevant Ethics Committee (Ethics reference number: FHEC07/170).

Date: _____/_____/_____

Candidate's signature: _____

ABBREVIATIONS

CEO	Chief Executive Officer
DHS	Department of Human Services
DoH	Department of Health
FHEC	Faculty Human Ethics Committee
LGA	Local Government Area
MPHP	Municipal Public Health Plan
MSS	Municipal Strategic Statement
PCPs	Primary Care Partnerships
SEIFA	Social and Economic Indexes for Areas
SES	Socio-economic Status

CHAPTER 1 – INTRODUCTION

There is widespread recognition that health improvement requires integrated social and environmental action. More integrated whole-of-government responses across policy domains such as transport, education and recreation are needed. The development of local public health and health promotion planning mechanisms is one approach that has been used for this purpose. This research is concerned with the factors that facilitate and impede the successful development and implementation of local public health plans within the context of municipal public health plans in Victoria. The focus of the thesis is on local rather than state government planning.

Thesis context

Health planning is a form of social action designed to achieve improved health outcomes. Municipal Public Health Plans (MPHPs) are a widely used local public health planning strategy for improving health outcomes, which have been in place in Victoria for over 20 years, thereby providing an important resource from which to learn.

Thesis questions

The research question for this study is:

- Local public health planning as a form of social action: What can be learned from the Victorian experience?

The sub-questions informing the research are as follows:

- Are the key elements of effective and sustainable change evident in local MPHPs?
- What factors and processes affect whether MPHPs include the key elements of an effective plan?
- What are the implications of the findings for local public health planning for health improvement and the future of strategies such as MPHPs?

Local public health planning: The Victorian context (1999–2008)

There are many opportunities for improving health outcomes and equity in Victoria. Obesity, tobacco smoking, poor nutrition and lack of physical activity continue to pose significant public health risks and to contribute to the high rates of preventable death

and disability in Victoria. People living in rural and regional locations and in areas classified as having a low socio-economic status (SES) experience worse health outcomes than those in the rest of Victoria.

Local public health planning provides an avenue for local institutions, organisations and agencies to manage the changes that are required to achieve improved health outcomes, and MPHPs are an important local public health planning strategy in Victoria that state governments have used as a strategy for achieving better local health outcomes for over 20 years. The Labor Government first introduced legislation making it compulsory for local councils to prepare MPHPs in 1988. At that time amendments to the *Health Act 1958* required local councils to identify the public health risks affecting local populations, develop and evaluate programs and strategies to prevent and minimise the identified risks, and prepare MPHPs every three years (DHS, 2001).[1]

The Bracks Labor Government identified improving the health and wellbeing of the Victorian population and redressing inequities between people and 'places' as a major priority following its election to office in 1999 (Department of Premier and Cabinet, 2005). Local public health planning for health promotion and disease prevention was a key mechanism through which the government acted to address these issues.

Following the 1999 election the government established a political regime that more closely aligned with the principles of 'third way' political models rather than the neo-liberal policies of the previous government. There was an emphasis on establishing partnerships between the state, the market and civil society, on building social capital, and on devolving responsibility to the local level. The government identified redressing social and economic inequities and improving the overall health and wellbeing of the Victorian population as priorities for action. Local councils were nominated as partners in this process.

The government enhanced the role and responsibility of local councils in local public health, but changed the focus from environmental health and infectious diseases to an approach that encompassed the wider social and economic conditions affecting local health outcomes (DHS, 2001). It maintained and strengthened MPHPs as a major

[1] The *Health Act 1958* has since been replaced by *The Public Health and Wellbeing Act 2008*. Under this Act, MPHPs are now titled Municipal Public Health and Wellbeing Plans (MPHWPs). Local councils continue to be responsible for preparing these plans, and are required to prepare them every four years rather than every three years as set out in the previous Act. There is provision in the Act for local councils to incorporate the issues to be covered in the MPHWP into the council's strategic or council plans rather than develop a separate plan. *The Public Health and Wellbeing Act 2008* came into effect in 2010, and is outside the scope of this research (DoH, 2009b).

strategy through which local councils were to respond to and manage local problems and conditions affecting health outcomes. Local councils continued to be responsible for the delivery of these plans. According to the guidelines developed for MPHPs, local councils were required to develop an integrated approach in their response to local public health issues in partnership with local agencies, organisations and individuals. This involved implementing actions that targeted the "social, built, economic and natural environments" (DHS, 2001).

The state government implemented a range of strategies to support local councils and local communities through this process, and in delivering MPHPs. In addition to the legislation mandating local councils to deliver MPHPs, and requiring councils to present these plans to the Secretary of the Department, the government published a framework and guidelines for MPHPs. This was informed by a social model of health and focused on strengthening and developing social capital. The government also provided time-limited, best-practice funding grants to a small number of local councils, and allocated state government regional and head office staff to support local councils with the MPHP planning process. Training and professional development programs were offered to council staff and local stakeholders, including elected council officials, and a website and newsletter relevant to MPHPs was established (DoH 2007).

Elements of an effective MPHP

Drawing on the literature reviewed in this thesis and on Swerissen and Crisp's (2004) framework action to achieve improved health outcomes within the context of health promotion requires coordinated social planning to prevent and reduce institutional, organisational and individual risk factors affecting population health outcomes. Local public health planning provides the means through which this can be achieved. It draws on social capital and is the mechanism through which local communities plan for and manage local problems. MPHPs are grounded in that idea.

Using a framework for developing health promotion strategies that lead to sustainable change developed by Swerissen and Crisp (2004), and drawing on the social model of health, previous research into MPHPs and organisational change literature an effective MPHP leads both to sustainable change in local social and environmental conditions that adversely affect health outcomes, and to the establishment of institutional and organisational rules, norms and practices that promote health and support individual change. Action to achieve this level of change requires a coordinated response targeting institutional, organisational and individual actions and the use of institutional

and organisational incentives and sanctions, such as the use of council by-laws, funding and taxation policies and enforcement strategies to encourage and support organisations to comply with new rules, laws and practices that create health-promoting environments.

A MPHP is likely to be effective in achieving this level of change when it is integrated into, and sustained within, a council organisation. Drawing on Swerissen and Crisp's (2004) framework for achieving sustainable change, the social model of health and the literature on achieving sustainable change within the context of health promotion, and effective planning for improved health outcomes, I argue in this thesis that an effective MPHP displays the following key elements:

- Evidence-based conceptual and analytical framework: Priorities for action and selected interventions are developed according to available evidence, including evidence for the effectiveness of interventions and an assessment of the local context and capacity and in collaboration with key stakeholders.
- Organisational integration: The plan implements coordinated action targeting the social built, natural and economic environment for each priority.
- Resources: Resources (funding, timelines, personnel, infrastructure) are aligned to the delivery of each priority.
- Targets and accountability: Specific and measurable targets are set for each priority and progress is reported regularly.
- Intervention level: Interventions target institutional, organisational and individual behavioural actions for each priority.
- Incentives and sanctions: Incentives and sanctions drive the establishment of social and organisational rules, norms, and practices that lead to and sustain individual behaviour change.
- Communication: A strategy to promote and report success, local health issues, and that provides a feedback loop into the planning cycle is described.
- Leadership: Senior and influential decision makers (Chief Executive Officer (CEO), elected officials) are directly accountable for MPHP outcomes.

The MPHP planning process as implemented in Victoria has been the focus of interest by a range of commentators including Bagley, Sainsbury, Wise, Keating, and Roger (2007). In 2006 a government-commissioned report of an evaluation of the MPHP planning process and framework was released (de Leeuw et al., 2006). Research into MPHPs generally supports an approach to achieving health improvement that encompasses disease prevention within the context of the social model of health.

There is an apparent consensus that local councils have a key role to play in ensuring the health and wellbeing of their local communities, and that MPHPs provide one way to achieve a coordinated and integrated local public health response. The theoretical framework underpinning MPHPs is consistent with the evidence for achieving sustainable changes to health outcomes within the context of health promotion and prevention. However the research also finds that the translation of these plans into action is less evident. And whilst local councils provide an active local response to ensuring the health and wellbeing of local populations, this is not always aligned to the MPHP planning process. It is also reported that, while ensuring community involvement in the planning process, the development of MPHPs and the requirement to meet multiple and competing planning requirements and priorities absorbs the majority of council resources allocated to the MPHP, leaving little capacity to do more than merely develop MPHPs (Bagley et al., 2007; de Leeuw et al., 2006).

There is little research that considers MPHPs as a form of social action aimed at achieving better health outcomes or that examines the way MPHPs lead to sustainable institutional, organisational and behavioural change for health improvement. So far, research has not focused on planning as a strategy to achieve social change to bring about better health outcomes, but has instead mainly focused on the process involved in and affecting the development of these plans, and on the way the social model of health is integrated into public health planning by local councils. Another gap in the research is the identification of a set of characteristics of a MPHP that will lead to sustainable health improvement and, which can be used to inform the development of future MPHPs. This thesis seeks to address these gaps.

Methodology

This thesis examines local public health planning as conceptualised by the Bracks Victorian Government following its attaining office in 1999, and as implemented through MPHPs between the years 2003 and 2008. It seeks to address a gap in the research into MPHPs and investigate local public health planning as a form of social action aimed at achieving better health outcomes within the context of MPHPs in Victoria. Based on the evidence reviewed in this thesis and on Swerissen and Crisp's framework I developed an analytical framework that develops and applies an existing framework for reviewing guidelines and plans such as MPHPs. The thesis proposes that eight key elements are required for a health plan to achieve effective and sustainable change and examines whether these elements were evident in local MPHPs and what factors and processes affected whether MPHPs incorporated these

elements. . Drawing on the findings, the implications for local public health planning for health improvement and the future of strategies such as MPHPs are considered.

The research was conducted using case study design. Data was collected from three case study sites in two studies. The first study involved content analysis of the most current (at the time of the study) MPHPs at each case study site. Each plan was analysed to assess the extent to which it incorporated each of the eight planning elements that this thesis argues are indicative of an effective MPHP. On this basis, the plans were categorised into one of three levels of change:

- Level one: change unlikely
- Level two: heading towards change
- Level three: sustainable change.

The second study involved semi-structured interviews with key stakeholders from each case study site. Participants' views were sought about the role and effectiveness of MPHPs in driving local responses to improving community health and wellbeing, and about the factors and processes that contributed to the successful development and implementation of these plans. The participants held senior positions and had responsibility for, or some level of involvement in, the local MPHP. Interviews were conducted with local council employees, CEOs from local community health centres and one local community health peak body, state government regional staff with responsibility for MPHPs in their regions, and elected council officials from each site.

The barriers and facilitating factors identified by participants were checked for consistency with the analytical framework of this thesis. The implications of the findings for local public health planning for health improvement, and for the future of strategies such as MPHPs, are then discussed. Conclusions and recommendations are made about the key elements of planning to achieve change in health outcomes, and about possible action by state and local governments to ensure local public health planning is an effective mechanism for achieving improved population health and wellbeing outcomes in Victoria.

Summary of findings and conclusions

The extent to which MPHPs incorporated the key elements

The study found that while MPHPs provide an important strategy for achieving improved health outcomes in Victoria, their full potential as a form of social action for

managing local problems in ways that will lead to sustainable health improvement has yet to be fully realised.

The results of Study 1 and Study 2 show that the case study MPHPs were unlikely to achieve sustainable change. Rather, the plans were assessed as being either heading toward or unlikely to achieve sustainable change. The analysis found that the three plans examined in this study fully aligned with only one key element: communication. Two plans were assessed as incorporating the majority of elements at a level indicative of a plan that was heading toward change and one plan was assessed as including the majority of elements at a level of a plan not likely lead to change.

This finding accords with the findings of Study 2. Participants expressed diverse views about the extent of the influence of the MPHPs within council and the wider community and about whether the plans would lead to improved health outcomes. Some described the MPHP as an influential plan that informed council's decisions, and others considered MPHPs to be relatively inconsequential, particularly when compared to other plans that councils were required to deliver.

In relation to the impact of MPHPs on health outcomes, most participants were either unsure or did not have a view. One participant, however, described MPHPs as having made little if any impact on population health outcomes since they were first introduced in Victoria over 20 years ago. This is notable given the primary intent of MPHP planning is to ensure better local health and wellbeing outcomes.

Factors affecting the inclusion of the key elements

This research identified a range of factors and processes affecting whether MPHPs incorporated the eight elements of an effective plan and whether they were likely to lead to sustainable change. Factors identified in the research included the level of resources allocated to MPHPs and the capacity of the council organisation and local community to adequately participate in, plan for, and manage local health priorities.

Competing priorities were found to affect the council organisation's capacity to undertake all stages of the planning cycle, as was access to relevant and appropriate data to measure and monitor both health issues and progress. The extent to which the state government and council organisations had established institutional and organisational rules, norms, practices and processes to both support the MPHP planning process and encourage compliance with actions designed to achieve improved health outcomes was also a key factor identified as leading to success. Involvement of influential decision makers and stakeholders in all stages of the

planning process was identified as leading to success. Involvement by influential decision makers in the MPHP affected the extent to which the plan became influential or remained the responsibility of one department. The nature of the problem to be addressed and the level of community and stakeholder support for particular health issue were identified as affecting whether an issue was likely to get funded. And finally whether strategies targeted different aspects of a problem in an integrated and coordinated way and whether different departments in council had responsibility for the plans implementation was important.

The factors identified by key stakeholders as contributing to or impeding the successful delivery of MPHPs were either consistent with or partially aligned with the eight key elements. The major discrepancy between participants' responses and the analytical framework was in relation to targets and leadership. None of the participants talked about specific and measurable targets for MPHP priorities, or referred to senior people such as CEOs being directly accountable for MPHP outcomes (leadership). This is consistent with the findings of Study 1. None of the plans was assessed as including specific or measurable targets or as having senior people accountable for the outcomes of MPHPs.

Participants talked about the contribution evidence made to the plan, but also identified the need to balance the evidence with existing constraints and priorities. The majority agreed that key stakeholder involvement in the plan made a significant contribution to its success. Participants also talked about the benefits of implementing coordinated action that targeted the social, built, natural and economic environments, and of the importance resources made to their capacity to deliver all stages of the MPHP.

Participants also described the plan as being effective when MPHP actions targeted institutional, organisational and individual behavioural actions of society and to the use of incentives such as tying funding to MPHP priorities. Several commented on the importance of reporting different aspects of the MPHP to a wide audience and described this as generating support for the MPHP and for specific priorities for action.

Implications for local health planning and the future of strategies such as the MPHPs

This thesis raises a number of issues about the use of local planning for health improvement and the future of strategies such as the MPHPs. It shows that future local public health planning and strategies such as MPHPs are more likely to be effective as a mechanism for achieving better health outcomes when there is coordinated action by

the three levels of government, business and the community and when there is institutional level action to embed these plans into the organisation and to generate the incentives and sanctions necessary to drive social change.

A critical challenge for state and local governments in the future development of local public health planning for health promotion and for strategies such as MPHPs is to ensure that the focus is on achieving sustainable change to the institutional, organisational and behavioural actions of society that lead to and support environments that promote health and support individual change. This level of action is needed for better health outcomes to be achieved and sustained.

Local councils have a range of institutional incentives available to them for encouraging local institutions and organisations to implement and then comply with new rules, norms and practices that are health promoting. This includes the use of council by-laws, taxation, funding and enforcement policies and strategies. Local councils can also rationalise the number of priorities included in MPHPs as a means of providing a more focused and intense response to health priorities during each year of the plan.

The analytical framework for this thesis posits key planning elements needed to ensure that MPHPs deliver sustainable change. It is consistent with the main tenets of the social model of health, with the framework developed by Swerissen and Crisp (2004) and with the factors identified by study participants as contributing to the successful development and delivery of MPHPs. Too often the focus of health planning is on the development of the plan, or on changing individual attitudes and behaviours in isolation from the social context that governs individual behaviours.

However, local councils operate within the context of state and Commonwealth government constraints as well as local constraints and competing demands. Multiple demands, competing planning requirements and political and economic constraints compete for limited council resources and are reported as impeding the successful delivery of coordinated local responses to achieving improved health outcomes using the MPHPs. Action to ensure local public health plans provide an effective strategy for achieving better health outcomes requires a coordinated response by all three levels of government as well as local organisations and agencies, rather than any one level of government in isolation from the rest. Greater accountability measures for MPHPs could be introduced. These could include CEOs and other senior people being directly accountable for MPHP outcomes, specific targets being tied to each priority and resources being allocated according to MPHP priorities and targets.

For the plans to be effective, the state government needs to rationalise the existing planning context and to better align existing plans and public health responses with the MPHP planning process, and develop indicators for an effective MPHP such as the analytical framework and eight elements of an effective plan set out in this thesis. One way to achieve this is through the *Environments for Health* framework (DHS 2001).

This framework provides the theoretical underpinning for MPHPs. Although it provides a good overview of the social model of health and planning, it provides limited guidance on the type of analysis that ought to be conducted to determine priorities, or strategies for structuring action for particular health issues in ways that will lead to the establishment of social rules, norms and practices that promote health and support individual change. There is limited guidance for local governments on the criteria of an effective MPHP to support the review existing and development of future MPHPs. There is also limited guidance for local governments on what targets to set, strategies to employ or ways to measure outcomes. There is limited resource support or sanctions and incentives for local governments to meet performance targets for their MPHPs. From an institutional analysis there has been limited leverage to establish a clear model that will improve health outcomes and embed these plans within local government. Instead MPHPs provide more of a communication and enabling document, and implementation rests on local advocates.

A better model would be for the state to develop indicators for an effective MPHP, set limits on the focus of MPHPs and establish priorities for action that are linked to overall state and Commonwealth government public health priorities, to allocate funding and resources to MPHPs to address identified health priorities, to set targets for change and to enhance accountability and reporting requirements. This will provide the means through which local councils can monitor existing plans, and will inform the development of future planning.

Structure of the thesis

This thesis consists of seven chapters. Chapter 1 provides the introduction to the study and includes a summary of the research findings and conclusions. Chapter 2 presents an overview of the relevant literature, including trends in Victoria’s population health and wellbeing, explanations of poor health outcomes and inequity, action to achieve sustainable social and organisational change for health promotion, and the role of planning to achieve sustainable change. This is followed by a discussion about the role

of government in improving health, and an overview of MPHPs as implemented in Victoria between 1999 and 2010.

Chapter 3 sets out the analytical framework and research questions investigated in this thesis. The elements of an effective MPHP are also described. The methodology is covered in Chapter 4. The next two chapters cover the study findings for Study 1 (Chapter 5), and Study 2 (Chapter 6). The final chapter, Chapter 7, presents the discussion and conclusion for the thesis.

CHAPTER 2 – LITERATURE REVIEW

Introduction

Municipal public health planning has been an important strategy for improving health in Victoria for over 20 years. Legislation making it compulsory for local councils to develop MPHPs was first introduced by the Victorian Government in 1988 following amendments to the *Health Act 1958* (Bagley et al., 2007). Following its election to office in 1999 the Labor government established a policy agenda aimed at improving population health and wellbeing outcomes and redressing social, economic and health inequities (Blacher, 2005; Department of Premier and Cabinet, 2005).

This chapter starts with an overview of the literature and research concerned with trends in the health and wellbeing of Victoria's population, explanations of poor health outcomes and inequity and the role of social capital in achieving improved health outcomes. This is followed by an overview of the factors and processes that contribute to achieving sustainable social and organisational change that lead to improved health outcomes within the context of health promotion. The role of local public health planning as a form of social action for achieving improved health outcomes, and the factors contributing to effective local public health planning, are then discussed. This is followed by consideration of the role of government in improving health and supporting local jurisdiction's response to local health needs and issues. The chapter concludes with an overview of local public health planning and MPHPs within the Victorian context between1999 and 2008, and a summary of the findings and gaps in the literature that this thesis seeks to address.

Victoria's health and wellbeing

While the health status of Victoria's population continues to improve, the health outcomes and benefits associated with such improvements are not distributed equitably, and there are opportunities for improving both health outcomes and equity (Australian Institute of Health and Welfare 2010; DHS, 2008b, 2008c; 2009; DoH, 2008; Victorian Auditor-General, 2007).

In 2008 approximately 81.5% of Victorians rated their health as being excellent, very good or good (DoH, 2008, p. 3). Between 1996 and 2007 life expectancy at birth for

both males and females increased by up to four years (DoH, 2010). The absolute number of avoidable deaths caused by ischaemic heart disease, lung cancer, colorectal cancer, suicide, breast cancer, stroke and road traffic accidents has declined, with reported rates declining by approximately 17% between 1997 and 2003 (DHS, 2008a). Individual risk factors known to contribute to disease, injury and death such as tobacco smoking were also reported as declining, with the percentage of Victorian adults reporting that they were regular smokers declining from 21.6% in 1999 to 17.3% in 2007 (DHS, 2008b, p. 6).

Despite these reported health gains there are still opportunities for improving health outcomes and equity. Mortality and morbidity rates from preventable diseases, such as diabetes mellitus, cardiovascular disease, and cancer, resulting from physical inactivity, unhealthy eating and tobacco smoking continue to pose major public health concerns (DHS, 2008a, 2008c; Victorian Auditor-General, 2007).

Between 1997 and 2003, 63% of the reported 87,521 deaths of people under the age of 75 in Victoria were identified as being potentially avoidable (DHS, 2008a). Tobacco smoking continues to be the leading cause of illness and death in Victoria, contributing 10% and 6.2% of Victoria's total burden of disease for males and females respectively (DHS, 2008b). Physical inactivity and inadequate fruit and vegetable intake contribute 4.1% and 3.3% respectively to Victoria's total burden of disease (DHS, 2008c, p. 20), and in 2006, 47.8% of adults over 18 years of age were reported as being overweight or obese (DHS, 2008c, p. 81). Following an audit of Victoria's response to the prevention of unhealthy eating, poor nutrition and inadequate physical activity, the Victorian Auditor-General (2007) commented that:

> Over the last 30 years, lifestyle changes in exercise and eating habits have led to more Victorians becoming overweight or obese. Taken together, physical inactivity and unhealthy eating are the most important, preventable causes of chronic disease and their impact is increasing (p. 1).

The evidence also shows that the health outcomes and benefits reported at a population level are not distributed equitably and that there are opportunities for achieving more equitable outcomes (DHS, 2008c, 2009; DHS, 2008a; DoH, 2010). People who are poorer, who live in rural and regional Victoria, and in some particular local government areas and neighbourhoods across Victoria, experience poorer health, lower life expectancy and experience more multiple and complex problems than does the broader population (DHS, 2008a, 2009; DoH, 2010; Klein, 2004; Vinson, 2007).

Between 1997 and 2003 the reported rates of avoidable mortality were significantly higher for people living in rural and regional Victoria than for those living in metropolitan Victoria, and for people living in the most disadvantaged areas of Victoria compared to those living in the least disadvantaged areas of Victoria (DHS, 2008a, pp. xiv, xv, 2008c). For example, life expectancy at birth for people living in rural and regional Victoria is lower than for those living in metropolitan Melbourne (1.9 years less for males, and 0.8 years less for females) (DoH, 2010), and rates of suicide, road traffic accidents, smoking-related cancers, diabetes, stroke and heart disease, asthma, emphysema and chronic bronchitis are higher (Australian Broadcasting Commission, 2007).

At the local government level, a male living in the local government area of Melbourne for the 2003–2007 period could expect to live 7.5 years longer than a male living in the Shire of Loddon (Melbourne 82.8 and Loddon 75.3 years) (DoH, 2010). A female living in the Shire of Glenelg during the same time period had a life expectancy rate 7.3 years lower than a woman living in City of Melbourne (88.9 years compared with the Shire of Glenelg 81.5 years) (DoH, 2010). Differences are also evident at the neighbourhood level with Klein (2004) reporting that people living in public housing estates are "more likely to suffer diseases, accidents and homicides at rates significantly higher than the rest of the state" (p. 110).

Explanations of poor health outcomes and inequity

Social determinants of health

To be effective, action to improve health outcomes needs to be informed by a social model of health. Health promotion efforts need to focus on creating social and environmental conditions that promote health, and on developing and strengthening social capital and civil society. MPHPs were a key element of the government's approach to meet these goals.

The main premise behind the social model of health is that an individual's health is influenced by conditions in the social, environmental, political, economic and built environments, as well as individual behaviour, lifestyle and biology (Commission on Social Determinants of Health, 2005). These conditions vary across geographical locations. The World Health Organization's (WHO) Commission on Social Determinants of Health states that: "The social conditions in which people live … are important determinants of most of disease, death, and health inequalities between and within countries" (Secretariat on Social Determinants of Health, 2004, p. 1).

According to WHO, the major determinants of health are: poverty; relative wealth; social exclusion and levels of social support; unemployment and workplace conditions; illicit drug use, tobacco smoking and alcohol dependence; access to healthy food and healthy transport; and the quality and experience of the early years (Wilkinson & Marmot, 2003).

According to the social model of health, the wider social and environmental context create environments that are either health promoting or damaging (Berkman & Kawachi, 2000; Wilkinson & Marmot, 2003). As the previous section on the health and wellbeing of the Victorian population has underlined, people who are poorer and who live in areas classified with a low social and economic status experience reduced health outcomes compared with those living in areas classified with a higher socioeconomic status (DHS, 2009).

This geographic impact on health is largely explained by the differences in material and social conditions between geographic areas. These include employment, income, and social relationships (Atkinson & Kintrea, 2001; Subramanian, Lochner, & Kawachi, 2003; Vinson, 1999; Vinson & Baldry, 1999). Proponents of a materialist explanation for the social model of health argue that access and exposure to the social and environmental conditions within which people function helps shape behaviour and influence health. For instance, people who live in areas with high levels of pollution, unsafe streets, inadequate or unsafe areas of open space, and high levels of crime are exposed to conditions that do not encourage or support healthy activity and that have an adverse effect on health. Alternatively people who live in areas characterised by safe streets and parks, adequate and safe housing, and a range of recreation, employment and education opportunities are exposed to and have access to environments that promote health and encourage and support healthy behaviours (Li, Mattes, Stanley, McMurray & Hertzman, 2009; Macintyre, Ellaway, & Cummins, 2002; Marmot & Wilkinson, 1999; Moore & Dietze, 2005).

In a study that examined the relationship between individual behaviour (namely the take-up of health promotion messages) and the type and quality of "local opportunity structures" in two socially and economically contrasting geographical locations in the United Kingdom, Macintyre and Ellaway (1999) found that an individual's capacity to engage in healthy behaviours and make healthy decisions, regardless of personal characteristics, was influenced by the "physical features of the neighbourhood". These included the "… availability of healthy environments; the provision of public and private services; the socio cultural features of an area; and area reputation" (p. 165). The

authors referred to these conditions as “local opportunity structures”. They found that “local opportunity structures” varied according to geographical location, and that lower socioeconomic status (SES) areas had fewer health-promoting local opportunities than higher SES areas. Specifically, nutritious food was more expensive, there were fewer recreation facilities and public transport options, and there were higher levels of reported crime (p. 165).

The materialist explanation of the social model of health is complemented by proponents of the psychosocial view of health. According to this view, the relative differences in socioeconomic status, the gap between rich and poor, and the perceptions that people hold about their relative position in society – these all lead to physiological responses, including stress, insecurity, and anxiety. These factors can also lead to harmful behaviours such as tobacco smoking (Li et al., 2009; Wilkinson & Marmot, 2003). As Wilkinson and Marmot (2003, p. 9) conclude: “it is not simply that poor material circumstances are harmful to health: the social meaning of being poor, unemployed, socially excluded, or otherwise stigmatized also matters”.

Underpinning the social model of health: Social capital

An important theoretical concept underpinning the development of the social model of health is that of social capital (Baum, 1997; Putnam, 1993, 2000; Szreter & Woolcock, 2004). Social capital is critical to health promotion because it creates the conditions for promoting and sustaining health-promoting behaviours. An important element of a social model of health is the idea that social capital has to be developed and strengthened (Australian Bureau of Statistics, August 2002; Baum, 1997; Berkman & Kawachi, 2000; Bush & Baum, 2001; Cox, 1995; Putnam, 2000).

Putnam (2000) defines social capital as the “connections among individual social networks and the norms of reciprocity and trustworthiness that arise from them” (p. 19). Others describe social capital as a socially constructed concept that exists within the context of ‘place’, or community, rather than being an attribute of the individual, as described by Putnam (Kawachi & Berkman, 2000, p. 174; Subramanian et al., 2003, p. 304). People living in areas characterised by high levels of social capital experience better health outcomes than people living in areas with low levels of social capital, regardless of individual characteristics (Baum, Ziersch, Zhang, & Osborne, 2009; Commission on Social Determinants of Health, 2008; Kawachi & Berkman, 2000; Subramanian et al., 2003; Vinson, 1999, 2007) and are more likely to act in response to local needs and issues (Baum et al., 2009; Kawachi & Berkman, 2000; Pridmore, Thomas, Havemann, Sapag, & Wood, 2007; Putnam, 1993).

According to Kawachi and Berkman (2000, p. 176) "… social capital should be properly considered a feature of the collective (neighborhood, community, society) to which the individual belongs", and whilst an individual may be socially connected and have "lots of friends", their health status depends "… on whether he or she resides in an environment that is rich or poor in social capital" (p. 177). Subramanian, Lochner, and Kawachi (2003) point out that while social capital is described as a collective characteristic, it is often measured by aggregating individual data to a spatial scale. They argue, however, that levels of social capital are influenced by the characteristics of a geographical location as well as individual risk factors and behaviours. According to the authors: 'neighbourhood differences in social capital can arise either because of differences in personal characteristics and/or because there is something inherently different about the neighbourhoods themselves' (Subramanian et al., 2003, p. 35).

Commentators, including Szreter and Woolcock (2004), Wakefield and Poland (2005), Putnam (2000), Pridmore, Thomas, Havemann, Sapah, and Wood (2007), and Fukuyama (2001), describe different types of social capital and suggest that not all forms of social capital are beneficial. In a review of social capital and its role in health promotion, Wakefield and Poland point out that some forms of social capital can lead to groups and individuals being excluded or marginalised, especially if they do not belong to a particular group, or if they fail to comply with or share a group's rules, values or norms. They go on to highlight that undesirable rules and norms may also be established and reinforced through the agency of social capital. They also warn that social capital alone will not redress inequities, or improve health outcomes. Wakefield and Poland conclude, however, that the positive benefits of social capital outweigh the potential costs.

How social capital leads to improved health outcomes

Putnam (2000), Vinson (2007) and Kawachi and Berkman (2000) argue that strong social connections and high levels of social capital act to intervene in and modify factors that impact negatively on health. Social capital for health promotion is produced through a series of local organisational and institutional arrangements, including families, local clubs and organisations and churches (Fukuyama, 2001; Nutbeam, 1997; OECD, 2001; Putnam, 1993, 2000). According to the OECD's *Wellbeing of Nations Report*, the main sources of social capital are: " (i) the family; (ii) schools; (iii) local communities; (iv) firms; (v) civil society; (vi) public sector; (vii) gender; and (viii) ethnicity" (OECD, 2001, p. 45). Fukuyama (2001) argues that educational institutions and, in some countries, families are important institutions in generating social capital. However, this is less the case in Western countries where there is an

emphasis on the development of social capital through voluntary groups and organisations beyond the family (Kemenade, 2003).

These local forms of organisation are also referred to as 'civil society' (Baum et al., 2009; Cox, 1995) and according to Baum (1997) are "… generally accepted to be those areas of society which are not directly part of either market or formal state activity" (p. 673). People participate to address important collective social needs, and in doing so work together for the benefit of the community rather than for market exchange (Kawachi & Berkman, 2000; Kemenade, 2003).

According to Bush and Baum (2001) participation by individuals in local groups and organisations is beneficial because: "activities … may in themselves be health promoting" (p. 202). Groups "bring people together and contribute to building networks and trust, the components of social capital … [and] may support health services functions" (p. 202). Participation in the articulation and development of local responses to local issues, including local health needs, is in turn reported as being beneficial to health and wellbeing outcomes (Baum, 2002; Marmot & Wilkinson, 1999; Putnam, 1993, 2000; Vinson, 1999, 2007; Wakefield & Poland, 2005). In this sense, communities with more social capital have stronger forms of social organisation in these local clubs and organisations through which to act in response to local needs and issues.

Local organisations and institutions generally operate according to established rules, values, norms and practices regarding issues such as membership, the allocation of resources, and codes of behaviour. These rules, norms, values and practices may be health promoting or compromising and are able to influence individual attitudes and behaviours. In this way, the local institutions and organisations of society "set the rules of the game" (OECD, 2001, p. 13), firstly between individuals within the group context and secondly within wider society, in what Fukuyama refers to as a "radius of trust" (Fukuyama, 2001, p. 8).

The local institutions and organisations of society, therefore, provide an important intervention point for health promotion and disease prevention activities. These local organisations provide the means to build social capital and to establish and reinforce health-promoting organisational and social rules, norms and practices (Kawachi & Berkman, 2000, p. 184), disseminate health information, and provide opportunities for individuals and local communities to participate in a range of health-promoting activities, in response to local needs.

Social capital and geographical location

Geographical location is important because the state, markets and civil society interact locally to create social norms, rules, contexts and conditions that help shape health outcomes. It is where the attributes associated with social capital and civil society – such as trust, respect, social cohesion and community engagement – interact. Ideally it is where community wellbeing, community strength and strong civil society develop.

Action that facilitates and supports local groups and organisations to act in response to local social needs and issues will lead to stronger communities better able to manage local problems. It will also lead to the establishment of health-promoting social rules, norms, values and practices, which will in turn lead to the creation of health-promoting environments that support sustainable changes to individual attitudes and behaviours. The state has a key role in facilitating and supporting local groups and organisations with this process.

Planning and social capital

Planning is a strategy institutions and organisations use to bring about change. Local planning is a strategy for changing local institutional and organisational norms, rules, the allocation of resources and so on to bring about changes in social processes and behaviour. Local public health planning within the context of health promotion and prevention draws on the concept of social capital. It provides a means of strengthening local communities in managing local problems and developing responses that lead to the prevention of problems from occurring in the first place rather than focusing on the provision of additional health services in response to already existing conditions. MPHPs are a form of local public health planning and are grounded within the context of social capital.

Individual determinants of health

In contrast to the social model of health, the individual view of health "holds individuals totally responsible for their actions and the consequences, including health" (Baum, 2002, p. 64). According to this view, poor health outcomes result from individual characteristics, behaviours and lifestyle choices (Shaw, Dorling, David, & Davey Smith, 2000). Action to improve health outcomes according to this view is geared toward achieving changes in individual behaviour by targeting individual risk factors, attitudes, and behaviours in isolation from the wider social and environmental context (Baum, 2002).

However, there is evidence that action to achieve improved health outcomes and to redress inequities based solely on individual lifestyle and behaviour change in isolation from the wider social and economic context are a less effective means of achieving long-term health improvement (Graham, 2000; Li et al. 2009; Marmot & Wilkinson, 1999; Moore & Dietze, 2005; Nutbeam, 1997; Swerissen & Crisp, 2004; Szreter & Woolcock, 2004; Wilkinson & Marmot, 2003). According to Marmot and Wilkinson (1999), individual risk factors account for "only a part of variations in the occurrence of disease" (p. 4). Approaches to health improvement that are based solely on addressing individual risk factors and on "trying to persuade individuals to change their behaviour" (p. 4) have therefore had limited success in achieving sustained change.

The relationship between the wider social and economic context, individual behaviour and health-related outcomes is illustrated in the study by Macintyre, Ellaway and Cummins (2002), as outlined above, and by Moore and Dietze (2005), who examined the factors influencing whether street-based injecting drug users responded to health promotion messages. In their study, Moore and Dietze found that while participants were aware of the factors and conditions that contributed to the risk of overdose and other drug-related harms, and while they knew what to do to minimise those risks, the majority continued to use drugs in ways that put their health at risk. The study found that conditions in the social, economic and poltical environment (over which the individual had little control) influenced individual decisions and capacity to implement health promotion messages. This is consistent with Shaw, Dorling and Davey Smith (1999, p. 216), who comment that behaviours that contribute to poor health outcomes "… need to be understood in the context of the constraints on everyday life which accompany them".

The social model of health does not exclude individual factors, rather it positions the individual in the wider social and economic context within which decisions are made and actions considered. As such the individual should be considered within rather than in isolation from the broader social context. For this reason, to improve health outcomes, action is needed that, while addressing individual risk factors, also focuses on conditions in the wider social, economic, political, legislative, environmental and built environments, and that leads to the establishment and reinforcement of health-promoting social and environmental conditions, and institutional and organisational rules, norms and practices that lead to and support individual change.

Achieving sustainable social and organisational change for health promotion

Achieving sustainable local health improvement depends on building sustainable action through the organisations of civil society (schools, chambers of commerce, sporting clubs, churches and so on). Changes to the values, rules, norms and practices of these organisations need to lead to and sustain behaviour change. Planning provides the means through which institutions and organisations manage this process.

Achieving and maintaining fundamental institutional and organisational change is reported as being complex, time and resource intensive, and difficult to achieve and sustain (Kanter, Stein, & Jick, 1992; Kotter, 1995, 2009; National Primary Care Research and Development Centre, 2000; OECD, 2001; Shediac-Rizkallah & Bone, 1998; Swerissen & Crisp, 2004). As Eagar, Garrett and Lin (2001, p. 252) conclude, “a challenge for health promotion programs is to achieve sustained effect, particularly a change in health outcomes or risk factors”.

Recent research into and evaluations of organisational change processes within the health promotion and business sector by Kotter (1995, 2009), Shediac-Rizkallah and Bone (1998), the Australian Institute for Primary Care (2003, 2005) and the National Primary Care Research and Development Centre (2000) show that the rate and pace at which organisations adapt to change varies between different agencies. They also show that efforts to achieve fundamental organisational change are affected by a range of interacting factors and processes rather than any one factor in isolation.

According to Shediac-Rizkallah and Bone (1998), Kotter (1995, 2009), Duck (1998), and Eagar et al. (2001), organisational change processes are influenced by multiple and interconnected factors and processes that act and interact in ways that create the conditions that either support or impede an organisation’s ability to implement and then sustain change.

Characteristics of programs achieving sustainable change

In a review of health promotion programs, Shediac-Rizkallah and Bone (1998) found that programs that had achieved sustainable change were influenced by (a) project design and implementation factors, (b) factors within the organizational setting, and (c) factors in the broader community (p. 87). According to the authors health promotion programs that achieved sustainable change were characterised by multiple factors including: the provision of adequate resources to develop, implement and then maintain programs; timelines to allow change at the institutional level to be affected;

the capacity of local organisations to respond and then maintain the desired change; involvement by influential leaders and key stakeholders in all stages of a program; communicating a program's achievements; and consistency between the new program and existing priorities (Shediac-Rizkallah & Bone, 1998)

Kotter (1995, 2009) identified a range of factors similar to those put forward by Shediac-Rizkallah and Bone (1998), including the provision of adequate resources; key stakeholder support for and involvement in the change process, planning for the change process prior to its implementation, and preparing the organisation for the change (Kotter, 1995, 2009; Kotter & Schlesinger, 2009). As Kotter (1995, p. 67) observes:

> change sticks when it becomes "the way we do things around here," when it seeps into the bloodstream of the corporate body. Until new behaviours are rooted in social norms and shared values, they are subject to degradation as soon as the pressure for change is removed.

According to Kotter (1995) organisational change efforts fail as a result of a lack of vision for the intended change, failure to acknowledge and reward short- and long-term progress, a loss of momentum and "organisational drift" away from the change.

Kotter (1995) identified eight steps that he argued, when implemented sequentially, would result in the successful implementation and maintenance of sustainable organisational change. These are as follows:

- Establishing a sense of urgency
- Forming a powerful guiding coalition
- Creating a vision
- Communicating the vision
- Empowering others to act on the vision
- Planning for and creating short-term wins
- Consolidating improvements and producing still more change
- Institutionalizing new approaches (Kotter 1995, p. 61).

According to Kotter (1995), each step relates to different stages of the change process. The first four steps related to actions prior to the change process. Steps five to seven relate to the implementation stage, while the last step involves actions to embed and sustain the change within the culture of the organisation.

The role of local health planning

Planning is a strategy institutions and organisations use to manage and change social processes and develop and implement coordinated and integrated action such as that espoused by Kotter (1995) and Shediac-Rizkallah and Bone (1998). Health planning is pivotal in determining priorities for action that can lead to improved health and through which local communities can respond to the health issues that affect them

In a review of the literature on program planning for health promotion, Eagar et al. (2001) argue that: “The overall aim of program planning is to achieve a change in the health of the target group” (p. 242). Local public health planning provides the mechanism through which local responses can be managed and health improvement achieved.

Local public health planning provides the means to coordinate the actions of the state, civil society and the markets in responding to local health needs and issues, and to manage the change process involved in the creation of local social and environmental conditions that promote health to achieve improved health outcomes.

Local public health planning is a strategy for strengthening local communities so that they can manage their problems effectively by changing the social and material conditions that effect health rather than by providing additional health services. MPHPs are a form of local public health planning used by government as a strategy for building social capital and managing local problems to achieve health improvement.

To be successful, local public health planning for health promotion has to focus on achieving sustainable change, specifically changes to the social and organisational rules, norms, values and practices that lead to the development of health-promoting environments that support healthy behaviours rather than on the provision of more services. In essence local public health planning provides the means to plan the action required to achieve this level of change.

In a review of planning for sustainability in health promotion programs, Shediac-Rizkallah and Bone (1998) argue that planning for sustainability:

> requires, first, a clear understanding of the concept of sustainability and operational indicators that may be used in monitoring sustainability over time … and the use of programmatic approaches and strategies that favour long-term program maintenance (p. 87).

The authors argue that “modifications in populations’ health habits are only slowly achieved through education and social change, hence the need for an environment in which change is supported and reinforced” (p. 93). The authors identified three measures of sustainability: “(1) maintenance of health benefits achieved through an initial program, (2) level of institutionalization of programs within an organization and (3) measures of capacity building in the recipient community” (p. 87). Swerissen (2007) in writing on planning for sustainability in health promotion describes indicators of success as being: health benefits are achieved and maintained over time; the benefits outweigh the costs; and the physical and social rules, norms and risks that impact on health are modified and healthy social norms and rules and practices are established and maintained (Swerissen, 2007).

Factors underpinning successful planning for health promotion

A successful health promotion plan is one that will lead to sustained health improvement. The literature suggests a range of factors that contribute to an effective plan.

Planning for the change process

Shediac-Rizkallah and Bone (1998) argue that successful health promotion planning occurs on two levels – firstly planning for the change process to establish the environ–ment and conditions to achieve the desired change; and secondly planning the type of interventions in response to specific health priorities. According to Duck (1998, p. 81) preparation is needed “to … prepare the organization to think, feel and act differently”. This is consistent with Kotter’s (1995) eight-stage process described previously.

The literature describes plans and the planning process as comprising a number of key components. According to Eagar et al. (2001) health planning is a “technical process” that involves a range of actions, including the “assessment of need*;* the identification of the target*s,* program goals, objectives, strategies and actions; implementation and evaluation” (p. 243). Consistent with Kotter’s (1995) eight steps for achieving sustainable organisational change, Swerissen (2007, p. 6) describes rational health planning models as comprising seven interconnected steps:

- Definition and assessment of problems, needs and demands;
- Analysis of the causal contingencies for need and demand;
- Establishment of goals and objectives for addressing need and demand;
- Design and implementation of strategies for achieving goals and objectives based on the analysis of causal contingencies;
- Allocation of resources to deliver the agreed strategies and activities;

- Monitoring and evaluation of performance.

Specifying the change to be achieved and actions to achieve this change

One of the key elements of an effective plan is that the type and level of change to be achieved is specified and the actions to achieve that level of change are identified (Eagar et al. 2001; Kalucy (2008); Swerissen (2007). According to Swerissen and Crisp (2004) this includes action that leads to change within the different levels of society.

Coordinated action by different levels of society

Action to achieve sustained change requires coordinated action by different levels of society (National Preventative Health Taskforce, 2009; Swerissen & Crisp, 2004). According to Swerissen and Crisp (2004) this involves action by the institutions and organisations of society, as well as by the individual.

Swerissen and Crisp (2004) argue that health promotion efforts for health improvement ultimately require individual behaviour change but that such change has to be understood within an institutional and organisational context. Consistent with the main tenets of the social model of health, the authors argue that attitudes and behaviours are shaped by, and occur within, the wider social and environmental context. Action to achieve sustainable individual change relies on the implementation of a coordinated and integrated response involving the state, civil society and markets to create the conditions that facilitate and support individual change. This includes the establishment of health-promoting organisational and institutional norms, rules, and practices, rather than action targeting the individual in isolation from the rest of society. Swerissen and Crisp describe four levels of society: the institutions; organisations; community partnerships; and the individual. The authors argue that each level acts and interacts to create the conditions and environments that ultimately influence and shape individual attitudes and behaviours, and that each level of society needs to act to ensure the establishment of healthy environments.

Planning to achieve improved health outcomes within the context of health promotion therefore needs to focus on actions that lead to the establishment of health-promoting institutional and organisational rules, norms and practices that support health-promoting attitudes and behaviours.

Swerissen and Crisp (2004) argue further that incentives that reward compliance and success and sanction non-compliance provide important levers to encourage and drive change at this level. Incentives and sanctions include the use of legislation, regulation, enforcement, funding, awards and penalties for non-compliance. More sustained use of

organisational and institutional incentives would include extensive changes to council by-laws and funding and taxing policies to address particular issues.

According to Swerissen and Crisp (2004) health promotion interventions are more likely to be successful in securing long-term change when programs: intervene at a systems level and are designed according to the health problem to be tackled; are geared toward achieving desired outcomes and effects which have been identified to be achieved; and are evidence based, relevant and appropriate to the level/s of society targeted for change (Swerissen & Crisp, 2004).

Balancing the evidence with local capacity and the wider political context

Swerissen and Crisp (2004) argue that effective health promotion responses are those in which there are logical links between the resources allocated to address a problem and the problem to be addressed, the interventions selected to address the problem and the evidence for success. According to Swerissen (2007) a health promotion plan is more likely to incorporate effective and relevant strategies to affect change when it is underpinned by a "sound logic" that is evidenced based and that "link[s] inputs, strategies, outputs and outcomes to solve health problems" (p. 6).

According to Swerissen and Crisp (2004), health promotion plans and programs fail when there is a mismatch between the desired outcome, the evidence about what action is needed for change, the selected intervention and the available resources. Plans and programs can also fail when one level of society is targeted for change in isolation from the rest of the system, for example when individual behaviour is targeted in isolation from action at an institutional and organisational level (Swerissen & Crisp, 2004). There are, however, limitations to the more rational approach as described by Swerissen and Crisp.

In the context of health promotion, the rational approach to planning is based on the view that successful planning depends on assessing and applying the available evidence. This includes an analysis of social and environmental conditions that cause poor health outcomes, and an assessment of the evidence to determine that the proposed actions and the allocated resources and inputs are adequate, correctly targeted and will achieve the specified outputs, outcomes and targets. Owen (1993, p. 3) describes planning as a process that "assumes that rational processes can be used to nominate resources and define appropriate future action which will promote desired outcomes" and that local agencies have the capacity, the means and the evidence to identify and implement the desired "end". Owen argues, however, that this is not always the case.

According to Eagar et al. (2001) the evidence of cause and effect and likely effectiveness of specific interventions is not always available. Kalucy (2008) highlights the difficulty in attributing cause and effect to more complex problems with multiple variables. While Aspin et al. (2010) argue that there is a gap in available evidence to support the delivery of effective responses to chronic disease conditions in part due to methodological constraints in investigating the wide range of interacting factors that contribute to disease (p. 390). Kalucy observes further that the way in which research is translated and disseminated to practitioners affects its application. According to Kalucy research is more likely to inform practice when it is disseminated in a way that is relevant, "timely and appropriate" to practitioners.

These factors can limit the extent to which plans can be developed according to a rational, evidence-based approach. However, as Eagar et al. (2001) argue:

> it is not necessary (even were it possible) to understand causal mechanisms fully in order to undertake prevention. The knowledge of small components in the web of causation can significantly contribute to prevention … (p. 22).

Organisations and local communities are also characterised by differences in existing capacity and programs, competing priorities, as well as diverse and potentially conflicting interests and needs. Moreover, these organisations sit within and are influenced by a wider economic and political environment (Baum, 2002; Eagar et al., 2001; Green, 1999; Moore & Dietze, 2005). Effective planning must take into account these constraints. Green (1999) argues that plans fail when they are "implemented but fail to respond adequately to the real needs of the population" (Green, 1999, p. 16). Green and Kreuter (1991) describe health plans and programs as failing when the "real need" is not accurately addressed. This can stem from inaccurate assessment of health needs and issues and their causal factors, and from interventions that are developed based on incorrect assumptions (Green & Kreuter, 1991).

Commentators, including Eagar et al. (2001) and Moore and Dietze (2005), point out that decisions to implement particular interventions for health promotion programs are often made based on a range of considerations other than evidence or logic. This can include resource availability, the extent to which an organisation has the capacity to act, competing priorities and opportunities as well as political expediency, economic considerations and political ideology (Aspin et al., 2010; Eagar et al., 2001; Kalucy 2008; Moore & Dietze, 2005; Yeatman, 2008).

In a review of policy responses to rising rates of chronic illness in Australia and New Zealand, Aspin et al. (2010) describe a system that is characterised by a "complex interplay" of commonwealth, state and local government "funding, policy and service delivery" requirements (p. 389) that limit the successful coordination, delivery and management of chronic disease programs and prevention activities particularly at the local level.

As Eagar et al. observe, "[while] planning may have elements of a rational, sequential process, in practice it is subject to political, social, cultural and economic factors which render implementation unpredictable" (2001, p. 347).

According to Eagar et al. (2001), Baum (2002), and Moore and Dietze (2005), health promotion action and public health planning is basically a political exercise. Decisions are made, resources are allocated and choices are selected within an environment characterised by competing priorities, limited resources, political ideologies, political expediency and economic constraints – in addition to the empirical evidence (Baum, 2002; Eagar et al., 2001; Moore & Dietze, 2005). As Yeatman (2008) points out the extent to which local governments can "take independent action is constrained and directed by state governments" (p. 1399).

Accordingly public health planning sits within, and is influenced by, the local environment and, as Eagar et al. (2001), Baum (2002), Moore and Dietze (2005), Aspin et al. (2010), Yeatman (2008) and Green (1999) describe, the wider political and economic context. Eagar et al. (2001, p. 9) argue therefore that: "Understanding power structures and historical constraints, alongside the technical analysis and recognition of opportunities for action, is central to successful planning". Therefore to achieve sustainable change, health planning needs to take into account – in addition to the evidence base – existing political, economic, social, cultural and organisational contexts, including local capacity, constraints, commitments and the likelihood of change.

This is consistent with an evaluation into the implementation of primary care trusts in the United Kingdom, which found that success depended on strategies being developed based on a robust evidence base, a focus on a theory of change, and the development of organisational systems, capacity, and infrastructure to implement the changes (National Primary Care Research and Development Centre, 2000). The evaluation also identified the need for clear and agreed objectives, and a shared vision that was meaningful to key stakeholders from different groups and agencies.

Key stakeholder support

Involvement in and support for the change process by key stakeholders is identified in the literature as a key factor in successful organisational change programs and planning processes. Aspin et al. (2010) argue that a collaborative response by key stakeholders from across disciplines is instrumental to the development of effective action to redress the "rising rates of multi-morbid chronic illness in Australia" (p. 390). According to the Victorian Quality Council (2009) people are "the most critical resource, supporter and barrier and risk when managing change" (p. 148). This is consistent with findings of the evaluations of the Primary Care Partnerships in Australia, and the Primary Care Groups and Trusts in the United Kingdom. Both reports found that involvement and support by a range of organisations and agencies were key factors to successful change (Australian Institute for Primary Care, 2005; National Primary Care Research and Development Centre, 2000).

According to Shediac-Rizkallah and Bone (1998, p. 103), "lasting widespread change is more likely to occur if a broad range of health professionals, health institutions, community groups and private citizens" work collaboratively to address both individual risk factors and the conditions that influence these behaviours.

Kotter (1995) argues that key stakeholder support is important to build the support and motivation needed to implement then maintain change. According to Kotter, failing to secure key stakeholder support for the change process results in "organisational drift" away from the change process and reduces the likelihood of change being implemented and then maintained. However, Kotter (1995) also argues that incentives are needed to "to drive people out of their comfort zones", "to comply with the change and which make "maintaining the 'status quo" the least attractive option (Kotter, 1995, p. 60).

Change champion

Having an influential leader or "change champion" in senior and influential positions is reported by commentators, including Kotter (2009), Shediac-Rizkallah and Bone (1998), Swerissen (2007) and Duck (1998), as being key to achieving sustainable change. According to Eagar et al. (2001) leadership is "the ability to influence people toward the attainment of goals" (p. 350). As Kotter (1995) concludes: "Change by definition, requires creating a new system, which in turn always demands leadership" (p. 60).

Similarly, the Australian Institute for Primary Care in its evaluation of Primary Care Partnerships found that the successful implementation of the partnerships relied on the

level and type of "leadership, vision, and commitment agencies bring" (Australian Institute for Primary Care, 2005, p. 5). As Kotter (1995) observes, "No matter how capable or dedicated the staff head, groups without strong line leadership never achieve the power that is required" (Kotter, 1995, p. 62).

According to the Australian Institute for Primary Care's 2003 evaluation report, a "poor understanding OR continued resistance to the Strategy, attitude of senior managers … [and] hostile, dominant stakeholders …" acted as major barriers to the success of these programs (Australian Institute for Primary Care, 2003, p. 57), whilst involvement by "a core group of committed senior managers/leaders" was identified as a significant facilitating factor (p. 57). Similarly Yeatman (2008), in a study into levels of activity by Australian local governments in food and nutrition priorities, found that the level of support generated by general managers and staff for food and nutrition as a priority correlated with the level of activity within particular local councils. The higher the level of support the higher the level of activity.

Resources and capacity

The research repeatedly shows that adequate resources and the capacity of the "host agency" to "deliver the desired change" (National Primary Care Research and Development Centre, 2000, p. 61) are key factors in the successful development, implementation and institutionalisation of organisational change. This includes the level of resources and capacity to develop, implement and institutionalise "new rules of the game" and in the process secure and manage key stakeholders (Duck, 1998; Eagar et al., 2001; Kotter, 1995, 2009; Kotter & Schlesinger, 2009; Shediac-Rizkallah & Bone, 1998; Swerissen, 2007; Swerissen & Crisp, 2004; Yeatman, 2008). As Yeatman (2008) found, the level of involvement in food and nutrition activities by local councils varied according to the level of resources and support provided by state and local government.

Eagar et al. (2001) observe that health promotion programs struggle to achieve long-term change because of a lack of ownership by key stakeholders, a lack of capacity to secure ongoing funding over the long term, and the implementation of "small scale programs" (p. 252).

The role of government in improving health

The welfare state and neoliberalism

The state has a key role to play in ensuring the health and wellbeing of the overall population through supporting and facilitating the development of health-promoting

environments and by supporting and facilitating local organisations and institutions to establish and reinforce health-promoting norms, rules and practices that lead to healthy behaviours. As the WHO's Commission on Social Determinants of Health (2008) states:

> The conditions in which people live and die are, in turn, shaped by political, social, and economic forces.
>
> Social and economic policies have a determining impact on whether a child can grow and develop to its full potential and live a flourishing life, or whether its life will be blighted (Commission on Social Determinants of Health, 2008, Introduction).

As argued previously and as stated by the OECD (2001), social capital is critical to health and wellbeing and is produced through local organisations and institutions (p. 65). The OECD, in its report on social and human capital, argues that the state has a key role to play in facilitating and supporting the development of social capital rather than attempting to create it. This approach is consistent with the views of Kawachi and Berkman (2000), who argue that the state has a key role in "identifying emerging forms of social capital" (p. 188), and in facilitating and supporting the organisations, institutions and "associations that foster social capital, such as neighbourhood associations, cooperative childcare, and youth organizations" (p. 188). Planning is a key strategy for the state and provides a means through which it can act to support local institutions and organisations act in responding to local needs and issues that lead to improved health outcomes.

As Giddens (1998) comments, a shift in power and funding from central government to the level of government closest to the community is needed to ensure that local processes and the organisations responsible for planning, developing and implementing local responses to locally identified problems have the mandate, capacity and influence necessary to act. If undertaken in isolation from the wider social and political context and without the support, resources and mandate necessary to facilitate and ensure change, local responses will be limited in the extent to which they can achieve and sustain change.

However, the policies of the traditional welfare state – with its emphasis on a strong central government, service provision and redistribution of wealth – and the neoliberal focus on market strategies, individual choice and user-pays policies, both act to

undermine organisations and their social capital (Fukuyama, 2001; Green, 1999; OECD, 2001).

In traditional welfare models the state has a role in addressing the same social needs as the organisations and institutions of civil society (for example, the child care, schooling, and sporting activities provided for children). According to Fukuyama (2001) the welfare state encourages local organisations and institutions to rely on the state to respond to local needs and issues. As Fukuyama highlights:

> The ability to co-operate is based on habit and practice; if the state gets into the business of organising everything, people will become dependent on it and lose their spontaneous ability to work with one another" (2001, p. 18).

The policies inherent in neoliberal ideologies and their focus on market forces in isolation from community and government action are also limited (Green, 1999). According to Green (1999), the market system fails to meet the conditions necessary to build civil society and social capital and to ensure the health and wellbeing of the population. Green argues that the conditions necessary for the free market to provide an equitable and effective health system, including the appropriate level of knowledge and information and the ability for individuals to pay the costs of health care services, are limited. Furthermore, the market system "discriminates according to ability to pay" (Green, 1999, p. 10).

Consequently, an alternative "third way" approach to the traditional welfare state and neoliberal market system that focuses on developing and strengthening the local institutional and organisations of a civil society is needed.

The third way and the role of local government

A central focus of third way models is the establishment of coordinated action involving the state, civil society and the market rather than having any one element working in isolation. As a part of this, there is an additional focus on strengthening local communities so that they can effectively identify and manage local problems. According to Giddens's (1998) third way model of politics, the state "act[s] in partnership with agencies in civil society to foster community renewal and development" (p. 69) and to facilitate and support local communities determine local responses to local need. In the case of health promotion and health improvement, this includes managing local issues concerning the local social and environmental conditions identified as having an adverse effect on the health and wellbeing of local communities. It also includes focusing on changing systems so that problems can be

prevented, and health-promoting environments created that can support and reinforce healthy attitudes and behaviours rather than simply providing additional services that respond to existing conditions and problems. According to third way models, local residents should work in partnership with the state, local government, business and local institutions to identify, advocate for, plan and then implement responses to locally defined issues.

A key feature of third way models of politics is "subsidiarity", which is the devolution of power to the level of government closest to the community best able to respond to and manage local problems. As the third tier of government and the level of government closest to the community, local government has a major role to play in improving local health and wellbeing outcomes, in developing social capital, in engaging local communities in determining local action and in supporting and facilitating local institutions and organisations to establish and reinforce health-promoting conditions and environments. Planning is a key mechanism through which local councils act to manage this change process. In theory local government is a key mediator and facilitator of social capital. As the level of government closest to the community, local councils have responsibility for strengthening local organisations and institutions (Giddens, 1998) and for "[increasing] their stocks of social capital" (Butler, 2005, p. 5). In 2008 the Victorian Government wrote that:

> Local government is ideally placed to develop local policies and influence actions related to key health determinants. It can encourage physical activity and social networks, for example, by its work in a range of areas, including transport, roads, parks, land use, housing and urban planning, recreation and cultural activities, and the creation of safe public places (DoH, 2008, p. 3).

With its emphasis on the devolution of power and responsibility for determining and responding to local health needs and issues from central governments to local communities, and with its focus on coordinated action by the state, civil society and markets, the third way model is consistent with the main tenets of the social model of health. It differs from the redistributive policies of the welfare state, where there is an emphasis on the state alone rather than on the state, markets and civil society working together, and from the neoliberal ideologies where there is emphasis on the free market system.

The Victorian Government's Neighbourhood Renewal Program provides an example of a third way approach to government. The Neighbourhood Renewal Program was designed to build local capacity to address social issues rather than just providing more

services (DHS, 2010). According to state government documents, the Neighbourhood Renewal Program was established to develop cohesive communities and build social capital in efforts to achieve a healthier and a more equitable society (DHS, 2010; Klein, 2004). Under this program, residents work in partnership with the state, local government, business and local institutions to identify and respond to issues in the local built, social, economic and natural environments that are having an adverse effect on local health and wellbeing (DHS, 2010).

Limitations of third way models

There are risks associated with the devolution of power from central government to the local context espoused by third way models. As argued in the previous section health improvement through health promotion requires coordinated action by all levels of government as well as the community and the business sector.

Baum (1999), Hancock (2000) and Reddel (2004) argue that approaches that focus on the devolution of power to the local level provide opportunities for the commonwealth and state governments to shift responsibility and costs for health improvement away from central government onto local communities. Moreover, Mendes (2004), Reddel (2004) and Hancock (2000) argue that devolving power and responsibility to local communities has the potential to increase inequities and further disadvantage communities that are already struggling. As Reddel points out, the inequitable distribution of social and economic wellbeing between communities means that not all communities have the capacity or resources to respond to local needs and issues. Devolving responsibility to already “under resourced, and disengaged local communities” (p. 135) without action to redress these inequities risks further “damaging” these already struggling communities (Reddel, 2004).

The evidence also shows that health needs and issues as well as levels of social capital vary between geographical locations, with some areas experiencing far greater problems and less capacity to respond than others (DOH, 2008; Vinson, 2007). As described by Macintyre and Ellaway (1999), “local opportunity structures” that provide the conditions for good health are less likely to be present in poorer areas. Furthermore, communities reporting higher levels of social capital have a greater capacity to respond to local needs and issues than areas with lower levels of social capital (Baum et al., 2000). This makes it harder for those areas with low levels of social capital to act in response to local needs and issues (Butler, 2005). The research also shows that that interventions designed to address a problem in one area have the potential to simply shift the problem to another area (Macintyre & Ellaway, 1999).

Petersen and Lupton (1996) make the further point that the extent to which local councils and communities can effect change and act to improve health outcomes is ultimately influenced by the policies, decisions and actions of central governments. For this reason they highlight the need for a coordinated and integrated response involving all levels of government. As the authors observe:

> while the focus on decentralised decision-making does allow for the development of solutions tailored to the unique needs of local groups, it diverts attention from the fact that most economic and social policy is national and transnational in character (p. 159).

According to Eagar et al. (2001) health promotion programs fail to achieve long-term change when the state fails to ensure that local communities have the necessary capacity to respond effectively. Butler (2005) observes that local councils are limited in the extent to which they can effect change without the cooperation of local communities. As Butler points out:

> It is clear that local government cannot facilitate and coordinate local efforts without high levels of support and cooperation from communities and through participatory relationships with all levels of government (p. 1).

According to Yeatman (2008), action at the local government level is influenced by the extent to which state governments support specific health priorities; by obligations attached to state government funding; and by constraints on their ability to raise revenue independently of the state government.

Despite the risks and limitations of an approach involving a partnership between the state, civil society and markets, an alternative model to the traditional welfare state and market-driven neoliberalism is needed, and this model must focus on developing and strengthening the local institutions and organisations of civil society. Third way models as espoused by Giddens recognise that involvement by local communities in the articulation and development of local responses to local issues, and in responding to and gaining control over the health issues that affect them, builds community capacity and social capital (which are in themselves key determinants of health and wellbeing) (Baum, 2002; Commission on Social Determinants of Health, 2008; Cox, 1995; Vinson, 2004; Wilkinson & Marmot, 2003).

A key role for the state therefore is to support and develop the organisations and institutions of a civil society. Local public health planning is one mechanism through which this can be achieved.

Local public health planning

There is widespread recognition that health improvement will require integrated social and environmental action, and that more integrated whole-of-government responses across policy domains such as transport, education and recreation are needed. One of the primary means through which the state can act to improve the health of the population is through local public health planning. Local public health planning involves local communities in the articulation and development of local responses to local issues, and in shaping responses to the health issues that affect them. The evidence reviewed in this chapter shows that effective approaches to improving health and wellbeing are those that achieve long-term changes to the social and environmental conditions that lead to and support an individual's health-promoting attitudes and behaviour. Strategies to produce sustainable local health improvement then depend on building sustainable action through the organisations of civil society (sporting groups, chambers of commerce, school, churches and so on). The values, norms, rules, practices and policies of these organisations may need to be changed to achieve sustained behaviour change. Local public health planning provides the means to coordinate the action required by the state, local communities and business to achieve this outcome.

When local public health planning forms part of a suite of interventions involving the different levels of society and government relevant to any specific health priority, it represents a useful tool for improving health outcomes. It provides local councils with the means to coordinate government and council actions, to develop and implement interventions that are designed specifically to meet local needs and issues, to build social capital, and to manage the change process inherent in health promotion and improvement.

The next section provides an overview of local public health planning within the Victorian context between 1999 and 2008.

The Victorian context, 1999–2008

In Victoria successive governments have employed MPHPs as a strategy for improving the overall health and wellbeing of the Victorian population (DoH, 2007). The Victorian Government first introduced legislation making it compulsory for local councils to

prepare MPHPs in 1988 following amendments to the *Health Act 1958*. This Act requires local councils to develop MPHPs every three years.[2]

In 1999 the Victorian Labor Party was elected to office where it remained until 2010.[3] On being elected, the government identified the inequitable distribution of health and wellbeing as a major issue and developed a policy response aimed at achieving a healthier and more equitable society (Blacher, 2005; Department of Premier and Cabinet, 2005).

The government developed an approach for improving health that was informed by the social model of health. It developed a theoretical framework for health promotion that was based on addressing the social, economic, built and natural conditions, as well as individual factors identified as affecting health (DHS, 2001). It also focused on supporting local communities to establish health-promoting environments through revitalising civil society and strengthening local capacity (Adams & Hess, 2001; Blacher, 2005; Department of Premier and Cabinet, 2005).

In Australia, local councils are governed by state government legislation and form the third tier of government (Department of Planning and Community Development, 2010b). The state government nominated local councils as a primary partner with responsibility for the health and wellbeing of their local communities, and maintained and strengthened local public health planning as a key mechanism through which local councils were required to act to discharge that responsibility (Department of Premier and Cabinet, 2005).

In Victoria there are 79 local government areas, which have different demographics, levels of health and wellbeing, health and social needs and issues, levels of wealth, and social and environmental conditions (Department of Planning and Community Development, 2010a; DoH, 2008, 2010; Vinson, 2007), and capacity (Bagley et al., 2007).

In Victoria, local councils have a mandatory responsibility for ensuring the health and wellbeing of local municipalities. At the time of writing, the Victorian Department of Planning and Community Development described local councils as being required to

---

[2] The *Health Act 1958* has since been superseded by the *Public Health and Wellbeing Act 2008. The Public Health and Wellbeing Act 2008* falls outside of the scope of this thesis, but as it provides additional background information about the Victorian context it has been referred to.

[3] In December 2010 state government elections were held in Victoria. At these elections a change of government occurred. The context of this thesis sits within the time period prior to the 2010 elections.

act on the local social and environmental conditions identified as having an adverse impact on health, develop local and targeted responses to address local needs and issues, involve local communities in processes and solutions to local issues and build social capital (Department of Planning and Community Development, 2010a; Department of Premier and Cabinet, 2005). According to the Public Health and Wellbeing Act 2008, Victorian local councils are required to "protect, improve and promote public health and wellbeing within the municipal district" (s.24) (DoH, 2009a, p. 4). Under the Act local councils have responsibility for:

- Creating supportive environments for health and strengthening the capacity of the community and individuals to achieve better health
- Initiating, supporting and managing public health planning processes at the local level
- Developing and implementing local policies for health
- Developing and enforcing up-to-date public health standards
- Facilitating and supporting local agencies with an interest in local public health
- Coordinating and providing immunisation services
- Maintaining the municipal district in a clean and sanitary condition. Source: *Public Health and Wellbeing Act 2008* (Vic), s. 24 (DoH, 2009a, p. 4).

Victorian local councils have a range of mechanisms through which they can act to fulfil this legislative responsibility and develop responses that lead to the establishment of local environments that support healthy behaviour and individual behaviour change. This includes the use of council by-laws, taxation policies and enforcement regimes such as fines. Local councils also have responsibility for maintaining local infrastructure such as roads, libraries, recreation facilities and parks; providing health and human services, including maternal and child health, youth, recreation, aged and disability services; and enforcing "State and local laws relevant to … land use planning, environment protection, public health, traffic and parking and animal management" (Department of Planning and Community Development, 2010a). Local councils also have access to funding and buildings to facilitate and support local organisations act in response to local social and health needs. One of the primary mechanisms through which local councils act to fulfil their obligation to ensure the health and wellbeing of local populations is through local public health planning.

Municipal public health plans

According to the 1993 general amendment to the *Health Act 1958,* local councils, in partnership with local communities, are required to establish the public health priorities

for the municipality, develop strategies to improve health outcomes relevant to each local government area, document these in their MPHPs every three years, and present the plans to the Secretary of the Department (DHS, 2001; Victorian Auditor-General, 2007). According to Section 29B of the *1958 Health Act*, municipal public health plans must:

"(a) Identify and assess actual and potential public health dangers affecting the municipal district;

(b) outline programs and strategies which the council intends to pursue to

(i) prevent or minimise those dangers;

(ii) enable people living in the municipal district to achieve maximum wellbeing;

(c) provide for periodic evaluation of programs and strategies" (DHS, 2001, p. 6).

This thesis focuses on MPHPs within the Victorian context between 1999 and 2008 and prior to the introduction of the *Public Health and Wellbeing Act 2008.*

Strategies to support MPHPs: 1999–2008

The state government implemented a range of strategies to support local councils and their communities in the development and implementation of MPHPs. In addition to legislation making it compulsory for Victorian local governments to implement and develop MPHPs, other strategies included the release of a framework (DHS, 2001), dissemination of information and implementation of training programs for local councils and key stakeholders, time-limited funding grants, as well as a website and newsletter to promote MPHPs and the social model of health. More recently the government released a review into the framework and MPHPs more generally (DHS, 2001). These are considered in more detail below.

Framework for MPHPs

Following its election to office in 1999, the state government broadened the role of local councils for public health from having responsibility for infectious diseases and environmental health to one which encompassed the social model of health and which required the development of a coordinated and integrated approach by both the state and local governments (DHS, 2001; Department of Premier and Cabinet, 2005). Instead of having one department responsible for infectious diseases and environmental health this change required local councils to spread responsibility for public health across several departments, some of which may not have been associated with health traditionally. Councils also had to involve local agencies and organisations in all stages of the MPHP process.

In 2001 the government released a framework to support local councils in developing and implementing this broader approach to local public health. The framework, entitled the *Environments for Health: Promoting Health and Wellbeing through Built, Social, Economic and Natural Environments* (DHS, 2001), provides an overview of the social model of health. The framework encourages the creation of local environments to promote health and the use of collaborative approaches involving key stakeholders from different parts of the system. It sets out the role and responsibility of local councils for local health and wellbeing outcomes, and for municipal public health planning. It also provides background information about public health planning within the context of a social model of health (DHS, 2001; Hay, Frew, & Butterworth, 2001).[4]

Information and education

The government also offered information and training sessions on the MPHP, the social model of health and other related issues. This included education and training programs targeting a range of key stakeholders such as council staff, elected officials and community representatives (Dibley & Gordon, 2002; DoH, 2009b).

The government also established a website and MPHP newsletters through which updates about the MPHP and examples of "best-practice" MPHPs and individual councils (DoH, 2007a, 2007b).

Funding and resources

State government funding for MPHPs was allocated through a time-limited short-term grants program during the early years of the program. Programs that received funding were documented and this information was made available on the department's website (DoH, 2009b). In addition, the government's website describes state government regional and head office staff as being allocated to support local councils with all stages of the MPHP planning process (Department of Planning and Community Development, 2010a).

Targets for change

The *Environments for Health* framework (DHS, 2001) makes only a cursory mention of the need to set specific and measurable targets to guide the development and implementation of MPHPs. And while there is a section on monitoring the MPHPs there

[4] In 2009 and at the time of writing this thesis the government released an adjunct to the Environments for Health Framework entitled: *A practical guide to municipal public health planning: a resource for public health and social planners in local councils* (DoH, 2009a). Its stated purpose is to facilitate a consistent approach to local public health planning by local councils and to provide updated information about public health planning (p. 1). The guide falls outside of the scope of this thesis.

is no reference to setting criteria or targets against which progress can be monitored. Rather, any references to targets are made within the context of other related issues, including a section on evaluation and investments in health, rather than in their own right.

Accountability measures

Reference to accountability and reporting measures are generally made within the context of monitoring and communication processes. There is a section in the framework on monitoring and communication, and on the importance of reporting to "embed health promotion in the organisation" (DHS, 2001 p, 43). However, this is broad, and while a range of communication strategies are described, the nature of accountability measures to encourage compliance and to ensure that all stages of the MPHP planning cycle are implemented is left open.

The legislation governing MPHPs requires local councils to prepare the plans and provide them to the Secretary of the Department. This requirement continues under the *Public Health and Wellbeing Act 2008* (DoH, 2009b) although the name of the plans has been changed to Municipal Public Health and Wellbeing Plans (MPHWPs) and there is provision in the Act for local councils to incorporate the issues to be covered in the MPHWP into the council's strategic or council plan rather than develop a separate plan (DoH, 2009b).

Evaluation

According to both the *Health Act 1958* and the *Public Health and Wellbeing Act 2008,* local councils are required to regularly evaluate their MPHP. *The Environments for Health* framework (DHS, 2001) also includes a section on evaluation that provides a brief overview of the benefits of evaluating progress and includes some pertinent questions that may be asked. Limited information is provided, however, about setting the criteria or indicators for assessing the likely overall effectiveness of the MPHP or its capacity to achieve organisational and social change, which research shows is a key element of effective health promotion planning and programs.

Key elements of an effective MPHP

The *Environments for Health* framework reports that "successful local public health strategies lead to prevention and reduction of disease and disability, and to the creation of communities and environments in which people can lead productive and rewarding lives" (DHS, 2001, p. 2).

To inform the development of the framework for MPHPs, the Department of Health, in partnership with the Municipal Association of Victoria and the Victorian Local Governance Association, surveyed Victorian local governments about MPHPs and about effective planning processes (DHS, 2000). In an unpublished report of the survey results, the department set out eight elements of an "effective" MPHP. These are as follows:

- Strategic plans containing clear goals, objectives, strategies, intended outcomes, timelines, performance indicators and evaluation strategies
- Local health issues highlighted
- Community involvement in identifying, prioritising and acting on local issues
- Embrace new public health principles (social model of health)
- Whole-of-council involvement in health planning
- Integration of MPHP with local, state and national issues
- MPHPs foster effective partnerships and networking between agencies
- Steering committees and working groups integral to successful planning (DHS, 2000, pp. 2–3).

While it was reported that the "elements were interdependent and would need to be implemented concurrently" (p. 2) a definition of an "effective" MPHP and how these elements would be translated into the framework was not provided, nor was there an indication of what an effective plan was likely to achieve in the long term or in relation to health improvement within the context of health promotion. This makes it difficult to assess the logic underpinning an effective MPHP or to identify what the intended result of these plans is. There is also a limited focus on the concept of change or on action that is needed to achieve sustainable health improvement, particularly in relation to the role of organisations and social institutions in creating the social rules, norms, practices and values that support and influence the individual attitudes and behaviours that ultimately effect heath improvement.

Recent reviews and evaluations of Victoria's MPHPs

There has been much interest in MPHPs in relation to the way in which local councils have developed and implemented a response to local public health within the context of a social model of health, and about the extent to which MPHPs have been embedded into the council organisation.

In 2006, the state government released an evaluation of the *Environments for Health* framework (de Leeuw et al., 2006). The evaluation covered a number of areas relevant

to both the framework and to the development and implementation of MPHPs, including:

- the extent to which the framework had contributed to a consistent approach to local public health planning
- the extent to which local councils had incorporated the framework and applied the social model of health to their overall response to public health
- the development and implementation of MPHPs in relation to the framework
- the extent to which local councils have positioned their MPHP as an influential and strategic plan within their overall planning context
- consideration of the factors and processes affecting the development and implementation of these plans, including action by the state government (de Leeuw et al., 2006; DHS, 2001, p. iv).

In another study Bagley et al. (2007) examined the impact of the legislation on the planning process. Their study examined the strengths and weaknesses of the current MPHP framework in Victoria, and sought to identify ways to enhance current public health planning systems in Victoria to achieve better health outcomes.

MPHPs were also considered as a part of the Victorian Auditor-General's 2007 audit into Victoria's response to the promotion of healthy eating and physical activity (Victorian Auditor-General, 2007). The audit included a review of a community-based health promotion related plans and programs, including MPHPs from seven local government areas. The plans and programs were examined to assess "whether the agencies had formed well-informed and coordinated plans; implemented these plans as intended; and evaluated how well plans had achieved their objectives" (2007, p. 2).

In the study into the level of activity by Australian local governments in food and nutrition, Yeatman (2008) also considered the factors influencing level of involvement. Whilst not directly related to Victoria's MPHP planning process, Yeatman found that of all the states Victorian local governments recorded the highest level of activity in ten activity areas, and partly attributed this difference to Victoria's MPHPs planning process.

Earlier studies and reports include a case study investigation of Victorian MPHPs reported in a paper on integrated public health practice by the National Public Health Partnership Group in 2000 (National Public Health Partnership Group, 2000) and an unpublished summary of a survey that was conducted by the Department of Health in

2000 (DHS, 2000) about MPHPs, the planning processes and planning models to inform the development of a framework to guide MPHPs (DHS, 2000).

The research and reports by Bagley et al. (2007), the Victorian Auditor-General (2007), and de Leeuw et al. (2006) would seem to support an approach to achieving health improvement that encompasses disease prevention within the context of the social model of health. There is an apparent consensus that local councils have a key role to play in ensuring the health and wellbeing of their local communities, and that MPHPs are an effective mechanism through which to achieve a coordinated and integrated response to health promotion and disease prevention.

There was a consistent view that action to achieve improved health outcomes requires a coordinated response by all three levels of government as well as local communities and the market, not just by local councils in isolation from the rest of society (Bagley et al., 2007; de Leeuw et al., 2006; Victorian Auditor-General, 2007). This view is consistent with Swerissen and Crisp's (2004) view of the need for fundamental social change to achieve sustainable health improvement.

De Leeuw et al. (2006) raised a number of factors that are consistent with risks associated with the devolution of local public health planning to the local level, as identified in the literature. These included the risk of further entrenching health and social inequities, the risk of further disadvantaging already struggling communities, and of shifting responsibility from the state to local government without the provision of resources, capacity or mandate to ensure success. The evaluation also reported that key stakeholders participating in the evaluation had different views about the extent to which the framework was effective in building community capacity, or contributing to the establishment of partnerships between different organisations beyond the council and the health sector (de Leeuw et al., 2006). Others commented that the government's framework did not provide guidance on how to redress social disadvantage (de Leeuw et al., 2006).

De Leeuw et al. (2006) also reported that the MPHP was generally viewed as a health plan rather than as a whole-of-council plan. Bagley et al. (2007) and de Leeuw et al. (2006) both reported that there was an emphasis on the development of a plan rather than its implementation.

Factors affecting the successful delivery of MPHPs

Funding, resources and capacity

As noted in the previous section, adequate funding and resources tied to all stages of planning are necessary to ensure the successful development and implementation of plans such as the MPHP. Bagely et al. (2007) and de Leeuw et al. (2006) report that there is an added complexity and cost in responding to health issues within the context of a social model of health.

Limited funding, resources and capacity were identified by Bagley et al. (2007) and de Leeuw et al. (2006) as reducing the capacity of local councils to deliver all stages of the MPHP planning cycle (de Leeuw et al., 2006). However, Bagely et al. and de Leeuw et al. also report that there is an added complexity and cost in responding to health issues within the context of a social model of health.

According to the Victorian Auditor-General (2007, p. 31):

> Current funding models limit the ability of agencies to properly plan for, coordinate and sustain health promotion programs. Lead agencies have recognised some of the challenges and limitations of current funding models and have taken steps to address some of these.

A CEO from a local council, in a submission to the Victorian Auditor-General in response to the Auditor General's report noting that local councils have a key role to play in health promotion through a social model of health and in evaluating MPHPs, observed that local councils have limited mandate and resources for health promotion. In the submission, which is documented in the Victorian Auditor General's report, the CEO argues that local government is

> not a major provider of health promotion activities (nor is it funded to do so) … the resources available to agencies in the shire for health promotion activities are minimal, and make it difficult to adequately address many of the priorities identified in health planning" (Victorian Auditor-General, 2007, p. 11).

These comments seem to contradict the very essence of the MPHP planning process and framework underpinning MPHPs, with its focus on disease prevention and health promotion, and on the requirement of local council to ensure the health and wellbeing of local populations.

De Leeuw et al. (2006) and Bagley et al. (2007) also reported differences between councils in terms of style, approach and level of influence attributed to the MPHPs. According to de Leeuw et al., the level of planning expertise and skill varied between

council organisations, and additional training programs were needed to ensure that each local council had the necessary planning expertise and capacity.

Action by the state government

There was a consistent view on the need for a coordinated and integrated approach to health promotion and disease prevention involving the Commonwealth and state governments, as well local councils, local agencies and communities and that the MPHP provided a mechanism to coordinate this action.

The Victorian Auditor-General found that the various strategies put in place by the state government to support local councils in developing local plans and programs to prevent unhealthy eating and a lack of physical activity had contributed to enhanced planning expertise and skill among local council staff and that the *Environments for Health* framework had "encouraged a coordinated approach to health promotion planning across government" (p. 32). However the report identified the need for additional evidence and information to "strengthen the evidence base used to guide and refine the State's investment; and the planning and coordination of programs across government" (p. 2).

De Leeuw et al. (2006) reported that the lack of dedicated state government funding for MPHPs continued to be a barrier to the successful implementation of the plans, and that some respondents were wary of the government's focus on MPHPs, describing it as a "cost-shifting" exercise.

An integrated and coordinated response

The Victorian Auditor-General's report highlighted the need for greater coordination of governance arrangements and responses by different government departments regarding health promotion. The report highlighted that there was duplication of effort and "The evidence base, and therefore the targeting of effort, could be improved, as could the planning and coordination of programs across government" (p. v). De Leeuw et al. (2006) also identified limited coordination between the state and local governments and also between the different state departments. The authors recommended that the state government implement strategies to increase the capacity of local councils to respond to local health needs and issues through the MPHP planning process, and modify the complex planning regime required of local councils.

Legislation

Two studies examined the contribution of legislation to the effectiveness of MPHPs. Bagley et al. (2007) considered the impact of legislation governing MPHPs on the

"planning process and outcomes", while the Victorian Auditor-General (2007) considered the role of legislation indirectly by examining the extent to which local councils evaluated MPHPs as a part of their audit into healthy eating and physical activity. Under the Act governing MPHPs, local councils are required to evaluate their MPHP.

Bagley et al. (2007) found that introduction of legislation governing MPHPs had led to the establishment of a "minimum standard", however "the extent to which the planning process had improved" was not clear. The authors also found that despite the legislation there were significant variations in approach between councils, specifically in the extent to which MPHPs were considered a priority and in the level of influence accorded to the MPHP. Bagley et al. (2007) also reported that there was an emphasis on the development of a plan, rather than its implementation. This is consistent with the findings of the Auditor-General's audit, which found that while the legislation governing MPHPs requires local councils to regularly evaluate the plans, evaluations were not evident at any of the seven local council sites visited as a part of the review (Victorian Auditor-General, 2007, p. 45). According to the report:

> Program evaluations, for the most part, did not provide sufficient information to determine whether plans had been effective. Evaluations were mostly limited to measures of process with few evaluations of program impact (Victorian Auditor-General, 2007, p. 31).

In response to this issue the Auditor-General recommended that "local councils regularly evaluate Municipal Public Health Plans and, in the design and scope of the evaluation, include information to understand how these plans have achieved their objectives" (Victorian Auditor-General, 2007, p. 4).

Summary of the key findings and gaps in the literature

The evidence reviewed in this chapter shows that health is influenced by conditions in the social, environmental, political, economic and built environments as well as by individual factors, and that material and social conditions of a geographical location – including employment, housing, income, social capital and social relationships – act and interact to affect health.

Local public health planning provides an important mechanism for coordinating the actions of the state, civil society and the markets in order to achieve improved health and wellbeing and to develop and strengthen social capital. Local public health planning is used by the institutions and organisations of society to manage change. It

provides local groups, agencies and individuals with the means of participating in and managing local conditions that affect health and wellbeing. In turn, this builds social capital and stronger communities. Local public health planning focuses on health promotion and disease prevention rather than on the provision of health services in response to already existing conditions.

Effective public health planning leads to social change

The literature identifies a range of factors and processes that contribute to effective local public health planning processes. Commentators including Eagar et al. (2001) observe that planning is essentially about change. The evidence reviewed in previous sections of this chapter show that an effective local public health plan is one that leads to sustainable change to the social and material conditions, rules, norms and practices that can influence and shape individual attitudes and behaviours. To be effective, local public health planning therefore needs to focus on change, and this change needs to be sustained in order to lead to better health outcomes.

As described by Shediac-Rizkallah and Bone (1998), sustainability includes the maintenance of health benefits, and captures the extent to which programs are sustained and institutionalised within an organisation. Swerissen (2007) argues that sustainability in relation to health promotion occurs when health benefits are achieved; when the benefits of change outweigh the costs; and when physical and social rules, norms and risks that affect health are modified and, in their place, new healthy rules and mores are established and maintained. The approach to achieving sustainable change for health promotion as presented by Swerissen and Crisp (2004) is consistent with the work of Kotter (1995) in considering transformational change within the context of organisations in the business sector and with the Victorian Government's approach to MPHPs. Kotter (1995) argues that sustainable change is achieved when "new rules of the game" are established and maintained: "Until new behaviours are rooted in social norms and shared values, they are subject to degradation as soon as the pressure for change is removed" (p. 67).

Action to achieve sustainable health improvements and individual change within the context of health promotion and disease prevention therefore needs to focus on changing the system and on coordinated and integrated action targeting local institutions and organisations of society as well as individual behaviour rather than on providing health services. Action needs to promote and strengthen social capital, facilitate and support local communities in responding to local social and economic conditions that affect health, and establish and reinforce organisational and institutional

rules, norms and practices that are health promoting and that lead to and support healthy attitudes and behaviours. The state has a key role in supporting and facilitating local communities towards this end.

Local public health planning in Victoria

In Victoria, MPHPs are the designated planning framework for the development and implementation of local public health responses. MPHPs have been in used Victoria for a long time as form of social action for achieving improved health outcomes, and as a mechanism through which local councils manage and respond to local issues affecting the health and wellbeing of local populations.

Local councils are the level of government closest to the community and in Victoria they have a mandate to ensure the health and wellbeing of local communities. MPHPs provide the mechanism through which local communities plan, develop and respond to local health needs and issues, and coordinate actions targeting the social, built, natural environments that influence health outcomes.

The Victorian Government's approach to local public health planning and MPHPs is based on the social model of health. The state government implemented a range of strategies to support local councils in the delivery of MPHPs and these partially align with what the literature suggests is needed to achieve sustainable change. The government developed and implemented a range of training packages for council staff and other key stakeholders, established promotional and communication networks and strategies, and introduced legislation that required local councils to deliver MPHPs in partnership with communities and in a way that aligned with the main tenets of the social model of health. The government also commissioned an evaluation into MPHPs.

The framework underpinning MPHPs is consistent with what the evidence tells us can lead to improvements in health, and it is also informed by the social model of health. It is set within the context of health promotion and disease prevention and emphasises achieving improved health outcomes by addressing the wider social, environmental and economic conditions that have an impact on individual factors affecting health (DoH, 2009a). It focuses on building social capital, on local self-determination and on involving local organisations and institutions in responding to local health needs and issues, including the provision of integrated and collaborative action by the state government, the community and local councils. An approach such as this is consistent with the social model of health and Swerissen and Crisp's (2004) approach to achieving sustainable change for health promotion interventions.

Recent reviews and studies into MPHPs and the supporting guidelines have found that MPHPs provide an important enabling process for the development of local solutions to health problems that lead to improved community health and wellbeing, and that the policy directions and framework supporting MPHP are consistent with the evidence for achieving better health (Bagley et al., 2007; de Leeuw et al., 2006; Victorian Auditor-General, 2007). There is less evidence to suggest that MPHPs and the framework underpinning these plans have been translated effectively into action by either the state government or local councils, or that action that leads to improved health and wellbeing has been achieved.

The findings of the evaluation undertaken by de Leeuw et al. (2006) and the research by Bagley et al. (2007) into the impact of legislation on the planning process, show that key stakeholders (including representatives from local councils and the state government) generally support the concept of the social model of health as the framework through which to achieve improved health, and indicate that this wider framework has generally been accepted across the various council organisations.

However, the research also shows that despite MPHPs having been in place for over twenty years, key stakeholders hold diverse views about the value and effectiveness of MPHPs, and about the contribution MPHPs make to overall efforts to improve population health outcomes. There is concern about the capacity of local councils to successfully develop and implement MPHPs. Furthermore, individual risk factors including obesity, lack of physical activity and poor nutrition continue to pose significant public health concerns and continue to contribute to increasing rates of preventable deaths and disease. In 2007 the Victorian Auditor-General reported that “the combined efforts of government have not significantly slowed the increase in obesity underpinning the rise in preventable chronic diseases such as type 2 diabetes” (2007, p. 2). In addition, health, social and economic inequities are still apparent between geographical locations and have yet to be addressed (DHS, 2008a, 2009; Vinson, 2007).

Recent reviews, research and evaluations into MPHPs show that while they are considered to be effective, there is still room for further development and enhancement to ensure the success of MPHPs as a local public health planning tool that leads to improved health outcomes. As reported in this chapter, additional resources and capacity were reported as being needed to ensure that local councils are able to deliver all stages of the planning process. The research also found that the legislation

governing MPHPs was influential to the extent that it provided the incentive for local councils to develop MPHPs. There was less evidence to show that this influence extended to implementation. Furthermore, local councils were faced with competing priorities, limited resources and a limited mandate to undertake all stages of the MPHP planning process, and to deliver the level of action needed to achieve type of change that would lead to better health outcomes.

There is also a lack of guidance about the key elements of an "effective" MPHP in both the framework that supports MPHPs and in current research and evaluations into MPHPs.

Gaps in the research and existing MPHP frameworks

Whilst recent research findings identify the need for MPHPs to be more outcome focused and have raised a number of key issues in relation to the future of MPHPs, current research is limited in the extent to which the plans and planning process are considered from a perspective of social action, change and sustainability. Previous research into MPHPs has generally focused on the process of planning including the extent to which local councils have made the transition from an environmental and infectious diseases response to one that encompasses the wider social model of health.

Local planning is a tool or process that has been developed to improve public health. There is little research into the factors and processes affecting the implementation of MPHPs as a form of social action aimed at achieving sustainable change within an institutional, organisational and behavioural context and which focuses on change. Also the current research and evaluative frameworks for MPHPs do not provide a succinct and consistent set of elements that are indicative of an effective plan and which can be used to inform the development of new MPHPs and assess the likely effectiveness of existing plans.

In the research into MPHPs, there was less of a focus on planning as a strategy for achieving sustainable social change to produce better health outcomes. Despite Shediac-Rizkallah and Bone's (1998) observation that there is a "growing recognition that lasting widespread behavioral change is best brought about by changes in the norms of acceptable behaviour at the level of the community as a whole" (p. 95), there is limited research into the extent to which MPHPs were developed with a social change perspective and the extent to which these plans achieved the institutional and organisational change that would lead to better health outcomes.

While existing research and evaluation identified a number of factors and processes that contributed to the successful development of MPHPs, guidance on the characteristics of an “effective” MPHP, and on the key indicators against which to measure success is limited. Research into the factors and processes affecting whether or not MPHPs meet identified criteria of successful planning within this context is also limited. This research seeks to address this gap.

CHAPTER 3 – ANALYTICAL FRAMEWORK AND STATEMENT OF RESEARCH PROBLEM

Introduction

This thesis is concerned with the specific factors influencing the effectiveness of local public health planning as a means of effecting social change to bring about better public health outcomes. The literature suggests a range of factors and processes that contribute to effective planning, such as MPHPs. These are encapsulated and applied in the analytical framework for this thesis. Chapter 3 sets out the research questions and analytical framework for this thesis.

Analytical framework and indicators of an effective MPHP

The analytical framework for this thesis was developed based on the literature reviewed in this thesis, the social model of health, applying Swerissen and Crisp's (2004) framework and in light of the evidence about how to achieve sustainable change within the context of organisations, health promotion and local public health planning. The approach to achieving sustainable change for health promotion as presented by Swerissen and Crisp (2004) provides a relevant framework to apply to Victoria's MPHP. It is consistent with the work of Kotter (1995) in considering transformational change within the context of organisations in the business sector, with the literature on achieving sustainable change within the health promotion context and with the Victorian Government's approach to MPHPs.

Applying Swerissen and Crisp's approach and drawing on the literature the following characteristics of an effective MPHP were developed:

- The priorities and actions set out in the MPHP would be developed according to the available evidence and an assessment of the local context and capacity and in collaboration with key stakeholders.
- Departments across the council organisation would be responsible for implementing action targeting the social, built, natural and economic environment for each priority identified in the MPHP.
- Specific and measurable targets would be identified and strategies to regularly review and report progress would be documented.

- Strategies would be developed based on an integrated and coordinated response involving behavioural, organisational and institutional strategies for each priority.
- Resources, including funding, timelines, personnel and infrastructure, would be available and aligned to the delivery of the plan.
- Incentives and sanctions would be included that encourage compliance and generate support for and participation in the MPHP, and that lead to the establishment and reinforcement of social and organisational rules, norms and practices that lead to and sustain individual behaviour change.
- A communication strategy would be provided to promote the MPHP, local health issues, and the evidence for effectiveness of selected interventions, and to monitor and report progress against the specified targets. This would also provide a feedback loop into the MPHP planning cycle.
- Senior and influential decision makers (such as CEOs, elected officials) would be directly accountable for the outcomes of the MPHP.

When these indicators are present the MPHP is more likely to lead to sustained change to the social and environmental factors that establish and reinforce health-promoting behaviours and lead to better health outcomes. Importantly, incorporating each of these elements into the plan would ensure that there is a logical link between the identified problem, the strategies to be implemented to address the problem, and the level of resources allocated to the delivery of the plan.

When this is the case council's organisational systems and processes are more likely to have been established and existing processes revised to incorporate the MPHP and the MPHP embedded into the organisation. Similarly it would be more likely that strategies would have been put in place to manage the change process in delivering the MPHP and that actions targeting different levels of society to bring about sustained change to improve health-promoting behaviour incorporated into the MPHP.

Applying Swerissen and Crisp's framework, the following eight indicators encapsulate the key components the evidence indicates are required for a MPHP to lead to sustained change. These eight indicators and their description are set out in Figure 1.

Indicator one: Conceptual and analytical evidence base

Measure: Priorities for action and selected interventions are developed according to available evidence, including evidence for the effectiveness of interventions and an assessment of local context and capacity and are developed in collaboration with key stakeholders.

Ideally a MPHP should be based on a theoretical and conceptual framework that combines a rational approach within the limitations and constraints of the local context is likely to be more effective. It should be based on the social model of health, include actions that build social capital and that lead to the establishment of health-promoting organisational and institutional rules, norms, practices and values. There should be a logical link between the following: the specified targets for the MPHP; the available evidence; an assessment of the local context, capacity and constraints; the resources allocated to the plan; and the selected interventions. The plan should be developed in collaboration with key stakeholders and influential leaders. When each of these elements is in place, a MPHP should have secured the support necessary to ensure that all stages of the plan are delivered, the strategies are those that the evidence shows will achieve the specified targets and address the social and economic conditions that affect specified problems, and the resources to deliver the plan are available.

Indicator two: Organisational integration

Measure: The plan implements coordinated action targeting the social, built, economic and natural environments for each priority.

Ideally, different council departments should have responsibility for implementing the various strategies set out in the MPHP, it is likely then that the MPHP has been developed based on the social model of health, that an integrated and coordinated approach targeting the social, built, economic and environmental conditions that impact on health will be delivered and that systems and processes are established within the council organisation that support the delivery of the MPHP.

Indicator three: Resources

Measure: Resources (funding, timelines, personnel, infrastructure) are aligned to the delivery of each priority.

Ideally resources should be allocated to the MPHP to enable the delivery of all stages of the planning cycle and to each priority of the plan. The plan should be delivered within the context of available resources and an assessment of the level and type of resources needed to achieve specified targets. Resources should be aligned to the delivery of each priority.

When resources are aligned to delivery for each priority then there is a rational relationship between the identified problem, the targets to be achieved, the actions set out in the plan and the available resources. Then it is more likely that the resources

necessary to undertake all stages of the planning cycle are available and that institutional arrangements within council including processes to select priorities for action, decisions about the allocation of resources and accountability and reporting measures have been adjusted and take into account the MPHP.

Indicator four: Targets and accountability measures

Measure: Specific and measurable targets are set for each priority and progress is reported regularly.

Ideally targets should be determined within the context of the problem and the desired change that is to be achieved, the available capacity to respond, and an assessment of the political and policy imperatives. Progress towards targets should be monitored and reported on regularly, and there should be accountability measures, such as the tying of funding to progress.

When specific and measurable targets are directly linked to each priority and progress is required to be reported on regularly, it indicates a commitment within the council organisation to the delivery of the MPHP. It also indicates that the MPHP is embedded within the council organisation, and that the resources necessary to successfully develop and implement the MPHP are available.

Indicator five: Interventions: level

Measure: Interventions target institutional, organisational and behavioural actions for each priority.

Ideally for each priority there should be a suite of institutional, organisational and individual actions that lead to the establishment and reinforcement of health-promoting institutional and organisational rules, norms and practices. These should lead to the creation of health-promoting environments that support individual behaviour change.

When institutional, organisational and behavioural actions are developed for each priority, then a MPHP is intervening at a systems level in a way that will lead to changes in the rules, norms, values and practices that influence individual attitudes and behaviour.

Indicator six: Incentives and sanctions

Measure: Incentives and sanctions drive the establishment of social and organisational rules, norms, practices that lead to and sustain individual behaviour change.

Ideally a MPHP should include interventions that encourage local institutions and organisations to comply with actions set out in the MPHP. This should include more sustained use of organisational and institutional incentives, such as extensive changes to council's by-laws and funding and taxing policies to address particular issues.

When a MPHP incorporates incentives and sanctions, the institutions and organisations of society are likely to comply with specified changes and individual behaviour change is more likely to be sustained.

Indicator seven: Communication strategy

Measure: The plan incorporates a communication strategy to report on successes, local health issues and that provides a feedback loop into the planning cycle.

Ideally the MPHP should incorporate a communication strategy that includes mechanisms for reporting back into the planning cycle progress, and noting changing trends and new and emerging issues. Communication strategies should be designed to target different stakeholders from within and external to the council organisation.

When such a communication strategy is in place, then a MPHP has incorporated action to secure and maintain the support and involvement of key stakeholders. When key stakeholders from within the council organisation as well as relevant external organisations and agencies are involved in and support the MPHP, the level of motivation and support for the MPHP and subsequent change process is maintained, and change is more likely to be sustained. When a system is in place to report changing trends, risks and progress back into the planning cycle, action can be developed and implemented as needed to adjust to changing circumstances.

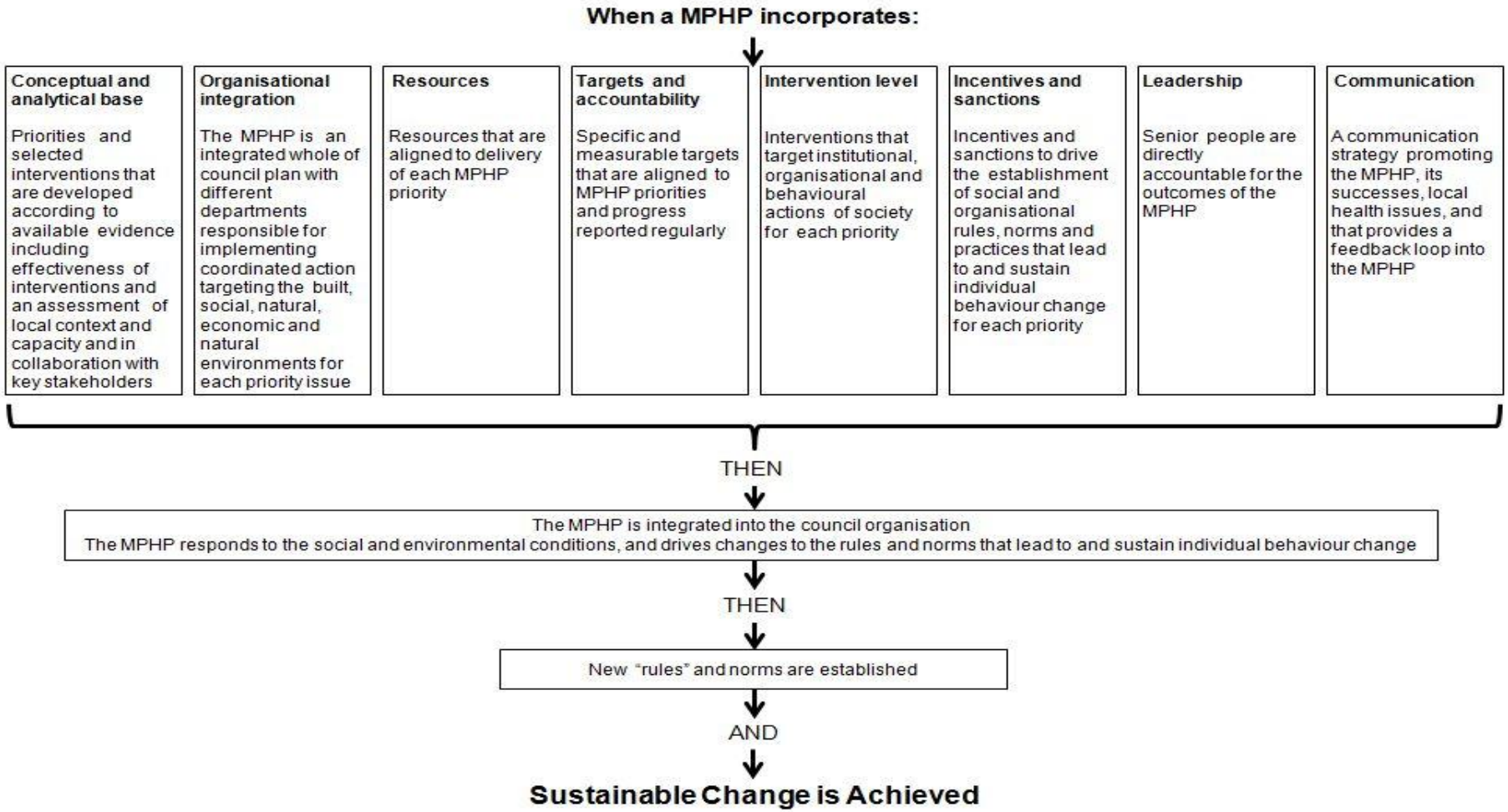
Indicator eight: Leadership

Measure: Senior and influential decision makers (such as CEOs) are directly accountable for outcomes.

Ideally the CEO of the organisation should be accountable for MPHP measures. Incentives, such as linking performance bonuses to the delivery of the MPHP, may be required.

When the CEO and senior leaders of the organisation are directly accountable for MPHP outcomes, then a MPHP should have the support and authority necessary to become an influential plan within council. This should ensure that all stages of the plan are more likely to be delivered, and specified targets and outcomes met.

Figure 1 – How the key elements lead to change



Drawing on the literature, and applying Swerissen and Crisp's (2004) approach, the eight key elements of an effective MPHP are summarised in Table 1.

Table 1 – Key elements of an effective MPHP

Indicator	Attribute
Evidenced based conceptual and analytical framework	The MPHP priorities and selected interventions are developed according to available evidence, including evidence for the effectiveness of interventions and an assessment of the local context and capacity, and in collaboration with key stakeholders.
Organisational integration	The MPHP is a coordinated plan with different departments responsible for implementing coordinated action that targets the social built, natural and economic environment for each priority.
Resources	Resources (funding, timelines, personnel, infrastructure) are aligned to the delivery of each MPHP priority.
Targets and accountability	Specific and measurable targets are set to each MPHP priority and progress is reported regularly.
Interventions: Level	Interventions target institutional, organisational and behavioural actions for each MPHP priority.
Incentives and sanctions	Incentives and sanctions drive the establishment of social and organisational rules, norms, and practices that lead to and sustain individual behaviour change.
Communication	A communication strategy to report/ promote the MPHP, including successes, local health issues, and that provides a feedback loop to the planning cycle is described.
Leadership	Senior and influential decision makers (CEOs; elected officials) are accountable for outcomes

Implications for the framework developed to evaluate MPHPs

Drawing on the analytical framework for this thesis, and the evidence reviewed in Chapter 2, an effective local public health plan will lead to sustainable changes to the factors and conditions affecting health outcomes. Frameworks developed to evaluate health promotion action therefore need to provide a mechanism for assessing the likelihood that MPHPs will lead to this level of change. Existing evaluation frameworks for MPHPs are limited in the extent to which they provide this perspective.

Addressing the gap – the research question for this thesis

This thesis seeks to address the research gaps identified in Chapter 2. It is concerned with the specific factors that affect the outcomes of the planning process. The literature covering organisational change and health promotion planning identifies a range of interconnected factors that underpin successful planning and action to achieve sustainable organisational change for health improvement. The analytical framework for this thesis with its eight key elements based on the evidence for achieving sustainable organisational and social change for health promotion and applies Swerissen and Crisp's (2004) framework.

This thesis interrogates the analytical framework by checking the efficacy of the key elements of an effective MPHP. If the key elements are effective the analytical framework will provide a mechanism through which future health promotion action can be developed and evaluated, and the eight key elements will provide a reliable set of indicators against which MPHPs can be assessed.

This thesis tests the analytical framework within the context of MPHPs in Victoria as conceptualised by the state government following the 1999 state elections, and as implemented by local councils between the years 2003 and 2008. It considers both the extent to which MPHPs align with the indicators of an effective plan and the factors and processes that contribute to the successful development and implementation of these plans.

The research question for this thesis is:

- Local public health planning as a form of social action: What can be learned from the Victorian experience?

The sub-questions informing the research are as follows:

- Are the key elements of effective and sustainable change evident in local MPHPs?
- What factors and processes affect whether MPHPs include the eight elements of an effective plan?
- What are the implications of the findings for local public health planning for health improvement and the future of strategies such as MPHPs?

The study applies the analytical framework (including its eight key elements) to (a) analyse MPHPs from three local government areas; (b) interview key stakeholders from the three local government areas about the elements that they consider to be critical to the successful development and implementation of MPHPs; and (c) analyse the extent to which the elements described by participants align with my analytical framework. The results will be considered, and implications for the state government's framework for evaluating health promotion planning will then be determined.

This study builds on the recent research and evaluations conducted into the MPHP planning processes. The research findings will provide additional insights into local public health planning and MPHPs as a mechanism for achieving improved population health outcomes within the context of social change.

Applying the research into organisational change and successful health promotion planning as a framework for analysis, this study examines the processes and factors

affecting the successful development and implementation of MPHPs. In doing so it will provide additional information about factors and processes that are needed to ensure the development and implementation of MPHPs that lead to sustainable improvements in health and wellbeing outcomes.

The research findings will contribute to the future development of MPHPs and health promotion planning frameworks by providing state and local governments with information about the factors and processes that affect the effective development and implementation of the plans. The findings from this study will also contribute to the evidence about the development of effective local public health planning processes through its focus on the planning process and on achieving sustainable changes to the social rules, norms and practices that shape individual attitudes and behaviour.

CHAPTER 4 – METHODOLOGY

Introduction

This study examined the translation of Victorian Government policy into local government planning frameworks for health. The study focused on MPHPs as conceptualised by the Victorian Government following the 1999 state elections and as delivered by local councils between 2003 and 2008. The study investigated the extent to which MPHPs incorporate the key elements of effective health promotion planning, and the factors and processes that contributed to the successful development and implementation of these plans.

This chapter describes the research methodology employed for this study. The chapter commences with a statement concerning ethics approval for this thesis. This is followed by a review of case study research, and a discussion about its relevance to this study and as it relates to MPHPs. The literature on case study research is then translated into a framework for this study and for MPHPs. The chapter then provides a description of the two data collection methods employed for this study – content analysis and semi-structured interviews.

Ethics approval

Ethics approval for Study 2 was sought and granted by the La Trobe University Ethics committee (Reference number: FHEC07/170). The approval notification is attached at Appendix A.

The Faculty Human Ethics Committee (FHEC) required minor amendments to be made to the submission. These were as follows: amending the start date to “date of approval”; all occurrences of A/Dean to be revised to Acting Dean; participant information sheets, consent forms and withdrawal of consent forms to be provided on letterhead; and amendments to the contact details for the Secretary of the FHEC. The amendments were made and provided to the FHEC in a memorandum. The FHEC did not require the entire application to be re-submitted.

Case study research

The research was conducted using case study design. Data was collected from three Victorian local council areas using two complementary methods: a content analysis of MPHPs and semi-structured interviews. The first study, Study 1, involved a content analysis of the most recent MPHPs for each site and examined the extent to which the plans align with the key elements of planning identified as contributing to achieving improved health outcomes. Study 2 examined the factors that contributed to the successful development and implementation of these plans. It was conducted using in-depth semi-structured interviews with key informants from each site.

Case study research is described in the literature as an in-depth examination of a defined and "bounded" phenomenon that is set within the context of a specified time period, usually current, and where the wider social context and system is relevant (Gerring, 2004; Yin, 2003). Gerring (2004) describes case study research as an examination of a "spatially bounded" unit or units of study. According to Gerring (2004, cited in Liamputtong 2009) these may be political units, social groups, events, organisations, or individuals.

Advantages and limitations of case study research

According to Yin (2003) case study research is relevant when focusing on "how and why" questions that sit within a contemporary context and which do not require control of behavioural events (pp. 5–9). Yin observes that case study research provides an opportunity to examine not only the specific case but also the wider "contextual conditions" relevant to the case or cases under investigation (p. 13). As Gerring (2004, p. 5) points out "it is the opportunity to study a single unit in great depth that constitutes one of the primary virtues of the case study method".

However, a number of criticisms have been directed towards case study research. As outlined by Yin (2003), Liamputtong (2009), Gerring (2004), and Flyvbjerg (2006), case study research has been criticised because it lacks accuracy, objectivity, scientific rigour, is resource intensive and because its findings cannot easily be generalised to wider contexts.

Commentators, including Flyvbjerg (2006), argue, however, that case study research is a rigorous and legitimate form investigation. Yin (2003, p. 13) argues that case study research is a valid form of inquiry and a "comprehensive research strategy". Liamputtong (2009) points out that other research methods can also be resource intensive, and may risk researcher bias. Yin and Gerring (2004) both highlight that it

takes only one case to disprove a theory. According to Flyvbjerg many of the criticisms levelled against case study research are based on “common misunderstandings” (2006, p. 219).

A strength of case study research is that it provides for a rich and deep investigation of issues within a particular context. According to Gerring (2004) a “case” forms one part of a much wider system. By “understanding” one part of a system “we gain a better understanding of the whole” Gerring (2007; cited in Liamputtong, 2009, p. 189). Gerring (2004) argues that this allows the findings of a case study to be translated to wider, yet similar, contexts.

The effectiveness of case studies is largely dependent on whether a plausible analysis is developed. The two basic methodological issues are *generalisability* and *validity*.

Generalisability and validity

According to Neuman (2003, p. 179) “… validity addresses the question of how well the social reality being measured through research matches with the constructs researchers use to understand it”. Findings can be generalised to planning problems and settings similar to the case studies provided it is plausible to do so. Plausibility depends on the extent to which other planning problems and settings share the features of the case studies. Valid inferences and conclusions can be made from a case study on the basis of the logical connections that are observed. The richer the observations the more the argument is supported.

Gerring (2004) argues that many of the limitations associated with case study research can be managed through ensuring that the case and study proposition are clearly “specified” and defined (p. 5). According to Gerring (2004), Yin (2003) and Stake (2005), defining or “bounding” a case adds rigour to the research. It also provides information about the “informal units” and the wider context within which a case is located; it provides information about the way in which the system functions in relation to the case, and assists with identifying potential data sources, while keeping the case and the research contained.

The application of case study research to this thesis

The broad parameters of this study are consistent with Yin’s (2003) technical definition of case study research in that it is an explanatory study seeking to explore “how and why” planning frameworks such as MPHPs translate from “plans” into action that result in sustained change. It focused on contemporary events, including an examination of existing MPHPs, which were in progress during the course of the study. There were

also multiple variables of interest. There are 79 Victorian local councils, and consequently 79 MPHPs, each of which could have been equally well studied.

This study also identified a diverse range of factors that could potentially affect the successful development and implementation of MPHPs. And, consistent with case study methodology, this study identified events and circumstances over which I, as the researcher, could neither control nor manipulate.

MPHPs sit within a wider context and this is relevant to the study questions and central study proposition. This research is concerned with the phenomenon of local public health planning within geographic catchments and as conducted through MPHPs. MPHPs and the factors that influence the planning process and successful development of these plans as a framework for change are the major focus. Local councils act within the context of the state government, as do many of the factors and processes that influence both health and wellbeing and the successful development and implementation of MPHPs.

The individual councils, while important, were not of primary interest, but rather were the mechanism through which a deeper understanding of local public health planning through MPHPs could be gained, and which would ultimately provide a greater understanding of MPHP planning as a whole. The study is not an evaluation of individual councils, nor is it a study of local governments per se. Rather as described by Yin (2003) this is an explanatory study of how and why planning frameworks such as MPHPs shift from being a static plan to an enabling framework leading to changes that support individual behaviour change. Findings can therefore be generalised from the particular local government case under investigation to another one that has similar features.

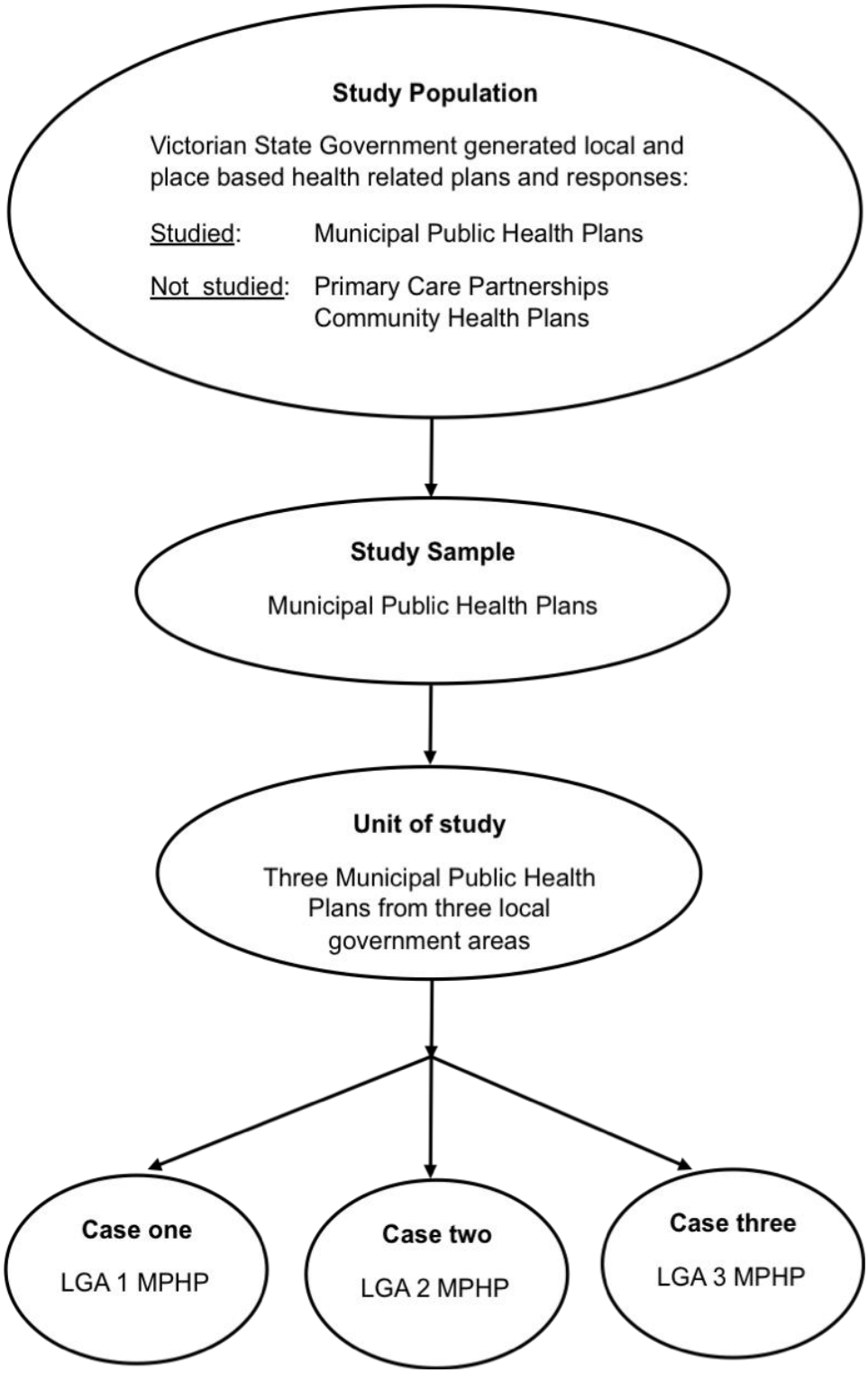
Defining the cases under investigation

Applying Gerring's framework, which was described in the previous section, the study population for this research involved state government policy and responses relevant to local public health, health promotion and disease prevention. Within this context MPHPs, community health plans, and Primary Care Partnerships (Australian Institute for Primary Care, 2005, p. 151) could be considered relevant and therefore make up the study population. Of these, MPHPs were studied and therefore formed the study sample. Local councils are the organisations responsible for the MPHP. There are 79 local government areas in Victoria, each with a MPHP, all of which could be included in this study. Of these, MPHPs from three case study sites made up the unit of study. The

unit of study for this thesis therefore comprised three MPHPs from three local government areas. Each site and its plan made up three individual cases.

The relationship between the study population, the study sample, the unit of study and the case/s for this study is set out in Figure 2.

Figure 2 – Study sample



Locating MPHPs within the wider context

The relationship between MPHPs and the broader system surrounding them is described briefly in the following section. To reiterate, local councils are required through legislation to respond to local health needs and issues. Local public health planning is a key strategy through which local councils act to achieve this. Through the MPHPs, local councils are required to influence and drive change to different parts of the "system" and the local environment identified as having an adverse effect on health. As such MPHPs are implicitly linked to the wider social and political system within which they are located.

Accordingly, MPHP are "nested" within the context of the three tiers of government, local community organisations and institutions, as well as individual behaviour and decisions. Commonwealth, state and local government policies, ideologies, legislation and funding allocations affect the social and environmental conditions that influence individual attitudes and behaviours and subsequently the successful delivery of MPHPs. Similarly MPHPs are influenced by a range of factors at the local level, including competing priorities and planning requirements, the level of resources allocated to the planning process, and the capacity of the local area to adequately address the priority issues that are adversely affecting health. The wider system is therefore relevant to this study.

Victorian local councils are responsible for the development of MPHPs and at the time of writing are required by legislation to develop MPHPs every three years. Local councils have a mandate to act to improve the health of their local jurisdiction and have a range of mechanisms through which they can intervene in the social, built, economic and natural environments negatively affecting health at the local level. Factors within the council organisation, including its policies, rules and practices, for instance funding criteria and priorities for action, need to be adapted to accommodate the MPHP, and will act and interact to influence the development and delivery of these plans.

The state government context is relevant because MPHPs occur within a state government policy and legislative context. While local councils are required by legislation to develop, implement and review MPHPs and to work in partnership with the local community, the state and Commonwealth governments also have responsibility for different parts of the system likely to affect health. Institutional measures, such as legislation, taxation and policies controlling the way in which funding is allocated, each affect the social, and environmental conditions that influence individual risk factors.

The local organisational and institutional context is also an important component of the MPHP planning process, and therefore is important to this study. Local councils are required to develop MPHPs in partnership with their local communities and are required to generate action to influence and change local conditions that affect health outcomes. Local councils through the MPHP are therefore required to drive changes to institutional, organisational and individual actions that are beyond their own mandate.

Each level of society not only provides the context within which MPHP processes and outcomes are developed and implemented, but is also likely to influence whether or not MPHPs succeed as a driver of change. As such the phenomenon of municipal health planning and the translation of MPHPS into action cannot be separated from the social, political, organisational and program contexts within which municipal health planning occurs. Therefore key stakeholders from within local government, the state government and from organisations external to councils are important informants for this study.

Case selection

Number of cases

This study examined three cases within a single unit of analysis involving across-case analysis. According to Yin (2003) and Gerring (2004) the number of cases to be included in a study is determined according to the study scope and proposition. Flyvbjerg (2006) and Gerring (2004) add that in determining the number of cases to be included in a study a balance must be achieved between the study's breadth and depth.

According to Stake (2005) case studies are either instrumental, intrinsic or multiple. Intrinsic case studies focus on the case itself, on "… the case's own issues, contexts and interpretations" (p. 128). Instrumental and multiple case studies focus on the issue of interest rather than on an actual case.

Yin (2003) argues that a single case study is relevant when the case: is a critical case (one which meets the conditions necessary to "confirm, challenge, or extend the theory" (p. 40); is an extreme or unique case (usually rare occurrences of a case); is representative (the case represents a typical phenomenon); is revelatory (a case previously not accessible for research); or is longitudinal (when one case is studied at different points in time) (p. 40). However, Yin argues that single case studies are not as "robust as multiple cases" (p. 19).

According to Stake (2005) multiple case studies are used when particular "phenomena" are of interest rather than the individual case itself. In this study it is the phenomena of

MPHPs generally that are of interest, and as such are investigated at three sites. Liamputtong (2009) argues that multiple case studies allow for a greater understanding of the wider context, offer more "in-depth or multifaceted insights than having only one case study" (p. 193) and are "often selected so that different aspects of the issue can be illustrated" (p. 193).

In arguing for the use of multiple cases Flyvbjerg (2006) suggests that the number of cases studied should be small enough so as not to compromise the depth of the study. This is an important consideration since the value of case study research is its in-depth nature, and the logical connections that can be observed. Inferences and conclusions from a case study are more likely to be valid, the richer the observations that are made. Consideration must therefore be given to keeping the number of cases included in a study small enough so that the richness, and depth of the study are not sacrificed for breadth, and to ensure valid inferences and conclusions can be drawn.

This study involved multiple case studies: three cases were selected to ensure depth while providing some breadth, and to meet the study scope and resource and time constraints. The primary area of interest of this study was on the factors that contribute to the successful development and implementation of MPHPs. Its focus was on understanding the issue of local place-based planning rather than an in-depth examination of a particular and unique case. I was interested in the phenomenon of local public health planning as a form of social action, as a means of achieving sustainable change and improved population health outcomes, and in the factors that affect the successful development and implementation of these plans. My interest was in MPHPs as the mechanism through which this occurred rather than in a particular plan at one site or local council area.

Case study site selection

In developing and implementing MPHPs, the 79 Victorian local councils are subject to Commonwealth and state government policies, legislation and funding decisions. As such the overarching context for MPHPs is similar for each local council in terms of comparability and representation. However, as de Leeuw et al. (2006) have found, Victorian local councils approach the MPHP process differently and are characterised by unique local characteristics, issues, needs and capacity.

Yin (2003) suggests a range of strategies for the selection of relevant sites for case studies, including discussions with "knowledgeable people", random selection, and existing and easy access arrangements. Yin argues against extensive screening procedures, which in turn risk becoming "mini case studies" (p. 79). Stake (2005)

observes that cases should be selected for inclusion in a study based on the level of information that each case can provide about the topic under investigation. According to Stake, cases may or may not share common characteristics.

Inclusion criteria

The criteria used to select the cases to be included in this research were modelled on Yin's (2003) process, with sites deemed to be eligible for inclusion based on the following:

- The site formed a local government area.
- The local government area had a completed and current MPHP.
- The site had ease of access because of prior contact and familiarity with staff from council.
- The site was geographically accessible (i.e. within geographical proximity to my place of residence).

The 79 local government areas in Victoria have diverse demographics, social and economic status and health and wellbeing outcomes. De Leeuw et al. (2006) reported that in 2006 every local council had completed and current MPHPs. Based on this finding I assumed that every local government area in Victoria met the first two criteria. Accordingly, the second two criteria, in addition to discussions with colleagues who also had contacts with different local government areas, were used to short-list councils for inclusion in the study. This list was then discussed with my study supervisor who also provided guidance on the selection process. Sites were chosen because of demographic similarity, to allow for a greater depth of study. Introducing sites characterised by contrasting demographics or geographical location would have added dimensions to the study that were beyond its scope and resources.

Exclusion criteria

During 2006–2007 a number of local government areas in rural Victoria were experiencing undue hardships because of severe drought, subsequent bushfires and flooding. In consideration of the additional strain and hardship placed on communities and relevant local government areas in responding to such conditions I decided not to approach affected rural areas to participate in this study. Rural regions were also excluded due to scope and resource constraints. Furthermore, I recognised that recent studies into MPHPs may have increased a risk of research fatigue and this may have had the potential to adversely affect this study. This was also considered in the selection process.

Recruitment process for council sites and participants

Once in-principle support was gained from a number of contacts within several local councils, participants were provided with a copy of the study abstract and background information. A statement that the study was not an evaluation of the local government was provided to potential participants, as well as an outline of a range of the potential benefits resulting from the study (see Appendix B).

Prior to providing this information I asked existing social contacts if they would be interested in supporting my study, and to gain advice on how best to approach councils to increase participation rates. Initially more than three councils were approached to guard against refusals and to ensure a viable case sample. The three councils included in the study are referred to as Council X, Council Y and Council Z.

The most current MPHPs from three local government areas were analysed for Study 1. The study was conducted during 2007 and 2008.[5] MPHPs were located using the internet search engine Google. Search terms comprised "municipal public health plan" and the location of each case study site. Confirmation that the MPHPs selected for analysis were the most up to date was sought and provided by participants at the time of interviews.

Data collection methods

Liamputtong (2009), Stake (2005) and Gerring (2004) differentiate between the case study as an approach to research and the case study as a research method. According to Stake case study research is best "defined by interest in an individual case, not by the methods of inquiry used" (p. 443). Stake argues that case study research is not a data collection method or "a methodological choice but a choice of what is to be studied" (p. 443). Rather, information about a case is collected using different methodologies and according to Baum (2002), Yin (2003) and Stake (2005), these may be both quantitative and qualitative.

Complementary methodologies were employed for this study as two studies were conducted. The first study was conducted using content analysis of MPHPs from the three selected local council areas, and the second study was conducted through semi-structured interviews with key informants from each site. Interviews were conducted with key informants from different perspectives and positions within the system and who were involved with the local MPHP plan and planning process. Each plan was

[5] Since the time of the study new MPHPs have been prepared. These were not considered as a part of this study.

therefore viewed from different angles and motivations. Fourteen stakeholders were interviewed. This number provided a mechanism to manage any potential researcher bias, and any preconceived notions held by the researcher. It also provided an additional breadth to the research.

Qualitative research

The study was conducted using qualitative research methodology. According to Baum (1995) qualitative research is useful in the health area:

> to explain the economic, political, social and cultural factors which influence health and disease; to gain an understanding of how communities and individuals within them interpret health and disease; and to study interactions between the various players who are relevant to any given public health issue (p. 464).

Methodological triangulation

The research used multiple methods or triangulation to examine local public health planning from "multiple positions" (Neuman, 2003, p. 137). Two methods of data collection were used. This enhanced the validity and rigour of the research. Different aspects of the problem were able to be examined and a more complete picture of MPHP to be drawn (Liamputtong, 2009).

The findings from each study were analysed according to the analytical framework developed for this thesis, which was based on a review of the literature and includes the eight elements of an effective plan. The analytical framework was then applied in Study 1 to assess the extent to which the key elements of effective and sustainable change were evident in MPHPs from each case study site.

The interviews conducted as a part of Study 2 were then analysed to identify the factors and processes that key stakeholders identified as contributing to the successful development of the MPHPs, and whether the eight elements of effective plans were incorporated within them.

The findings of Study 1 and Study 2 were then compared to assess consistency and to test the analytical framework presented in this thesis. This was achieved by: assessing the extent to which the elements identified by participants as contributing to success aligned with the eight elements set out in this study's analytical framework; comparing the extent to which participants considered the MPHP to be a successful and influential plan in achieving sustainable change; and considering factors that that might explain the differences between cases.

The next part of this chapter describes the research method for each data collection method.

Study 1 Content analysis

Study 1 involved content analysis of the most current plans (at the time research was conducted) from each site and examined the main research question:

- Are the key elements of effective and sustainable change evident in local MPHPs?

The findings are reported in Chapter 5.

According to Neuman (2003) content analysis is a process that examines meaning through an analysis of the written text. It is:

> a technique for gathering and analysing the content of text. The content refers to words, meanings, pictures, symbols, ideas, themes or any message that can be communicated. The text is anything written, visual, or spoken that serves as a medium for communication (p. 311).

The text and content included in MPHPs provided the material for the content analysis undertaken in Study 1. According to Lupton (1999) and Perakyla (2005, p. 870) much of the social world is constructed in text. Content analysis provides an opportunity to understand the social context and "how notions and experiences of the social and material worlds are constructed and reproduced in textual form" (Lupton, 1999, pp. 450–451).

In this sense, the text and content found in MPHPs provide access to information about ways in which local councils develop plans to respond to local health needs and issues, and about the concept of MPHPs as implemented in Victoria. It also provides information about the extent to which MPHPs have been integrated into the council organisation and how they will influence action that leads to long-term change to the social and economic conditions influencing health-promoting environments.

Advantages of content analysis

Content analysis is described by Lupton (1999) as an unobtrusive data collection method. Neuman (2003) says that analysing the content of a document allows the researcher to "reveal aspects of the text's content that are difficult to see" (p. 311). Lupton describes several advantages to using content analysis, namely that it is a method that reduces the risks associated with other methods, such as interviews. It reduces bias, misinterpretation of questions, and responses that are provided to meet

perceived expectations of the interviewer (Lupton, 1999, p. 451). Lupton argues that content analysis is more cost effective and accessible than other methods, including interviews (p. 451).

Criteria for analysis: levels of alignment

Each plan was analysed to assess the extent to which the plans incorporated the eight elements of an effective MPHP set out in Chapter 3, which are based on the research literature and the framework developed by Swerissen and Crisp (2004).

If a plan aligns with the eight elements it is likely that the MPHP will achieve sustainable change and new institutional and social rules will be established, both within the council organisation and the wider social and economic context. To allow for a more finely graded analysis I developed 3 levels of alignment.

Each plan was assessed against the eight elements and according to three levels of change. The three levels of change were as follows:

- Level one: Change is not likely
- Level two: Towards change
- Level three: Sustainable change

The more a plan aligns with the eight elements in level three then it is argued that it is likely the MPHP will achieve sustainable change and new institutional and social rules will be established, both within the council organisation and the wider social and economic context.

The indicators for each level of alignment are described below.

Level one: Change is not likely

- Evidence based conceptual and analytical framework: There is no rational basis for priorities or selected interventions.
- Organisational integration: The MPHP is a departmental plan rather than a council-wide plan.
- Resources: There are little to no resources available for implementation.
- Targets and accountability: Type and level of change is not specified and is not measurable. Limited or no accountability measures are in place.
- Intervention level: Interventions target one level of society / focus on individual risk factors.
- Incentives and sanctions: Interventions focus on the provision of education and information.

- Communication: There is no communication within the council organisation or to the community regarding the MPHP.
- Leadership: Leadership is at the departmental level only.

> Plans that align with a majority of level one indicators are unlikely to achieve change.

Level two: Toward change

- Evidence based conceptual and analytical framework: Some aspects of the MPHP are based on an analysis of available data, the local context and in consultation with key stakeholders.
- Organisational integration: Different departments within the council are responsible for implementing some MPHP priorities.
- Resources: Resources (funding, timelines, personnel, infrastructure) are allocated to some priorities.
- Targets and accountability: Some priorities have specified targets and are reported against.
- Intervention level: Some interventions target institutional, organisational and individual behavioural actions for some priorities.
- Incentives and sanctions: Some priorities for action include incentives to drive change.
- Communication: There is some communication about the MPHP to some areas of council and key stakeholders.
- Leadership: There is some involvement in the MPHP by influential decision makers.

> Plans that align with the majority of level two indicators are likely to be heading toward change.

Level three: Sustainable change

- Evidence based conceptual and analytical framework: Priorities for action and selected interventions are developed according to available evidence, including evidence for the effectiveness of interventions and an assessment of local context and capacity and in collaboration with key stakeholders.
- Organisational integration: The plan implements coordinated action targeting the social, built, economic and natural environment for each priority.
- Resources: Resources (funding, timelines, personnel, infrastructure) are aligned to the delivery of each priority.

- Targets and accountability: Specific and measurable targets are set for each priority and progress is reported regularly.
- Intervention level: Interventions target institutional, organisational and behaviour actions for each priority.
- Incentives and sanctions: Incentives and sanctions drive the establishment of social and organisational rules, norms, and practices that lead to and sustain individual behaviour change.
- Communication: A communication strategy designed to promote and report success, local health issues, evidence for change and that provides a feedback loop into the planning cycle is established.
- Leadership: Senior and influential decision makers (e.g. CEO, elected council officials) are directly accountable for MPHP outcomes.

> Plans that align with the majority of level three indicators are more likely to achieve sustainable change and drive the establishment of new institutional and social rules.

These levels of alignment are tabulated in Table 2, which provided the data management tool for Study 1.

Method of analysis and data management

Table 2 was used to record the alignment of each plan with the indicators and to outline the way in which the plan addressed each criterion. During the course of the analysis the plans were read and reread multiple times. During this time the initial criteria developed to assess the plans proved to be unwieldy and at times repetitious. The list was revised and the number of elements reduced until the eight elements and three levels of change finally used to assess the plans were developed. This resulted in a more succinct and manageable table and assessment process. The three plans were then assessed according to the eight elements and the three levels of change and the results recorded in the data management table.

The three plans were then analysed criteria by criteria to assess for alignment. The plans were then examined in detail against each element to ascertain the relevance of the criteria to future planning scenarios.

While the intention was to complete Study 1 prior to the commencement of the interviews (Study 2), the process occurred concurrently and Study 1 was finalised after the interviews. However, the initial analysis of the plans informed the development of the second study. The findings of Study 1 are reported in Chapter 5.

Table 2 – Data analysis and management table

Components of planning	Level 1: Change unlikely	Level 2: Toward change	Level 3: Sustainable change
Evidenced based conceptual and analytical framework	No rational bases for priorities or selected interventions	Some aspects of the MPHP are based on an analyses of available data, the local context and in consultation with key stakeholders	Priorities for action and selected interventions are developed according to available evidence including evidence for the effectiveness of interventions and an assessment of local context and capacity and in collaboration with key stakeholders.
Council X			
Council Y			
Council Z			
Organisational integration	The MPHP is a departmental plan rather than a council-wide plan	Different departments within the council organisation are responsible for implementing some MPHP priorities	Coordinated action targeting the social, built, economic and natural environment for each priority.
Council X			
Council Y			
Council Z			
Resources	Little to no resources for implementation	Resources (funding, timelines, personnel, infrastructure) are allocated to some priorities.	Resources (funding, timelines, personnel, infrastructure) are aligned to the delivery of each priority.
Council X			
Council Y			
Council Z			
Targets and accountability	Type and level of change is not specified and is not measurable. Limited or no accountability measures are in place.	Some priorities have specified targets and are reported against	Specific and measurable targets are set for each priority and progress is reported regularly.
Council X			
Council Y			
Council Z			
Intervention level	Interventions target one level of society/focus on individual risk factors	Some interventions target institutional, organisational and behavioural actions for some priorities.	Interventions target institutional, organisational and behavioural actions for each priority.
Council X			
Council Y			
Council Z			
Incentives and sanctions	Strategies focus on the provision of education, and information	Some priorities for action include incentives to drive change	Incentives and sanctions drive the establishment of social and organisational rules, norms, and practices that lead to and sustain individual behaviour change.
Council X			
Council Y			
Council Z			
Communication	No communication within the council organisation or the community regarding the MPHP.	There is some communication about the MPHP to some areas of council and key stakeholders	A strategy designed to promote and report success, local health issues, and that provides a feedback loop into the planning cycle is described.
Council X			
Council Y			
Council Z			
Leadership	Departmental leadership only.	Some involvement in the MPHP by influential decision makers.	Senior and influential decision makers (eg CEO; elected officials) directly accountable for MPHP outcomes.
Council X			
Council Y			
Council Z			

Study 2 Semi-structured interviews

Study 2 analysed each case study site to determine the factors and processes that affect whether MPHPs incorporated the key elements of effective change. The study

aimed to explore the MPHPs from the range of different perspectives held by key stakeholders from within and external to the local council. Study 2 was conducted using semi-structured interviews and addressed research sub-questions one and two:

- Are the key elements of effective and sustainable change evident in local MPHPs?
- What factors and processes affect whether MPHPs included the eight elements of an effective plan?

The following section provides an overview of the literature about semi-structured interviews and the methodology used for this study. The study findings are presented in Chapter 6.

In-depth interviews provide a means to access information and "areas of reality that would otherwise remain inaccessible" (Perakyla, 2005, p. 869). According to Liamputtong (2009, p. 43) "the essence of this method is the assumption that people have essential and specific knowledge about the social world that can be articulated by verbal messages". Semi-structured in-depth interviews were selected for this study because they enable the story behind the development and implementation of MPHPs, as well as any achievements occurring as a consequence of the plans, to be explored according to different perspectives (Liamputtong, 2009).

Advantages and disadvantages of semi-structured interviews

There are a number of advantages of using in-depth and semi-structured interviews. According to Liamputtong (2009, p. 61) semi-structured and in-depth interviews provide the opportunity to examine topics of interest in depth, and to clarify the information as it is provided. As Baum (2002, p. 170) observes, in-depth interviews "provide richer, more complex data than tick-in-a-box surveys".

Semi-structured interviews provided the means to explore MPHPs with stakeholders from the local council, the state government and the community. Respondents had different levels of involvement with the MPHP planning process, and had different understandings and perceptions about the plans, their effectiveness, and the factors contributing to their success. The interviews also provide a complementary source of data to the content analysis conducted for Study 1, including information about MPHPs

and the associated planning process that cannot be sourced through the analysis of the written plans alone.

However, there are limitations to the use of qualitative methods including in-depth semi-structured interviews. Neuman (2003) points out that the use of interviews can be time consuming and costly. There is also a reported risk of interviewer bias (Neuman, 2003) and that the interview process can be unduly influenced by the researcher (Liamputtong, 2009).

Selection process

The interviews for Study 2 were conducted between 2008 and 2009 and were based on MPHPs current at the time of the study.[6] The participants for this study were selected to capture a range of different views, perspectives and interpretations of the MPHP, from people who were involved in the planning and implementation of the MPHP and who were from different parts of the system. This provided an opportunity to view the MPHP and planning process from several different angles.

Key informants who had a role in the MPHP planning process, either in a planning, decision-making or management role, as well as a governance capacity were recruited from "inside" local government. Key informants were also recruited from the local community health centre or equivalent and from the state government regional office.

Sample size

Liamputtong (1999) and Baum (2002) both observe that there are no set criteria for determining an appropriate size for an interview sample. Rather, Liamputtong says that the decision needs to be informed by "whether the sample provides enough data to allow the research questions or aims to be thoroughly addressed" (p. 15). The sample size should ensure that quality and depth are not compromised (Liamputtong, 2009). Baum (2002) highlights that the sample relates to the research question being posed, the purpose of the research, and resource constraints. Baum suggests between six to eight interviews for a "homogenous sample" and between 12 and 20 for "maximum variation" (p. 176).

Fourteen interviews were conducted for Study 2. Interviews were conducted with five informants at two sites and four from the third. At each site interviews were held with

[6] Since the time of the interviews, a review of the Health Act has been finalised and a new Health and Wellbeing Act introduced into Parliament, and in December 2010 the Victorian state elections resulted in a Liberal Coalition gaining office. New municipal public health plans have also been developed for each case study site.

two council staff, one elected official, one state government officer from the regional office relevant to the local government area and with the CEO of the community health centre or equivalent organisation as in the case of Council Y.

Conducting interviews with key stakeholders with different levels of responsibility within the council organisation and the wider environment provided an opportunity to cross-check information and gather alternative views (Yin, 2003). The different perspectives and connections that each informant had with the MPHP planning process provided this study with a rich and diverse sample of views and responses. Similarities and differences were identified in the analysis, and opportunity for "negative cases" provided.

Recruitment process

Sampling occurred through "snowballing", based on my knowledge of the field and through accessing known contacts to assist in locating interested people within local government or within their own council organisation. According to Liamputtong (2009) snowballing "requires researchers to initially select a few research participants and ask them if they know others who might meet the criteria of the research" (p. 14). Contacts were followed up to gain support prior to the selection of the council as a case study site. Case study sites were selected for inclusion once participants from each category (for example, local council, state government regional office, community health) had given verbal agreement and then formal consent to participate in the study. Initially more than three councils were approached to guard against refusals and to ensure a viable case sample.

Potential participants were contacted via email and phone, and the research purpose and intent was explained. Participants were all provided with an abstract of the study and consent form (see Appendix B) at the time of first contact via email and then again at the time of the interview. The background information included a statement that the study was not an evaluation of the local government, as well as an outline of the potential benefits resulting from the study. Details of the ethics proposal and relevant information sheets and consent forms are discussed at the commencement of this chapter.

Participants were advised that they could cease the interview at any time, and withdraw their comments. Permission was sought at the commencement of each interview to tape the interview and to use interview comments as quotes. Participants were also asked to advise me whether they would like to be informed about the quotes that may be included in the final report. This question was asked again at the completion of each

interview. Consent was provided in each case. Permission has since been sought where possible from those participants wishing to be contacted to use the quotes that were included in the study.

The interview schedule

An interview schedule based on the research questions was developed for the interviews. Two sets of interview questions were prepared. The first set of interview questions were designed for council staff and elected officials. Minor modifications were made to these questions so that they were relevant to those who were external to the council organisation, i.e. state government regional officers and community health officers. The questions were not piloted however interview schedule was also adapted during the course of the interviews depending on participants' responses.

The interview commenced with a brief outline of the study, its methodology, purpose and a brief description of the way in which the concept of change in relation to the MPHP was being interpreted for the purpose of this study. Participants were then asked again for their approval to tape the interview, and were invited to talk about their role and involvement with the MPHP relevant to their local government area (LGA). The interview schedules were included in this study's ethics application and are attached as Appendix C.

On completion of the interview I asked the participants if they would like to add anything further. I then thanked them for their time and contribution, asked them if they would like me to seek their approval for any quotes that I may wish to use in the thesis and explained study time lines and anticipated completion dates.

Description of participants

At the time the interviews were conducted participants all held senior positions within the three sites and were at the time of writing employees of local councils; the state government (regional office with responsibility for the MPHP within their jurisdiction); elected local government officials; and CEOs from community health centres or associated health advisory group. The local council respondents at each site included the council planner responsible for the MPHP, a senior executive with decision-making capacity and an elected council official.

Five participants were selected for interview at each case study site except in one LGA where one state government employee was responsible for the MPHP in two LGAs. A single interview was conducted with this person, covering the two LGAs. Recent staff changes at one site meant that the planner was represented by the coordinator of the

department responsible for the MPHP. This person was actively involved with the MPHP. See Table 3 for a breakdown of the employment status of the interview participants.

Table 3 – Employment status of interview participants

Organisation	Role	Position	n
Local Council	Elected official	Councillor/ Chair MPHP advisory committees	3
	Senior decision makers	Director, General Manager, Manager	3
	Planner responsible for MPHP	Coordinators, Planner	3
Victorian State Government	Regional office responsible for MPHP	Senior policy advisors	2
Community health	CEO of community health centre (2) CEO of peak regional health group (1)	CEO	3

All respondents reported a long involvement with MPHPs, public health planning and community health, local government or work as elected officials. Some reported up to eight years and others over twenty years experience. Three of the fourteen interviewed reported being involved with MPHP at the time they were originally introduced by the state government in 1988.

Location of interviews

Participants were all invited to nominate the location for the interview. In all cases they elected to be interviewed at their place of employment. Interviews were conducted at each participant's workplace, in a quiet space that was separate from the rest of the work environment.

Data management

Validity and rigour

Prior to the interview permission was sought from participants for the interview to be audio recorded, and permission was granted in all cases. However, in one case the audio recorder failed and notes were taken instead. Recording the interviews reduced any possible distractions as a result of note taking, and allowed closer examination and analysis of the interview "as required in qualitative research" (Liamputtong, 2009, p. 55).

Field notes were also made at the time of interview and then shortly after the interview and prior to transcription. Notes were also recorded at various stages of the analysis process. Once transcribed the audiotape was listened to on several occasions in conjunction with the transcript and field notes.

Thematic analysis

I transcribed the interviews verbatim. As Liamputtong (2009) comments transcription by the researcher is the first step in data analysis, and provides an opportunity for the researcher to "become familiar again with the interview" (p. 57).

Once the interviews were transcribed they were analysed to identify themes and patterns. Liamputtong (2009) describes two steps in conducting a thematic analysis. Firstly reading and analysing each individual interview transcript to make sense of and become familiar with the data; and secondly reading the transcripts as a "collective set" to find repeated ideas and "patterns of meaning" (p. 284).

Each transcript was read following Liamputtong's two-step process. Individual transcripts were read and reread several times (initially and throughout the analysis) and then the transcripts were read as a "collective set" to identify emerging themes and patterns. Themes and categories were generated and then refined at each reading. Each theme, category and sub-category was colour coded and recorded on large sheets of paper, one theme and category per page. Sections of text were allocated to the different themes and categories. During the analysis the themes and categories were revised and refined multiple times. The original themes and sub-categories are included as Appendix D.

Whilst reported on separately, many of the factors that were described by participants were connected and interwoven.

Position of the researcher

I was interested to do this study because at the time my role in the workplace was concerned with understanding and providing advice about changing social norms, rules and behaviours governing our society in relation to alcohol and drug prevention. I was interested to know more about the way in which public health plans and funding expectations translate into practice at the local level and about the factors necessary to facilitate the transition of public health planning processes into more outcome-focused processes that result in real and sustained improvements in health and wellbeing at the local level. I was also interested in understanding how local place-based planning relevant to achieving improved health outcomes could best affect outcomes and what

was required to ensure that such plans – including MPHPs – did not just remain “plans on a shelf”.

I had also worked in local council for three years and was concerned about the planning requirements placed on local councils and local communities by the state government. I was also seeking to better understand the capacity of local councils to undertake effective and sustainable planning processes within the political, social and economic conditions that sit outside of local government control. I was also interested in understanding what was required to ensure that local planning processes, such as MPHPs, were relevant and useful frameworks in contributing to improved health and wellbeing at the local level. I was mindful during the course of the study to abstain from sharing my views and perspectives resulting from this experience with the research participants.

Working with state government I was also mindful to separate my professional role from the role of researcher, to ensure that it did not influence responses and reduce the reliability of the study. I was working in a different division from the department responsible for MPHP, which stepped me away from having any involvement in MPHPs. During the course of the interviews, and later during the analysis and reporting stages of the research, I took care to observe my attitudes and perceptions and to put them aside and I continued to check them during the course of the research analysis and reporting phase.

Throughout the course of the research as well as this constant checking of my views and position, I wrote a diary, discussed my views with my supervisor and trusted colleagues in order to identify and be aware of my assumptions, as well as any prejudices and preconceived ideas. When necessary I put my views aside.

CHAPTER 5 – STUDY 1 FINDINGS

Introduction

Chapter 5 presents the research findings for Study 1. The findings for Study 2 are presented in Chapter 6.

Study 1 examined the main research question of the thesis, investigating whether the key elements of effective and sustainable change were evident in Victorian MPHPs. As described in Chapter 4, the research was conducted using case study design. Data was collected from three Victorian local councils. The first study involved a content analysis of MPHPs from each site. This section begins with a summary of the criteria used to assess the three MPHPs before outlining the study findings.

Study 1 involved a content analysis of the most up-to-date MPHPs (at the time of the study) from each of the three case study sites. The three plans were examined against the eight elements of an effective plan, and classified according to the three levels of change described in Chapter 3 (change unlikely; heading towards change; and sustainable change). The indicators used in this study were developed from the literature reviewed in Chapter 2, and Swerissen and Crisp's (2004) framework and are set out in Table 1 in Chapter 3.

The results of the analysis are reported in the following section and are displayed in Table 4.

Findings

The three councils were all compliant with the legislation governing the development of MPHPs. At the time of the study each council had up-to-date plans, and each council demonstrated a commitment to the idea of local public health planning within the context of a social model of health.

As illustrated in Table 4, two plans (Council Y and Council Z) were assessed as aligning with the majority of indicators for a MPHP that was heading toward achieving sustainable change (level two). One plan, the plan for Council X, met the majority of indicators for level one. The plan for Council X was therefore assessed as unlikely to

Table 4 – Alignment of case study MPHPs with key elements

Components of planning	Level 1: Change unlikely	Level 2: Toward change	Level 3: Sustainable change
Evidenced based conceptual and analytical framework	No rational bases for priorities or selected interventions	Some aspects of the MPHP are based on an analyses of available data, the local context and in consultation with key stakeholders	Priorities for action and selected interventions are developed according to available evidence including evidence for the effectiveness of interventions and an assessment of local context and capacity and in collaboration with key stakeholders.
Council X			
Council Y			
Council Z			
Organisational integration	The MPHP is a departmental plan rather than a council-wide plan	Different departments within the council organisation are responsible for implementing some MPHP priorities	Coordinated action targeting the social, built, economic and natural environment for each priority.
Council X			
Council Y			
Council Z			
Resources	Little to no resources for implementation	Resources (funding, timelines, personnel, infrastructure) are allocated to some priorities.	Resources (funding, timelines, personnel, infrastructure) are aligned to the delivery of each priority.
Council X			
Council Y			
Council Z			
Targets and accountability	Type and level of change is not specified and is not measurable. Limited or no accountability measures are in place.	Some priorities have specified targets and are reported against	Specific and measurable targets are set for each priority and progress is reported regularly.
Council X			
Council Y			
Council Z			
Intervention level	Interventions target one level of society/focus on individual risk factors	Some interventions target institutional, organisational and behavioural actions for some priorities.	Interventions target institutional, organisational and behavioural actions for each priority.
Council X			
Council Y			
Council Z			
Incentives and sanctions	Strategies focus on the provision of education, and information	Some priorities for action include incentives to drive change	Incentives and sanctions drive the establishment of social and organisational rules, norms, and practices that lead to and sustain individual behaviour change.
Council X			
Council Y			
Council Z			
Communication	No communication within the council organisation or the community regarding the MPHP.	There is some communication about the MPHP to some areas of council and key stakeholders	A strategy designed to promote and report success, local health issues, and that provides a feedback loop into the planning cycle is described.
Council X			
Council Y			
Council Z			
Leadership	Departmental leadership only.	Some involvement in the MPHP by influential decision makers.	Senior and influential decision makers (eg CEO; elected officials) directly accountable for MPHP outcomes.
Council X			
Council Y			
Council Z			

achieve sustained changes to the conditions that lead to and support individual behaviour change.

The alignment of each council's MPHP with the eight elements of an effective plan is shown in Table 4 and reported in detail in the following section. The shaded area depicts alignment with the criteria.

Alignment with the key indicators

Indicator one: Evidence based conceptual and analytical framework

Indicator one relates to the conceptual and analytical evidence base for the MPHP. Two plans (Council Y and Council Z) were assessed as meeting level two for this indicator: there was some evidence of a clear link between the selected priorities, interventions, and the evidence, and of some aspects the MPHP were developed based on an assessment of available data, an analysis of the local context and in collaboration with key stakeholders.

One plan (Council X) was assessed as meeting the criteria for level one. Rational bases were not provided for MPHP priorities or selected interventions. From the information included in the plan it was difficult to determine the rationale as to why specific actions were included or to determine a link between the selected strategies, the evidence, the existing context, and the changes that were expected to be achieved.

However, each plan did provide, to varying degrees, background information describing the council's approach to achieving improved health outcomes that was consistent with the social model of health. Each council identified the need for action that targeted the local social, built, natural and economic environments, and for action to support and facilitate local responses to local issues. The three plans included background infor–mation about the MPHP (or referred to additional publications) and subsequent plan–ning process, an overview of the local area characteristics (including local health needs and issues), and a summary of the social and environmental conditions affecting local health outcomes. The three plans described the connection between the MPHP and other council plans. The plans for councils Y and Z also described the MPHP priorities within the context of Commonwealth and state government public health priorities.

Each plan identified a range of priorities for action. Several priorities were consistent with the evidence, and with identified public health priorities such as healthy eating, physical activity, mental illness, alcohol and drugs, community capacity, child and maternal health, and tobacco smoking (in the case of Council Y). Key stakeholders were also reported as being involved in all stages of the MPHP at each site. Council

Z's action plan included a description of the partnership agencies that were involved for each specific strategy. However, the link between the theory underpinning the MPHP, the evidence, and the selected interventions in all three plans was less clear and at times open to interpretation.

While the plan for Council X included some analysis of the local context, including a description of the theory underpinning the council's approach to addressing local public health issues, and information about the local area context, the translation of this information into the plan and related activities was not evident. It was difficult to determine any relationship between the described issues, the priorities identified for action and the selected interventions. For instance, the priority goals set out in the plan for Council X are as follows:

- reduce health inequalities
- build collaborative efforts
- strengthen community amenity
- celebrate participation in community life.

The mechanisms through which these goals were to be achieved were specified as follows:

- leadership and advocacy
- capacity building
- community engagement
- ongoing initiatives.

A range of actions was then allocated to each of the above headings. According to the plan "annual strategy plans will implement activities under each of these key roles". However, there was either no explanation of how the selected actions or priority areas and goals were selected or would address identified public health issues referred to in the plan or the explanation was open to interpretation. For instance, actions related to two of the four priority areas described in the plan are shown in Table 5.

Table 5 – Actions related to two of the four priority areas, Council X

Priority area	Action	
Leadership and advocacy	Physical activity	Build a clear picture of physical activity initiatives in Council X. Bring together a range of stakeholders to coordinate existing activities, plan for new projects and address gap.
	Early Years Plan	Continued coordination of the plan
	Food Security coalition.	Build on previous work done in Council X Establish and maintain a food security coalition in partnership with a range of stakeholders
Capacity building	Planning for a healthier Council X forums	Build partnerships between the council and related health groups; hold a forum
	Injury prevention report	Undertake a research report on the impact of injury, suicide and self-harm.

The health issues or problems that the actions are intended to address are not specified, nor are the types of change that are expected to be achieved once the actions are implemented. This makes link between the plan's goals and interventions open to interpretation. The plan for Council X was therefore assessed as meeting the criteria for level one in this category, and as not having clear rational basis for the priorities or selected interventions.

Indicator two: Organisational integration

The second indicator of an effective plan is that it is an integrated whole-of-council plan with different departments in council having responsibility for implementing action targeting the social, economic, built and natural environments identified as contributing to poor health outcomes for each priority area.. Each plan was examined to assess the extent to which it demonstrated an integrated approach. None of the plans was assessed as providing an integrated approach that involved across-council action for each priority.

One plan (Council X) was assessed as providing a departmental plan rather than an across-council plan because one department, primarily the department responsible for developing the MPHP, appeared to be responsible for the plan's implementation and the majority of actions targeted one environment- the social context. This plan was therefore assessed as meeting level one for this particular indicator.

In two plans (councils Y and Z) several departments had responsibility for implementing some of the actions for some of the priorities set out in the MPHP. The two plans were therefore assessed as meeting level two for this indicator. For instance, councils Y and Z identified food security, healthy eating and physical activity as priority

issues. In responding to these issues the two plans recorded different departments as having responsibility for delivering some strategies, including environmental services, engineering, local infrastructure, recreational services, community development and areas responsible for human services.

In the plan for Council Z departments responsible for environmental service, recreational facilities, open space and disability services, including building services, were described as being responsible for the provision of additional infrastructure and services to support and encourage increased levels of physical activity. The department responsible for recreational services was responsible for the development of revised service models and the provision of incentives, including discounted membership for the local gym. The department responsible for local infrastructure was identified as being responsible for upgrading footpaths, and for providing additional outdoor seating, lighting and toilets to encourage outdoor activity.

Action to achieve a more integrated whole-of-council response to the MPHP was included as a priority in the plan for Council Y, signalling an intention to involve more council departments in the MPHP. Strategies to achieve this goal that were documented in this plan included:

- the establishment of a MPHP committee involving representatives from the different council departments and the community to oversee and review the MPHP
- promotion of the MPHP “to improve strategic integration and opportunities for collaboration”
- increase[d] level of participation by council staff in community-based networks.

However, in council Y and Z plans, one department was documented as being responsible for implementing many of the interventions. Rather than demonstrating an integrated and coordinated approach that involved multiple departments in the plans implementation for each priority area, there were instances where the interventions selected to address particular priorities involved only one or limited number of departments. For instance many of the interventions listed in the plan for Council Y were either the responsibility of one or two departments. In one example two departments – the department responsible for community planning and advocacy and the department responsible for environmental health were identified as being responsible for the following actions in response to healthy eating and food access:

- the requirement for new or refurbished council facilities to include kitchens as a means of increasing community access to healthy food

- the intention to establish a policy that required healthy foods to be served at all council functions and facilities
- action to secure additional funding to develop community gardens, and to provide additional food relief
- implementing social impact assessments on new residential developments for food security
- the provision of rent and fee subsidies for charitable organisations running food premises
- the facilitation of forums and partnership meetings with local agencies.

In the plan for Council Z, interventions designed to address the priority area of income insecurity were the responsibility of three departments and involved actions targeting one of the four environments for health (namely, the social environment). In another example one department, the department responsible for family services and community planning was responsible for implementing actions in response to family violence: attendance at local networks and the establishment of a taskforce.

At Council Y, action to address the priority area of mental illness was documented as being the responsibility of one department (community development). The plans for councils Y and Z were assessed as meeting level two for this criterion, with different departments in the council having responsibility for implementing some priorities.

Table 6 provides a brief summary of examples of responses for this element.

Table 6 –Organisational integration

	Issue	Department/program area
Council X	Access to healthy food	Department responsible for Community and social health and wellbeing
	Council leadership and advocacy	Department responsible for Community and social health and wellbeing
	Physical activity	Department responsible for Community and social health and wellbeing
Council Y	Lack of physical activity	Recreational services Open space Disability services Building services
	Food security and access	Community planning and advocacy Environmental health
	Mental illness	Community development
Council Z	Physical activity	Recreational services Local infrastructure Disability services Engineering and local infrastructure
	Domestic violence	Family services
	Increase access to healthy food	Aged and disability services Culture and community planning Family services
	Income insecurity	

Indicator three: Resources

The third indicator of an effective MPHP is the provision of resources, including funding, timelines, and personnel, strategically aligned to the delivery of each priority.

Each plan was assessed to determine the level and type of resources that were allocated to the delivery of the MPHP. The analysis revealed little information about the level or type of resources that were allocated by any of the three councils to either the MPHP as a whole, or in relation to specific actions. There were, however, two instances in the plan for Council Y where specific funding was recorded as being allocated to the delivery of these actions. This included details of small grants from the Department of Human Services to implement a MPHP best-practice project related to the goal of achieving a more integrated approach to the MPHP, and for the council to participate in a regional best-practice planning project.

There were several instances in each plan where it could be assumed that funding and resources had been allocated to the MPHP. The plan for Council Y included a commitment to the "upgrading of existing spaces to encourage physical activity", an action that if it were to be implemented would require funding. However, information about the extent and nature of the upgrades, about the level of funding and resources needed for the upgrades and about the level of resources allocated to achieve the unspecified upgrade was not provided. In another example action included the provision of subsidies to charitable organisations to increase access to healthy food. Whilst it could be assumed that funding and resources had been allocated to deliver this action, details about the level of funding and the extent of change to be achieved as a result of this action were not specified.

A similar scenario is evident in the plan for Council X. The plan described the allocation of funding to increase the number of local walking groups in different locations. As in the previous examples, information about the number of groups, the extent of the program's reach and therefore the level of funding to be allocated to this action was not provided. There were also several instances in the Council Z plan where implementation was reported as being subject to budget availability and hence unknown.

The plan for Council Y was assessed as allocating some resources to some MPHP priority areas because it included reference to the amount of funding that was allocated to two actions. The lack of information about the resources to be allocated to the MPHP in the plans for councils X and Z resulted in those two plans being assessed as meeting level one for this indicator and as allocating little or no resources for implementation.

Indicator four: Targets and accountability systems

The fourth indicator of a successful MPHP is the inclusion of specific and measurable targets that are aligned to MPHP priorities for action, and the inclusion of accountability systems to monitor and report progress.

None of the three plans included specific or measurable targets for any aspect of the MPHP, leaving the plans and intended results open to interpretation. However, all three plans included information about each council's overall vision and also included broad goals for each priority area. As the following examples illustrate these were broad and non-specific and therefore not measurable: "to achieve optimum …" (Y); "to aid in the prevention of …" (Y); "to improve …" (Y); "to increase …" (Z); "to effectively manage …" (Z) "to reduce …" (Z, X); and "to strengthen …" (X). Consequently, the three plans

were assessed as meeting level one for this category, as the type and level of change is not specified and is not measurable.

Each plan included statements signalling an intention to monitor and report on the MPHP's progress and achievements. The plan for Council Y described an intention "to determine the 'overall performance of the plan' including evaluating the results of strategy objectives; monitoring local health indicators; and the perceived performance by key stakeholders". The plan for Council X included a section on monitoring and evaluation that outlined the reporting requirements and timelines for the MPHP. This included presenting Council with the results of "mid-year reviews" and annual progress reports, as well as the publication of a report outlining achievements. The plan for Council Z included a section on implementation, monitoring and review. According to this section the MPHP action plan would be reviewed annually and a progress report provided to Council each year. The plan for Council Y also included a statement that progress measures would be developed in the first year so that progress could be measured and monitored.

Despite the commitment to accountability the lack of specific and measurable targets made it difficult to determine the level and type of change that was to be achieved or reported on. Nor was it clear how and according to what targets progress would be measured, monitored or reported or how departments were accountable for the MPHP's delivery and subsequent success. Without this level of information accountability for the plan and its delivery is limited.

The plans were therefore assessed as meeting level one for this indicator.

Indicator five: Intervention level

The fifth indicator of an effective MPHP relates to the type and level of interventions implemented by the different departments across the council organisation.

Two plans provided some evidence of an integrated approach involving institutional, organisational and behavioural responses for some priority areas (councils Y and Z). However this was not consistently applied to each priority area, and there were examples in each plan of actions targeting only one level of society. The primary focus of the plan for Council X was community partnerships and networks. As such it provided a more narrow approach with action targeting only one level of society.

Institutional actions

A more sustained use of institutional and organisational actions would include extensive changes to council by-laws and funding and taxing policies to address particular issues. Action at this level was evident for some priorities in the plans for councils Y and Z. For instance the plan for Council Z included several strategies targeting council policies relevant to food security. These included:

- the development of a food security policy and food and nutrition plan
- the introduction of council policy for the provision of healthy food options at all council functions and council services
- the establishment and implementation of a unified pricing equity policy to encourage greater use of … leisure facilities by a broader section of the community.

Similar examples were found in the plan for Council Y in response to physical activity. This included action to develop a policy and planning context that facilitates built, natural and environmental strategies designed to create conditions to encourage walking and cycling.

Each plan also included varying degrees of actions requiring local councils to advocate for state government support and funding to increase local access to healthy food and physical activity opportunities. For example, Council X's plan documented a commitment to seek state government funding for the "establishment of community gardens to increase access to healthy foods and reduce social isolation". Lobbying the state government for additional funding to increase opportunities for physical activity was incorporated into the plan for Council Z and action to raise awareness about refugee health and food security formed a part of the plan for Council Y.

Organisational actions

Action targeting the institutional level was complemented by actions targeting local organisations and community partnerships regarding the issue of food security in the plans for councils Y and Z. This was less evident in the plan for Council X. For instance, each plan included actions to influence and support local organisations and local community groups, to promote service access and opportunity, and support individual behaviour change. The plans for each of the three councils documented strategies to facilitate and support community participation in the MPHP planning processes, including its implementation, participation on relevant MPHP committees and involvement in community consultation processes.

Each plan also included a range of actions designed to support and promote local community networks and agencies act and respond to local issues. For instance the plan for Council X included action to facilitate regular meetings between local organisations, community groups and residents as a means of sharing information about food access issues and initiatives. Other examples included the use of committees with non-government organisations and state representatives to monitor the implementation of policies relevant to road safety.

Individual actions

All three plans included at least one intervention that targeted the individual, including the provision of information and education about healthy eating, food access and physical activity, as well as discounts to encourage greater participation in local sports venues.

Table 7 provides a brief summary of examples of responses for each council to the goals of increased physical activity and health eating, showing institutional, organisational and individual actions. It shows that plans for councils Y and Z provide a more consistent approach, targeting the different levels of society, while Council X's plan focuses on local organisations.

The plan for Council X differed from the other two plans in that the MPHP priorities targeted council's role rather than the local health issues. For instance many of the strategies included in the plan focused on providing support to community programs and partnerships through the provision of information and the establishment of networks. There was little evidence to show that this was implemented in a coordinated way involving institutional, organisational and individual actions. Whilst this level of action is important to build community capacity, it was undertaken in isolation from institutional and individual actions, so changes to the social rules and norms that support organisational change are less likely. Consequently the plan for Council X was assessed as meeting level one for this category, with actions targeting only one level of society. The plans for councils Y and Z were assessed as fulfilling the criteria for level two, with some interventions targeting institutional, organisational and individual actions for some priorities.

Indicator six: Incentives and sanction

The sixth indicator of an effective MPHP is that incentives and sanctions drive the establishment of social and organisational rules, norms and practices that lead to and sustain individual behaviour change.

The use of incentives and/or sanctions as a mechanism for achieving change was evident to some extent for some priority areas in two plans (councils Y and Z) while the third plan focused on the use of education and information (Council X).

Examples of incentives in the plan for Council Z included the use of membership discounts, reduced entry fees to the local sports centre and the distribution of travel packs to those who used public transport, walked or rode to their local sporting centre. The tying of funding to priorities was evident in plans for councils Y and Z with the criteria for community grants being adapted to include MPHP priorities.

Incentives were also provided to encourage and support local organisations act on and provide for social needs. For example, the plan for Council Y included action to reduce registration fees for food premises operated by not-for-profit community groups. At Council Z, funding was to be allocated to support and maintain community support programs for meals and in the plan for Council Y inspections by the environmental health services teams were to be conducted to ensure compliance with kitchen

Table 7 – Institutional, organisational and individual actions to achieve the goals of increased physical activity and healthy eating

Issue	Institutional actions	Organisational actions	Individual actions
Council X MPHP			
Healthy eating Food access	▪ Seek state government funding for the "establishment of community gardens to increase access"	▪ Establish and support community partnerships ▪ Facilitate workshops on the issue ▪ Scope options to establish community gardens in specified locations	
Physical activity Activities to increase levels of physical activity	▪ Identify where action is needed to increase participation by residents in physical activity	▪ Establish walking groups for residents	
Council Y MPHP			
Healthy eating Access to healthy food and nutrition	***Policy development*** ▪ Incorporate healthy food choices at all council functions and facilities ▪ Introduce council policy for the provision of healthy food options at all council functions and council services ▪ Incorporate healthy eating strategies in the council plans for aging and early years ***Advocacy*** ▪ Seek funding for community gardens and range of other programs and services and partnerships ***Funding*** ▪ Reduce registration fees for the not-for-profit groups providing meals ***Built environments*** ▪ Have kitchens approved by environmental health officers in council facilities	▪ Establish community forums and partnerships ▪ Disseminate information to schools to build partnerships ▪ Introduce pilot for a community cafe	▪ Provide free fruit to children through local schools

Table 7 continued

Issue	Institutional actions	Organisational actions	Individual actions
Physical activity Activities to increase levels of physical activity	***Policy*** ▪ Implement the bike and walking trails policy ***Resources and Funding*** ▪ Appoint disability access staff to encourage people with disabilities to participate in physical activity ***Built environment***	▪ Establish and support partnership programs with key agencies in the municipality ▪ Include the promotion of physical activity in the community grants program criteria for funding ▪ Enhance skills in working with at-risk groups through staff training programs ▪ Provide incentives for staff to participate in physical activity	▪ Implement programs for specified groups and in specific high-risk locations ▪ Introduce reduced membership fees for the local gym and provide incentives for target groups to join the local gym
Council Z MPHP			
Healthy eating Access to healthy food and nutrition	***Policy development*** ▪ Develop a food security policy and food and nutrition plan	▪ Establish community forums and partnership ▪ Disseminate information to schools to build partnerships	
Physical activity Activities to increase levels of physical activity	***Policy development*** ▪ Develop a physical activity plan for the municipality ***Resources and Funding*** ▪ Establish and implement a unified pricing equity policy to encourage greater use of … leisure facilities by a broader section of the community ***Built environment*** ▪ Identify opportunities to upgrade infrastructure that will encourage physical activity and walking	▪ Establish and support partnership programs with key agencies in the municipality ▪ Enhance skills in working with at-risk groups through training programs for staff ▪ Provide incentives for staff to participate in physical activity	▪ Implement programs for specified groups and in specific high risk locations ▪ Introduce reduced membership fees for the local gym and provide incentives for target groups to join the local gym ▪ Provide incentives for people who walk or ride to leisure facilities

regulations. At Council X funding was made available to encourage additional walking groups in the area.

However as Table 8 shows, there was limited evidence to show the use of institutional and organisational strategies – such as council by-laws, taxation and funding policies, and other enforcement regimes such as fines – to address health priorities. For example, this could include the introduction of council by-laws and enforcement strategies such as fines and education strategies targeted the regulation of the consumption of alcohol in public places to address substance abuse as set out in the plan for Council Z. Subsequently two plans were assessed as using incentives in some instances, albeit limited, and were therefore assessed as meeting the level two criteria for this category. One plan (Council X) focused on the use of education and information and was therefore assessed as meeting the criteria for level one.

Table 8 – Examples of incentives

	Institutional	Organisational	Individual
Council X	Funding to be made available to encourage additional walking groups in the area.	Hosting forums and training	
Council Y	Funding tied to MPHP priorities through the use of the community grants program Kitchen facilities to be assessed as meeting environmental health standards	Action to reduce registration fees for food premises operated by not-for-profit community groups Inspections by the environmental health services team to be conducted to ensure compliance with kitchen regulations	
Council Z	Funding tied to MPHP priorities with the criteria for community grants being adapted to include MPHP priorities	Funding to be allocated to support and maintain community support programs for meals	Membership fees for the local gym reduced Travel packs to those who used public transport, walked or rode to their local sporting centre

Indicator seven: Communication strategy

Indicator seven is that the plan describes a communication strategy designed to promote and report successes, local health issues, and to provide a feedback loop into the planning cycle. The three plans were each assessed as having met this criterion.

Each plan provided a description of a detailed reporting and communication process for the MPHP, including the requirement to provide an annual report to the council. The plan for Council Z included a statement signalling the intent to develop a

communication strategy: “A Communication Strategy will be developed to ensure the aims and objectives of the MPHP are clearly communicated and understood by a variety of audiences”. The three plans also provided a communication tool in their own right, as each plan included background information about the MPHP, the theory and legislation underpinning MPHPs and a description of the council policy and program context.

Indicator eight: Leadership

The eighth indicator of an effective plan is that senior and influential decision makers (e.g. CEO and elected officials) are directly accountable for outcomes.

The three plans each recorded some involvement by influential leaders, namely elected officials, in the MPHP. At councils X and Y elected council officials were reported as chairing the relevant MPHP advisory groups. At Council Z the CEO was described as being responsible for the implementation of one action. However, information describing the CEO and other senior people as being directly accountable for the MPHP outcomes was not apparent. Consequently the three plans were assessed as aligning with level two for this indicator.

Summary

MPHPs from three case study sites were examined to assess the extent to which the plans aligned with the key indicators of an effective local public health plan. These eight indicators were developed from the literature, from the social model of health and applying the framework developed by Swerissen and Crisp’s (2004) approach to change. The eight elements covered the conceptual and analytical evidence base, organisational integration, resources, targets and accountability measures, intervention level, incentives and sanctions, communication, and leadership.

The more a plan aligned with the indicators the more effective the plan was assessed as being, and therefore the more likely a particular MPHP would achieve sustainable changes to the social and environmental conditions leading to and supporting healthy behaviour. Three levels of alignment were defined: level one indicates that change is unlikely, level two that plans are heading toward change and level three that plans are likely to bring sustainable change.

The analysis revealed that the plans either partially aligned or failed to align with the majority of elements. Two plans were assessed as heading toward change while one plan was assessed as level one, with change unlikely to be achieved.

Each plan included to varying degrees a description of the social model of health and statements to the effect that the MPHP and the council's approach to addressing local public health issues was based on the social model of health. Each plan provided to varying degrees a summary of the local health needs and issues relevant to its area, including details about the health priorities for the local area to be addressed over the course of the three-year planning cycle. Each plan included annual action plans outlining programs and strategies. The plans also provided a good communication tool and framework to inform council and the wider community about the health issues of an area, about the MPHP, the social model of health, and about the role of council in improving the health and wellbeing of the local population.

Each plan also included statements describing the council's commitment to targeting the built, social, economic and natural determinants of health, and identified a commitment to supporting and facilitating local communities act in response to local needs and issues and participate in the MPHP planning process. There was also evidence to indicate that each council had established processes to communicate and promote different aspects of the MPHP.

However, there was limited evidence to suggest that any of the three plans would be implemented or would achieve sustainable change in ways that would lead to better health outcomes for identified health priorities. The rationale and evidence for the selection of specific interventions was not always apparent, the level of change to be achieved was not specified or measurable and the level of resources allocated to the delivery of the MPHP was not documented. While each council reported an intent to provide an integrated and whole-of-council response to addressing local public health issues through the MPHP this tended to be inconsistently applied, and implementation was often recorded as being the responsibility of one department in each of the three plans rather than the responsibility of different departments across the council organisation. As a result, the capacity to measure, monitor and report progress was limited, and it was not clear how or if the actions would ultimately lead to sustained change.

There was also limited evidence to show that a coordinated and integrated response targeting institutional, organisational and individual actions had been developed in response to each priority set out in the plan. The use of incentives and sanctions to encourage change, while evident to some extent, were limited in terms of the use of such things as council by-laws, enforcement, taxation and funding policies that the evidence shows is effective in achieving organisational change. As such, two MPHPs

were assessed as heading toward change, and one plan was assessed as unlikely to achieve change.

Study 2 sought to identify the factors that either contributed to, or acted as barriers to, the successful development and implementation of MPHPs at each site.

CHAPTER 6 – STUDY 2 FINDINGS

Introduction

This chapter reports on the findings of Study 2, which examined the factors and processes that contributed to the successful development and implementation of MPHPs. The study aimed to explore MPHPs from the perspective of key stakeholders from within and external to the council organisation, and to use the findings to test the analytical framework that is presented in this thesis. The findings of the two studies were then reviewed from the perspective of the analytical framework to see if they were consistent with the framework.

Study 2 used in-depth semi-structured interviews with key stakeholders from each of the three case study sites. At each site interviews were conducted with senior local government employees, an elected council official, the local community health centre CEO (or equivalent as in Council Y) and with the state government officer from the relevant regional office (one officer had responsibility for two of the LGAs included in this study). Respondents each had knowledge of, responsibility for, or were in some way involved with, the local MPHP. Fourteen interviews were conducted in total. The methodology for Study 2 is explained in Chapter 5.

The questions informing Study 2 are as follows:

- Are the key elements of effective and sustainable change evident in local MPHPs?
- What factors and processes affect whether MPHPs included the eight elements of an effective plan?

Participants' responses were analysed to identify themes and patterns in the data using a variety of processes, including observation of themes emerging from the interviews, a consideration of the interview questions, the literature reviewed in Chapter 2 and the analytical framework developed for this thesis. The themes were reviewed and refined several times and finally considered in conjunction with the key elements of an effective plan. The interview schedule is set out in Chapter 4 of thesis.

There were instances when participants' responses were relevant to more than one theme and text was assigned to more than one category as appropriate during the analysis process. In general, responses were allocated to only one theme.

This chapter is divided into four parts. The first part reports on participants' views about the extent and nature of the influence of the MPHP and provides a brief overview of the achievements that participants described as resulting from the MPHP. The second part reports on the key factors described as facilitating and impeding the successful development and implementation of the plans. The next section considers the alignment between the factors identified by participants and the analytical framework presented for this thesis. Possible explanations for the difference between the three case study sites as assessed in Study 1 are then discussed. The chapter concludes with a summary of the study findings.

Findings

The level of influence of the MPHP

Participants were asked about the level of influence attributed to MPHPs and any achievements resulting from these plans. There was general agreement by participants that local public health planning through the MPHP should continue in one form or another in Victoria (Councillor at Council X, Planner at Council X, Councillor at Council Z, state government Regional Officer at Council Z). Several favoured a shift away from the requirement to develop a separate MPHP, to an approach where a statement covering MPHP priorities was included in the council's corporate plan[7]. As the Manager at Council Y reflected: "the take home message is no MPHP, [rather] a municipal strategic statement"

He continued:

> Our current thinking at the moment is a move away from a plan, more toward an – overall I guess we are calling it – a health statement to be included in our corporate plan … Because if you have a look at the more … corporate structure … the strategic objectives of corporate plans are almost identical to the strategic objectives of Environments for Health that we are using for MPHPs. Environmental, social, cultural, … the whole lot – they are almost exactly the same framework.

In responding to this question participants expressed diverse views. Differences of opinion were apparent even within the same case study site and between those in similar positions at different sites. At each site there were participants who described the MPHP as an influential plan (councillors from councils X and Y, Director from

[7] This has since been enacted with the introduction of the *Public Health and Wellbeing Act 2008.*

Council Z, General Manager from Council X, planners from councils X and Y, and the Executive Officer Community Health from Council Y, Planner at Council Z, Director at Council Z). Others considered that the MPHP had little influence, either within the council organisation or community (Manager at Council Z, Planner at Council Y, Planner at Council Z, Community Health CEOs councils X and Z). As the comments below reveal, there were some instances when participants who described the plan as being influential also expressed the contradictory view that the MPHP held little influence within either the council organisation or the wider community.

A driver of change

Several participants considered that the MPHP was an influential plan and a "driver of change" (Councillor at Council Y). According to that councillor the plan "informed the sector of the direction that it needs to take". The Director, Councillor and the Planner at Council Z described the MPHP as influencing the development of council's strategic directions, and also various other plans including the Municipal Early Years, and the Positive Ageing plans. According to the Director the MPHP provides "a very useful strategic planning tool in terms of driving change and promoting … the emerging themes promoting change … within council".

At Council X the General Manager described the MPHP as influencing the entire organisation: "the program actually permeates all of council". The General Manager and the Planner both reported that the MPHP had led to the employment of additional staff to work on the MPHP and health-related issues.

A summary of existing priorities and actions

Several commented that the MPHP provided more of a summary of already existing plans and activities, and that many of the actions identified as resulting from the plan would have happened or were happening anyway (Director at Council Z, Manager at Council Y, planners at councils Y and Z). The Planner at Council Z explained this as follows: "this MPHP, well the one that was adopted by council, was probably in some ways a collection of a whole bunch of actions that council was already undertaking".

At Council X, the Community Health CEO commented that partnerships between the council organisation, the community health centre and community-based agencies were established independently of the MPHP.

The Director at Council Z observed that while achievements resulting from the MPHP may well have happened regardless of the MPHP, he still considered that the MPHP was an influential, and strategic, plan: "whether it would have been done without the

MPHP there is another matter – it probably would have been, but … the MPHP is a very useful strategic planning tool in terms of driving change and promoting change".

At one site several participants commented that the MPHP had become increasingly influential over recent years. At Council Z, the Director and Planner both commented that while the MPHP had originally developed as a summary of other plans, this was now changing and the plan was gaining more influence within council. According to the Director, the MPHP had moved:

> from being a 70–80% a reflection of existing, yeah, initiatives that were rebadged or sat in council plan or branch plan and were collected to inform the plan … and probably less about driving initiatives within the organisation to now moving more towards 50:50 in terms of the plan informing activities across council so it's … it is being seen as a bit of a driver.

Limited influence

Other comments reflected a view that the MPHP held little influence either within the council organisation or the community (Manager at Council Y, planners at councils Y and Z, Community Health CEO at councils Z and X). In considering the outcomes and influence attached to the MPHP more generally, the Manager at Council Y made the following observation: "Not one initiative has necessarily been because of the MPHP".

Several participants (Director at Council Z, General Manager at Council X, Manager at Council Y, and planners at councils Y and Z) described the MPHP's level of influence within the council organisation as being inconsistent, with some areas of council being "much more influenced by the MPHP than others" (Director at Council Y). This was illustrated in comments made by the Planner at Council Y: "Some other areas of council do know about it and perhaps refer to it but other areas of council don't … know about it".

Others interviewees, including the Planner at Council X, and the Manager at Council Y, described other mandated plans, such as the Municipal Strategic Statement and the Disability Plan as carrying more "weight" than the MPHP. The Manager at Council Y summarised this as follows:

> the equivalent piece of work around land use planning is the Municipal Strategic Statement (MSS). That document informs nearly every single land use planning decision of council so it is really important … it is embedded in some really robust data and every single planning decision is determined by

> that land use document and the planning scheme. There is not even close to an equivalent for MPHP.

Achievements resulting from the MPHP

Participants were also asked about any achievements that may have resulted as a consequence of the MPHP.

Enhanced planning and organisational capacity

At each site there were participants who described the MPHP as "strengthening" council's planning capacity and as leading to a greater capacity within council to respond to local public health issues. At Council Y, the Planner reported that the MPHP had led to "changes to the way in which the council has gone about pulling their plan together". While the Councillor at Council Y commented that the MPHP had led to a more integrated and "multi-dimensional approach rather than a silo approach to planning".

In addition to planning, participants identified MPHPs as influencing organisational capacity. The Planner at Council Z indicated that the plan had "strengthened other local stakeholders' work … in terms of the integration of their work".

At councils Y and Z several participants described the MPHP as being instrumental to their capacity to develop funding submissions that better reflected local priorities and needs. The Planner at Council Y explained this as follows:

> I guess the value I think the health plan has had is that, particularly if we are trying to get additional funding from elsewhere, we have had that strategic framework where we have already identified those issues … we have actually planned some of those things that we want to do, so that enables us to put a case forward about why we should be funded … I think that has probably been the most value.

At Council X, the General Manager said that the MPHP had resulted in greater capacity and expertise across the organisation to respond to public health issues. She provided several examples, including the council's response to graffiti and chroming: "for example, the chroming issue: should it come again we have got so much understanding and knowledge and response now that you would draw upon your own expertise".

The Planner at Council Z and the General Manager at Council X both described the MPHP as contributing to a greater awareness by staff about the social determinants of

health. As the Planner at Council Z explains: “I just think it is the principles about social model of health I think have been well grasped”.

At Council Z, the Director described the way in which one department had developed a response to better align with a wider view of health: “Leisure is an interesting example where they have actually changed from a fitness lifestyle to a community health focus”.

The Councillor, the Planner and the Director at Council Z each talked about how a more accessible and appropriate service response had been established for groups and individuals not currently accessing council’s recreation facilities.

Greater collaboration

Participants at councils Y and Z, including the state government Regional Officer and the Executive Officer Community Health at Council Y considered that the MPHP had led to the establishment of partnerships and a greater alliance between the local community and council. This was evident in comments by the Councillor at Council Y, who reported that some of the key MPHP achievements included the establishment of partnerships, the discussions that occur between key stakeholders, and increased knowledge about the service system and about how to “extract value for money”.

Both the Executive Officer Community Health and the state government Regional Officer for Council Y concurred with these views. The Community Health Executive Officer commented that the plan had led to changes in the way council had developed the MPHP, developed partnerships and “articulated” need. The state government Regional Officer made the following comment:

> [the] food security project was probably really instrumental in getting all the emergency food bank type people … and all these sort of NGOs [non-government organisations] around the table for the very first time ever talking to one another … that was a very significant outcome.

At Council Z the Planner described a more integrated approach between state government and locally identified priorities to public health:

> I think at this stage the main benefits of the MPHP has been in the … work towards a more integrated policy and planning approach internally, and externally better aligns our approaches with state regional and local priorities.

The allocation of funding to priorities

Several interviewees described the introduction of incentives to encourage local organisations and individuals to act in response to particular health priorities. For

example at councils Y and Z several participants talked about the way the Community Grants Program incorporated MPHP priorities to encourage community organisations and agencies to focus on particular health-related issues. At Council Z, participants described the introduction of discounts and awards to individuals to encourage participation in the local recreation centres as an achievement (Councillor, Director and Planner), while others described the MPHP as leading to new and improved facilities such as bike paths.

Impact on health outcomes

While not receiving much comment, several participants made reference to the impact of the MPHP on health outcomes. One participant described the MPHP at Council Y as leading to improved health outcomes, but did not provide specific examples:

> there are some very real … health outcomes I think that have been achieved especially through things like the food security project that they have been involved in … (Executive Officer Community Health Council Y).

The majority of those who did comment on health outcomes were of the view that the plan had had little impact. In considering the effect of the MPHP over the past 20 years, the Manager at Council Y made the following observation: "[MPHPs] have been so at the margins in terms of really making inroads into population health outcomes for people".

Several added that it was difficult to assess the long-term impact of the MPHP (General Manager at Council X, Planner at Council Y). The Planner at Council Y explained this as follows:

> I think that is one of the problems with public health plans is that we don't really know, we don't actually know, what the impact is. I mean we often know whether we have actually achieved some of the individual actions that we have said, but in terms of the short- or long-term impact on communities then we never measure it.

The Planner at council Z commented that that it was too early to tell whether the plan would lead to improved health outcomes: "The degree to which the MPHPs themselves directly influence health and wellbeing outcomes for community, I think is still too early to tell it or yet to be proven".

The intent of local public health planning as set out in the legislation governing MPHPs is to achieve better health outcomes for local jurisdictions. It is therefore notable that there were few comments about the level of influence or subsequent achievements of

the MPHP on health outcomes. Instead, comments tended to focus on planning processes and systems relevant to the development of the plans, and on the extent to which the plans were recognised within the council organisation as important strategic documents.

Factors affecting the successful development of MPHPs

Participants were asked about what they considered to be the factors that contributed to the successful development and implementation of the MPHP.

Resources and capacity

Participants described the level of resources, including funding allocated to the MPHP, and the capacity of the organisation to deliver all stages of the planning cycle as being critical to the plan's success. The following comments by the Planner for Council Y illustrate the impact additional funding made to the organisation's capacity to respond more effectively to the issue of food security:

> I think the key to that one has been that we have had external funding for positions related to food insecurity. We have had two significant projects over the last seven years … that has allowed us to have quite a focus on that particular issue within our department.

The state government Regional Officer for Council Y reported that the provision of additional funding to the issue of food security had resulted in the development of council policies in this area "because they were funded … for a demonstration project … The … focus of the project was to embed food security policy into the MPHP and in Council business. That was a great outcome".

Participants from each site commented that the number of staff with expertise allocated to the MPHP contributed to the plan's success. Several commented that when additional staff were appointed to work on the MPHP, identified health priorities were more firmly embedded in the council's agenda (General Manager at Council X, planners at councils X and Z, Executive Officer Community Health at Council Y). The Planner at Council X explained this as follows:

> if they hadn't appointed a health planner they would have had a lot of trouble doing the work … you have got your plan but you have also got the technical expert who is able to actually draw down on their own professional skills and background and give advice to the committee.

The General Manager for Council X shared a similar view: “if you didn’t have an officer responsible … it would be hard to imagine how you would have the sophistication to get … buy-in … from all those agencies”.

At Council Z, the Director, Planner and Councillor all talked about the importance of ensuring that council staff had the expertise needed to deliver the MPHP actions. They described the impact staff training programs had had on the way in which council officers delivered programs. In one example staff developed an outreach gym program to access groups who did not traditionally attend the council’s recreation facilities.

At each site there were participants who commented on the role individual staff played in generating support for the MPHP. As the Executive Officer Community Health Centre for Council Y commented it was “the experience – almost the personality – of the officer responsible” that contributed to the MPHP’s success.

The Planner for Council X, and the state government regional officers for councils X and Z reported that staff networks played a major role in generating council support for the MPHP, rather than organisational processes and systems. According to the Planner for Council X:

> By virtue of our own personal networks within the organisation we have got cross-organisational commitment and we have given this work a profile. People understand it and know that we do it, but there could be more formal structures.

This view is also reflected in comments by the state government Regional Officer for councils X and Z, who remarked:

> We find it is often staff member to staff member connections that often result in joined up work out there in the community, not necessarily the fact that the planning processes are really strongly aligned.

Key stakeholder involvement

Another factor described by participants as contributing to the MPHP’s success was the involvement by key stakeholders in all stages of the planning cycle (Community Health Centre CEO at Council Z, Executive Officer Community Health at Council Y, Director of Council X). According to the Executive Officer Community Health for Council Y, the MPHP was successful because “everyone had a stake in it”. She commented that the MPHP plan at Council Y was “written in such a way that … [council staff] aren’t the only people who action things”, rather different service providers were responsible for the “rollout [of] various dimensions of the plan”.

In considering the role of key stakeholders at Council Y, the Executive Officer Community Health spoke about the council's approach to the issue of food security. She considered that it was successful because the "right people", whom she described as being those with seniority, expertise and influence, were "sitting around the table" determining priorities, participating in the decision-making process and reaching consensus on the strategies to be included in the plan.

The Councillor at Council Y also reported that the MPHP represented the combined views of different stakeholders. According to the Planner at Council Z previous MPHPs had failed "because they weren't grounded in the community". The CEO of the Community Health Centre at Council Z illustrated this point further:

> At the end of the day the public health plan is as effective as the groups that are involved in it decide to put their resources together and march forward together on the issues. That is really the strength of it. It is not really something the local government can do on its own … I mean it is there to facilitate the process but we – what I mean by that is other public organisations, and I count ourselves as a part of that – have to support the process and have to support the activities and the outcomes.

The Community Health Centre CEO for Council X commented that the involvement of community-based agencies in the MPHP planning process was important because it provided them with an opportunity to work together with council, to influence the council's priorities and to raise issues affecting the wellbeing of the community. Using community safety to illustrate her point, she commented:

> those sort of things that … aren't our core business, but we can sort of influence them and say look you haven't got the lighting right means that people are telling us that they don't go out to walk at night those sort of things. So we work together like that. So we have got the relationship and we have got the sort of data and then we advocate and we basically have got to the point where we work out who's the best to lead.

In the following quote the General Manager for Council X described the benefits of key stakeholders working together with the council to determine the priorities that were to be included in the MPHP:

> [when] people feel empowered they come together, they work as a community with the people who provide the services, agree on what is wrong, agree on what is going to be solved and know that it is going to be done.

The state government Regional Officer for Council Y commented on the importance of local and state government working together on the MPHP. She observed that "good" relationships were instrumental to the success of the MPHP. In considering the role of the state government she attributed the success of the MPHP to the legislation governing the MPHP, a "great amount of good will" and a strong relationship between local governments and the Department of Health regional office: "the relationship building that goes on between the region and the individual local government is paramount to the successes".

Organisational processes and systems

Several participants reported that the establishment of organisational processes and systems to support the planning process had resulted in council staff and external stakeholders having responsibility for the MPHP implementation. At Council Z, participants commented that the establishment of organisational "structures to drive and promote" plans such as the MPHP had led to the MPHP being recognised as an influential and strategic document by different council departments (Director, Planner and state government Regional Officer at Council Z). The Director described this as follows:

> We have a process whereby we engage with the councillors, we ask the organisation – so managers, coordinators – to have input into the planning process reasonably early, so around October, September of each year. We know what are our emerging themes and priorities for the next year, we then take them into a council executive workshop and we come out with directional statements whereby those are hardly ever knocked off but some of them are given higher order status in terms of council priority. That is before Christmas. So by the time people are working on their plans … there is, I suppose, an acceptance that they have been involved in the development of the priorities, … signed off through the council process.

The state government Regional Officer for Council Z considered that the MPHP was influential because it "is embedded very firmly" in the council organisation. She also said that the planning schedule had been aligned to ensure that the MPHP influenced budget decisions: "their internal planning is now quite focused, they have set up the timing so that the MPHP can inform their budget decisions".

At each council, participants reported that key stakeholder support for the MPHP was more likely to be achieved when a variety of processes, such as meetings, community forums and the MPHP advisory committee were implemented. At councils X and Y,

participants reported that community forums provided an opportunity for local agencies to respond more effectively to addressing local health priorities, such as food security. They commented that community forums had led to the establishment of new partnerships, a greater level of awareness about particular issues, and the development of a more coordinated response by local government and community agencies (Council X state government Regional Officer, Community Health Centre CEO, Director and Planner).

The nature and extent of a problem

Another factor raised by participants as affecting the success of the MPHP was the extent to which community agencies and council staff supported particular priorities. Participants at each site and from different positions reported that an issue was more likely to be supported when it was identified by a majority of groups and agencies as a major problem (planners and Community Health Centre CEOs at councils Y and Z, the Manager at Council Y). The more complex and marginalised an issue, the more difficult it was to secure support, and the less likely it was that changes to the conditions affecting health outcomes would be achieved.

In one example, the Executive Officer Community Health and the Planner at Council Y reported that support by the local council to act in response to the issue of food security had gained momentum following the release of local research into the issue. According to the Community Health Centre CEO, there was increasing evidence showing that more people were struggling to access affordable and nutritious food than previously, noting increasing fruit and vegetable prices and the closure of local food stores. She also remarked that local agencies were reporting increased demand for food relief.

Involvement in the MPHP by influential decision makers

Several participants described the involvement of influential individuals as being key to the MPHP's success (General Manager and Planner at Council X, Manager and Planner at Council Z, Executive Officer Community Health at Council Y). At one site (Council Y), the Executive Officer Community Health talked about the importance of leadership. She commented that involvement by the executive level of the council was important:

> Leadership – I mean the leadership at the senior levels … she is the director of this area and she is a very supportive and strong advocate for the plan – so she would keep it on the agenda … she is present at most things even for a short period. So she is involved.

The majority of participants reported that elected council officials acted as advocates for the MPHP generally and more specifically for selected priorities. The Planner at Council Y commented that:

> councillors … have different interpretations and approaches, but I think it is definitely a strong factor in ensuring the framework or the MPHP itself was adopted and guiding principles and … priorities that we would focus on.

The Director and Planner at Council Z shared a similar view. They both described the Councillor as being instrumental to the success of the MPHP. The action of the Councillor was reported as contributing to additional funding being allocated to MPHP priorities, and to a greater level of support for the MPHP by the council. The Councillor at Council Z reported that she had secured in-principle agreement by the state government to partially fund a new sports centre for the municipality, and council agreement to provide funding to a local school to build additions to their sports venue. The Councillor summarised her role as an advocate for the MPHP and particular priorities as follows:

> I have always said at council meetings when council plan comes up or budget … this is part of our MPHP, and we need to ensure to deliver it. It is compulsory to have MPHPs. So I am always reminding people at meetings, whether it is my colleagues or members of executive or other senior managers who aren't in that area of council specifically responsible for MPHPs, that this is a statutory requirement. We [have] got [the] plan and need to use that as a tool to implement our policies and assist in improving our health as a community as a whole.

The types of interventions

At each site participants said that the strategies that were included in the MPHP had contributed to its success. At Council Z, the Manager, the Planner and the Councillor each talked about the council's response to obesity. Interviewees described a variety of strategies that were designed to increase the amount of physical activity undertaken by local residents. Strategies included the staff development programs, revised service delivery models to better meet the needs of groups and individuals who were not accessing council's recreation centres, the provision of funding to the local school to build better sporting facilities, and the introduction of awards and discounted gym memberships.

At Council Y, participants described an approach to food security that was similar to that described by participants at Council Z. In one example the state government

Regional Officer described the local bus company adjusting its bus routes to accommodate neighbourhoods with little access to public transport. This enabled people with no transport to access additional food outlets.

In another example the Director at Council Z described strategies to promote the MPHP and to "celebrate the success" as generating support for the MPHP.

Barriers to success

In considering the factors contributing to the achievements of the MPHP, participants also described a range of barriers. The majority of barriers are the obverse of the factors that participants identified as contributing to the success of the plan.

Implementation

One of the key factors underpinning a MPHPs success was whether or not the plan was actually implemented. Several participants commented that while they had successfully developed a plan they really struggled with its implementation. For instance at Council Y the Planner said that while council had developed a plan, implementation was "patchy". According to the Manager at Council Y, actually translating the MPHP from a framework into action had yet to be achieved:

> the plans are good descriptions of what is, rather than of what to do … I think they are really, really good at describing the context, the public policy environment, the epidemiology – and then once we start wanting to translate that, it becomes … meaningless. We are actually quite hamstrung, so that all we tend to do then is to leave the plans alone and do some community planning where it makes sense, but we do it because we are legislated.

Limited resources and organisational capacity

As described in the previous section participants said that adequate resources and organisational capacity were essential to deliver all stages of the MPHP. However several participants observed that MPHPs were generally under resourced. Several participants reported that inadequate funding and staffing levels had had an adverse effect on their capacity to deliver all stages of the MPHP planning cycle (councillors at councils Y and Z, Planner at Council Y).

Participants commented that the level of state and local government funding allocated to the MPHP was insufficient to implement the plan and to ensure that the plan was an influential plan across the council organisation. The Planner at Council Y pointed out that insufficient funding often meant that the MPHP was developed but not implemented or evaluated:

> In terms of the short- or long-term impact on communities then, we never measure it because we simply just don't have the resources, because in fact so much resources goes into writing these documents … our implementation can be quite patchy and … certainly our evaluation is incredibly weak.

Several described funding as being limited and often uncertain. They remarked that limited funding in addition to short timelines often affected their capacity to intervene to the extent necessary to secure changes to the social and economic conditions affecting health (Planner and Manager at Council Y). The Planner at Council Y described the challenges of responding to the structural causes of poor health outcomes within an environment of uncertain and time-limited funding:

> I guess that frustration is – and I don't know if that will ever change, because a lot of the issues do need a long-term consistent sort of chipping away approach … we get offered one-year funding for things and … by the time you get someone on board and get the issues talked about, they are finished.

Others said that inadequate staffing levels affected the extent to which different departments in council took responsibility for implementing different aspects of the MPHP. As the Planner at Council Z described, limited staffing levels reduced their capacity to establish an integrated approach to the MPHP:

> It was … really a shared position. It was probably a 0.5 position, half health planning half community safety, which was one of the difficulties in getting ownership and also ability to … take an integrated approach as well.

Participants commented that the level of resources available to deliver the MPHP was often influenced by the characteristics of the local area. At each site there were participants who described the MPHP as being undertaken in an inequitable and changing environment. Participants described inequities between geographical locations in terms of the type and level of health-related issues facing local communities and in the level of available resources (planners at councils X and Z, Councillor at Council Z, Community Health Centre CEO at councils Y and Z). Participants described some LGAs as operating in an environment of "scarce resources" and competing priorities (Manager and Planner at Council Y, Planner at Council X), where "demand outstrips supply" (Councillor at Council Y), and other LGAs as being "resource rich" (Planner at Council D, Director at Council D).

At Council Z, the Planner described the LGA as being characterised by a rapid turnover in the local population. The Planner commented that this affected their capacity to

monitor changing trends, and to measure any achievements that may have occurred as a consequence of the MPHP:

> If you look at the indicators of socio demographics, we know every 5 years with the census and so forth that the … things like the SEIFA8 index is improving but … because of gentrification it is not necessarily the same people. Here … almost 50% of the population between census periods … moves in and out, so it is really hard … given that you haven't got a stable population that you can actually measure that.

The Director at Council Z also commented that there was a need for additional state resources to support the planning process:

> stepping down and facilitating or assisting good planning processes, and it is about the provision of data, the provision of expertise, the provision of resource packs and the like because the state does have access to enormous resources.

Competing and multiple planning requirements

Others described the MPHP as occurring within an environment characterised by multiple and competing planning requirements, and program and funding opportunities that did not necessarily align with those of the MPHP.

The Executive Officer Community Health at Council Y explained that: "municipalities have in excess of 50 plans due each year to state government and … it might be better to … to kind of loosen that up … and to create a couple of … plans". According to several participants this reduced their capacity to respond adequately to the MPHP (Councillor at Council X, Manager at Council Y, Director at Council Z, planners at councils Y and Z, state government regional officers at councils X, Y and Z) and affected their capacity to successfully deliver all stages of the MPHP.

The Director at Council Z was of the view that the state government had a key role to support and facilitate local councils with the MPHP planning cycle. He argued that there was a need to rationalise the existing planning requirements to avoid duplication and to better support local councils:

[8] The SEIFA refers to the Socio-economic Indexes for Areas. The Australian Bureau of Statistics describe the SEIFA as comprising four indexes that measure different aspects of the social and economic characteristics of a geographical location. The four indexes for the 2006 SEIFA are Index of Relative Socio-economic Disadvantage; Index of Relative Socio-economic Advantage and Disadvantage; Index of Economic Resources; and Index of Education and Occupation (Australian Bureau of Statistics, 2006).

> I think there does need to be a level of rationalisation of the plans that are mandated, so where there is MSS, where there is MPHP, where there is council plan, where the budget is … rather than just mandating, they [the state government] need to have a sort of facilitative role in terms of lifting performance and making it easier to clarify …

The Community Health Centre CEO at council X and the Executive Officer Community Health at Y concurred with the Director at Council Z in arguing that action was required to avoid 'duplication of effort" (Community Health Centre CEO at Council Z).

The planners at councils Y and Z described multiple advisory structures, "health and wellbeing working groups", and community action plans that were not necessarily linked to the MPHP and that needed resources.

Several described the social model of health as making the planning environment more complex and difficult to manage. They commented that whilst the approach had increased the opportunities for local councils and communities to respond to public health issues, it had increased its complexity, making it harder to secure support or respond to the extent necessary as many of the factors needing to be addressed were beyond the capacity, scope or mandate of local council. The Planner at Council Y commented as follows:

well sometimes I think it is a waste of time…because what is the point of telling people not to smoke cigarettes if they haven't got secure housing and they are unemployed and their kids aren't getting a good education? Really, what is the point? I mean, and that is such a little part – look I know there [is] a health impact, but in some ways, like – but it is such a bandaid thing.

The Community Health Centre CEO at Council X observed that the breadth of issues that could be responded to according to a social view of health could in effect reduce the level of ownership. She argued that:

> because it is so broad and of course if you take a broad view of health then it needs to be broad, but it is sort of hard to know how to actually do it, because it could be volumes really … if you wanted to document everything . But I don't think you can and by default some people won't feel any ownership of it.

The planners at councils Y and Z, and the General Manager at Council X talked about multiple planning processes that targeted similar priorities to the MPHP, but were either disconnected or undertaken independently of the MPHP. The Planner at Council Y

explained this as follows: “You have got the council plan on top and then the MPHP and the MSS and then below that you have got a whole raft of policies and plans and strategies”.

At Council X, the Planner and the CEO of the local Community Health Centre described a range of council plans and documents relevant to health and wellbeing, and in doing so commented that there was “a lack of clarity” about which document actually comprised the “public health plan.”

The planners at each council, and the Community Health Centre CEO at Council X reported that introduction of state government programs and funding opportunities, such as Neighbourhood Renewal, had detracted from their capacity to respond to, and be involved in, the MPHP. According to the Community Health Centre CEO at Council X:

> Perhaps we haven’t been able to do as much so on physical activity … because of that is about changing circumstances and not changing resources, people coming and going, people advocating for something and then getting it like Neighbourhood Renewal, which changes the whole thing … it hasn’t had quite the same focus, so it is about timing and it is about capacity – those sorts of things.

The Planner at Council X highlighted the need for a flexible approach that allowed priorities to be adjusted and resources reallocated in response to new and emerging issues and funding opportunities:

> say in health we had five projects in one year … but along came Neighbourhood Renewal project, where locational disadvantage was identified, and we were lucky that we got the funding … so we have sort of realigned that … it is sort of a push and pull with resources.

The majority of participants considered that the requirement to develop multiple plans and respond to new program initiatives had detracted from their capacity to deliver all stages of the MPHP (planners at councils X, Y and Z, Director at Council Z, Councillor at Council X, the Manager at Council Y, and Community Health Centre CEOs at each site). Multiple planning processes and requirements were reported as absorbing limited resources, which often meant that while the MPHP was developed it was not always implemented or evaluated.

According to the Planner at Council Y, multiple planning processes combined with inadequate staffing levels affected their capacity to adequately resource all facets of

the MPHP, including providing the resources necessary to support the MPHP advisory committee:

> I guess the thing is that we have the health plan and then we have the community safety and drug strategy and they are sort of three key – just resourcing committees like that is time consuming, and we have sort of have limited resources over the last couple of years to actually do a lot of that.

The state government Regional Officer for Council Y described attempts to align the development of the MPHP with other community and health plans but commented that this had been difficult because of the changing local context:

> to align at least our MPHPs to be done around the same time and we got a commitment from … local government around that, however reality is some–one goes on … leave or something happens and you can't recruit and they have ended up being staggered in the end and so … it is a bit idealistic it seems.

Whilst all those interviewed talked about the extensive involvement in the MPHP by community agencies, health services and other relevant groups in the community, they were mindful that local agencies had a range of other responsibilities that were not necessarily related to the MPHP. Interviewees commented that local organisations were also confronted with competing demands, which limited their capacity to be involved in the MPHP. The General Manager and Community Health Centre CEOs at councils X and Z commented that community-based agencies and organisations have their own priorities, planning requirements, and reporting processes, in addition to the MPHP. As the Community Health Centre CEO at Council X explained:

> We just don't sit with them at the MPHP, we sit with them at the PCPs [Primary Care Partnerships] and we sit with them at Best Start meetings and we sit with them at neighbourhood renewal meetings … We have a health promotion coordination group …

The Community Health Centre CEO at Council Z and the Planner at Council X agreed that "reaching some sort of shared understanding and some cooperative approach" between agencies was important (Community Health Centre CEO at Council Z). They warned, however, that the requirement for local agencies to work with council on various plans such as the MPHP added an additional burden to these agencies and, according to the Planner at Council X, "risks … burning out our partners". The Community Health Centre CEO at Council Z commented that it "can actually weaken the development of the sort of relationships you need to have to attract resources".

The Planner at Council X commented on the DHS framework *Environments for Health* guidelines and suggested that the evaluation component of the framework could be strengthened:

> I think that Environments for Health is great … but it falls down in the evaluation side. It gives you the tools to do it but it doesn't give you the tools to say we have made a difference. But it is all based on evidence, so you assume … the assumption is that you are on the right track.

Organisational systems and support for the MPHP

Several respondents reported that existing planning and organisational systems and processes within the council organisation limited efforts to establish the MPHP as an influential plan (state government regional officers at councils X and Z, Planner at Council Y).

The state government Regional Officer for Council Y argued that a more integrated approach by the state government was needed:

> [It is] not as well articulated at the state level as it needs to be. I think there is movement toward a whole-of-government approach, but those government departments that have most to do with local government … could do much better.

Participants commented that the level of influence attributed to the MPHP was affected by the timing of the planning cycle within the council organisation and the wider community. Key to this was whether "the plan [MPHP] came first or not" (Executive Officer Community Health at Council Y and Planner at Council Z).

Comments by participants at councils X and Y revealed that the MPHP needed to be more firmly embedded within the council organisation. The MPHP was still viewed as a health plan and the responsibility of the department responsible for council's public health response, rather than a whole-of-council plan. At Council Y, the Planner made the following observations:

> I don't think there is a strong grasp. It still seems to be seen as a human services responsibility rather than, yeah, how the built natural environments can shape health outcomes.

Inadequate funding, and an emphasis on individual staff rather than on organisational systems and processes in part explains the struggle experienced in securing across-council involvement in the plan, and in establishing the MPHP as an integrated plan with different departments having responsibility for its implementation. The Planner at

Council X described the success of the MPHP as relying on the actions of an individual staff member. This created a problem when the staff member left the organisation or was no longer available to work on the MPHP because of other commitments. As the Planner reported, projects lost momentum and in one case the issue "then just went off the boil". The state government Regional Officer for Council Z observed that high levels of staff turnover had had a significant impact on the progress of the MPHP within council and a need for the organisation to "re-engage" with the MPHP.

At Council X, the state government Regional Officer observed that while staff turnover had "disrupted" the progress of the MPHP, the failure to embed the MPHP into the council organisation had had a greater impact on MPHP:

> [Council X] has fairly consistent staff representation, however, having said that, one of the key players left and that caused a bit of a disruption as well … But again it is probably not that the people have been consistent at [Council X] but the processes I don't think have been terribly strong to in terms of their … where the MPHP sits in the sort of structure of the MPHP so … it works both ways I guess … perhaps having a turnover of staff might have caused some other changes, it has been fairly consistent but not at a very strong base within council.

Individual ideologies and priorities were reported as more likely to influence the development of the MPHP when the plan was not supported by organisational systems and processes. As the state government Regional Officer for Council Z observed: "[at one site] the councillor had a very different take of health … and literally led the committee meetings off track … they had a great deal of influence".

Others commented on the need for the three levels of government to work more closely on addressing particular health priorities. According to the Manager at Council Y:

> there needs to be an intergovernmental planning process … the three spheres of government begin to identify our joint responsibility and … an ongoing relationship built between those three levels of government who will look at joint resourcing, funding, discussion, the whole lot.
>
> So I think what we need is an overarching guide statement and commitment of having intent about health the way that we do around land use planning and other things, and then that really it should be part and parcel of the corporate plan, and from that I think based on our local knowledge we could then identify a range of place-based plans or communities of interest or program plans.

The Manager at Council Y emphasised that there was a need to make better use of existing information and to rationalise the number of community consultation processes that were required:

> less community consultation because we have got information all around, use the information we have got, and really really consolidate that intergovernmental discussion about how we are going to do that.

Limited access to relevant and appropriate data

Several participants commented that access to relevant and appropriate data was limited and that this impeded their efforts to measure and monitor the MPHP. According to the Planner at Council Y:

> On some of the risk factors … the particular health issues often – we don't even – can't measure that locally. Sometimes the data is just not available to us to measure even if we had the ability to do it … it often doesn't drill down to the municipal level.

The state government Regional Officer for Council Y reported that in: "terms of measurement and sustainability and all these things, the measurement tools just haven't been there".

Others considered that it was either too difficult, given the many variables affecting health, or too early in the evolution of the MPHP to assess any changes to population health outcomes (General Manager at Council X, Community Health CEO at Council Z, Planner at Council Z). The Community Health CEO at Council Z explained:

> measuring effectiveness or success against some of those loftier goals is very difficult, not just because they are long term. Generally the effects are – generally the effects certainly aren't measurable in the short term but … because of the very complex set of relationships that need to come into play to – in a sense to – realise any type of those goals.

The Community Health Centre CEO at Council Z commented further that because it was a council plan with an internal focus, any outcomes or possible influence that could be attributed to the plan were not apparent beyond the council organisation.

At one site (Council X), the state government Regional Officer commented that there was little evidence of the plan being developed based on evidence; rather interventions were developed in isolation from the evidence. She commented further that this was in part generated by political imperatives:

> They almost jump straight to the … interventions without really working through the planning processes, which involves gathering data, talking to people, working out the best ways of intervening, … to be fair there is a lot of political imperatives to be seen to be doing something.

Legislation and accountability measures

The state government Regional Officer at Council Y commented on a lack of accountability measures for the MPHP at the state government level and of the impact this had on their capacity to support local councils with the planning process:

> we from state government level don't have any requirement other than to say you have to have a MPHP. No one says how you have to do it or you have to show some outcomes.
>
> … I don't have any more authority to kind of push that. That really needs to be them seeing the MPHP as a whole and elevating [it] within their own organisation to make sure it has those connections.

She continued:

> I guess it makes me think about how we at DHS [Department of Human Services] level can support better the planning process. We are certainly aware that that is a role, but again we need to have the means and authority to do that … Centrally they have had a restructure, and local government seems to have kind of fallen off the agenda a little bit, but we are increasingly recognising that local government is the platform that we would see as the most useful to work through, particularly if we are broadening it out to the social determinants.

Participants also discussed the role of the legislation governing MPHPs, and whilst several commented on the benefits of legislation requiring local councils to deliver a MPHP, participants shared the view that the impact of the legislation was limited without additional state government funding and support being provided (state government regional officers at councils Y and Z, Planner, Director and Councillor at Council Z, Planner and General Manager at Council X, Manager at Council Y). According to the General Manager at Council X: "I think the fact that you have to have a MPHP … in the legislation now I don't think it necessarily by itself has any weight".

The Director at Council Z argued that the legislative mandate did not equate to good planning, nor did it guarantee outcomes:

> It doesn't really matter what the legislative requirements or mandated requirements are … It should be a by-product of good planning, and a mandated MPHP doesn't mean you will get good planning, it will mean that you will get a product of some sort with a MPHP badge on it.

Alignment between factors and the analytical framework

The next section considers the extent to which the factors identified by participants as contributing to the success or failure of the MPHP aligned with the analytical framework of this thesis.

Participants described a range of factors affecting the success of the MPHP: the level of resources allocated to the MPHP, the extent to which the organisation had the capacity to respond to all stages of the planning cycle and the involvement of key stakeholders. Several participants reported on the importance of organisational processes and systems to support the planning process, and others commented that issues that were underpinned by a strong evidence base were more likely to get funding and support. The involvement of influential decision makers in all stages of the MPHP planning process was also identified as being important, as were the type of strategies selected to address the identified priorities.

Participants also identified a variety of barriers to the MPHP planning process. They commented that inadequate resources and competing and multiple planning requirements detracted from the organisation's capacity to undertake all stages of the planning cycle. Participants also reported that the plan was not embedded in the council organisation and that a lack of organisational systems and processes often meant that the MPHP success relied on advocates and individual staff. Several reported that there was a gap in the available data to adequately measure and monitor the progress of the MPHP and changing population health trends. Others commented that more support by the state government was needed if the MPHP was to be an influential and strategic plan.

The factors identified by key stakeholders as contributing to or impeding the success of the MPHP were compared with the eight elements of the analytical framework of this thesis. The results are set out in Table 9. This analysis shows that the factors participants identified as either contributing to or impeding the successful delivery of the MPHP were mostly consistent with the eight planning elements. The majority of factors either aligned with or partially aligned with the eight elements. The exceptions were that participants made no reference to the use of specific and measurable targets

Table 9 – Factors identified by key stakeholders as contributing to or impeding the success of the MPHP compared with the analytical framework

Key element of an effective MPHP	Factors identified by participants as contributing to success and extent of alignment	Factors identified by participants as barriers to success
Evidence based conceptual and analytical framework Priorities for action and interventions developed according to available evidence including evidence for effectiveness of interventions and an assessment of the local context and capacity and key stakeholders	***Partial alignment:*** ▪ Involvement in and support for the MPHP by key stakeholders ▪ Council and community-based agencies are responsible for the MPHP's implementation ▪ Involvement by key stakeholders with authority ▪ A collaborative relationship between the state government and local council ▪ The extent to which a problem is felt to be a problem (the local context) ***Not aligned:*** ▪ Evidence for effectiveness not referred to	Limited local capacity, local area characteristics, multiple and competing planning requirements and changing priorities Lack of stakeholder involvement: MPHP not grounded in the community Responding within the social model of health Lack of relevant and appropriate data to monitor and measure progress Lack of capacity to evaluate the MPHP
Organisational integration The MPHP is an integrated whole-of-council plan with different departments responsible for implementing coordinated action targeting the social, built, natural and economic environments.	***Partial alignment:*** ▪ Organisational processes and systems support the planning process ▪ Some examples of some action by different departments targeting different aspects of a problem	Failure to embed the MPHP into the council organisation Lack of organisational systems to support the MPHP planning process Reliance on individual staff and their networks
Resources aligned to delivery of each priority	***Aligned*** ▪ Adequate staffing levels to work on the MPHP ▪ Skilled and experienced staff responsible for the MPHP ▪ The personality of individual staff working on the MPHP ▪ Organisational capacity to deliver the MPHP	***Lack of funding*** Inadequate staffing levels Lack of resources and capacity to implement and evaluate the MPHP
Targets and accountability Specific and measurable targets are set for each priority and progress reported regularly	***No reference***	

Table 9 continued

Key element of an effective MPHP	Factors identified by participants as contributing to success and extent of alignment	Factors identified by participants as barriers to success
Interventions: Level Interventions target institutional, organisation and behavioural actions for each priority	***Partial alignment:*** ▪ Some actions described as targeting some institutional, organisational and behavioural actions of society ▪ Some actions target different aspects of a problem	
Incentives/sanctions Incentives and sanctions drive the establishment of social and organisational rules, norms and practices that lead to and sustain individual behaviour change.	***Partial alignment:*** ▪ The legislation governing the MPHP ▪ Community grants funding tied to MPHP priorities	Lack of accountability measures for the MPHP by the state government The legislation governing the MPHP was limited without additional state government funding and support
Communication A communication strategy that reports local health issues, and that provides a feedback loop into the planning cycle	***Partial alignment:*** ▪ Celebrating the success of the MPHP	
Leadership Senior and influential decision makers (CEO) are directly accountable for MPHP outcomes	***Partial alignment:*** ▪ Involvement in and support for the MPHP by elected officials ***Not mentioned:*** ▪ Senior and influential decision makers (CEO) are responsible for outcomes	

or to the CEO or other senior people being directly accountable for the MPHP's outcomes.

Explanations for the differences between the three plans

The findings of Study 2 were analysed to identify possible explanations for the differences between the plans as assessed in Study 1. This section reports on those findings.

Study 1 found that the MPHPs at two case study sites (councils Y and Z) were assessed as heading for change, while the MPHP from Council X was assessed as not likely to achieve sustainable change. The results of Study 1 are documented in Table 4 in the preceding chapter. As can be seen from the table and the discussion in Chapter 5, the plan at Council X was assessed as complying with six level 1 indicators; one level 2 indicator, and one level 3 indicator. The plan at Council X was assessed as

providing more of a departmental plan rather than a council-wide plan indicating that the plan lacked across-council involvement and influence and was likely to result in actions generally targeting only the social environment, whereas the plans at Council Y and Z incorporated some actions to be implemented by different departments from across the organisation and were therefore more likely to affect changes to the social and economic environment that would support individual behaviour change in a way that could be sustained.

The plan at Council X generally targeted one level of society namely organisations rather than providing a coordinated response targeting institutional, organisational and behavioural actions for each priority. This compares with the plans at Council's Y and Z both of which incorporated some interventions targeting institutional, organisational and behavioural actions for some priorities.

There were also similarities between the three plans. None of the three plans set specific and measurable targets for each priority and had limited or no accountability measures. Each plan described some involvement in the MPHP by influential decision makers, and included a strategy to promote and report success, local health issues and provide a feedback loop into the planning cycle.

After considering the participants' responses, a definitive explanation for the differences between the three case studies sites was not able to be found. However there were some comments that partially explain the differences between the three MPHPs.

A failure to embed the MPHP into the council organisation

One of the apparent differences between the three plans was that there was more evidence to indicate that the plans at councils Y and Z had been embedded to some extent into the council organisation whilst the plan at Council X remained very much a departmental plan. Interviewees at Council X described a lack of alignment between the MPHP, the council's overall response to public health, and wider planning and organisational structures. And while the MPHP was considered by some at Council X to be an influential document, participants also commented that an individual staff member and one department were ultimately responsible for the MPHP's delivery (the Planner and the state government Regional Officer).

Interviewees at councils Y and Z described a plan that appeared to have more traction within the overall organisation, however and as the planner at Council Y commented a

more coordinated and integrated approach to planning within the council organisation was needed:

> [The MPHP is not] strong enough at the moment that it is actually influencing the allocation in, say, engineering or leisure or open space to design walking tracks or things like that … I think … the next challenge for us is to take it to that level …

This is consistent with the findings of Study 1 in that the Council X plan was assessed as providing more of a departmental plan than an across-council plan, whilst the plans at councils Y and Z were assessed as having several departments responsible for the implementation of some of the priorities.

The state government Regional Officer at Council X also described a lack of clarity as to where the MPHP "sits in the … [council] structure". She commented that there was "not a very strong base" in the council organisation for the MPHP. This comment is consistent with those by the Planner at Council X when he described an individual staff member and their networks as being critical to the plan's success, and commented that the MPHP was put aside when new funding and program opportunities became available.

Whilst participants from councils Y and Z also revealed that the success of the MPHP relied on the efforts of an individual staff member, they commented that new planning systems and processes had provided greater organisational support for the MPHP, indicating that the MPHP was more likely to be embedded into the organisation than the Council X plan. Comments also revealed that there was a greater alignment between the MPHP and various council plans and departmental priorities at councils Y and Z, than at Council X. Furthermore, participants from councils Y and Z described different departments as having responsibility for the plan's implementation – a view that is consistent with the findings of Study 1.

One of the issues raised by both the Planner and the Community Health Centre CEO at Council X was that there was confusion about exactly *which* council document was the MPHP. Whilst this was not discussed in any great length, these comments highlight a level of confusion and ambiguity about the MPHP, and raise issues about the extent to which the MPHP was considered to be an influential document beyond the department responsible for the plan.

Summary

Participants all agreed that local action based on a coordinated and collaborative response involving the three tiers of government, and the community and business, was crucial to achieving improved health outcomes. And whilst several participants described the social model of health as having significant resource and capacity implications for local councils and communities there was overall support for having the social model of health as the theoretical framework informing both the state government and local council response to achieving improved health outcomes.

Participants considered that the state government had a key role in supporting and facilitating local councils with the MPHP planning and implementation process. Participants identified a need for greater coordination between different state government departments. They also described multiple planning requirements and suggested that the state government rationalise these to avoid duplication. Several described the need for additional state and local government funding for MPHPs to ensure that all stages of the planning cycle were implemented.

Participants expressed diverse views about the role and influence of the MPHP. Responses varied from those who considered it to be an important and influential plan, to those who described it as having little influence either with the council organisation or beyond. At one site the level of influence of the MPHP was described as having increased over time.

There was a general view that the impact of the MPHP on health outcomes was limited; that it was too early and difficult to measure the MPHP's success or achievements in relation to overall health outcomes; and that the tools and data to measure impact were not available. There also appeared to be no clear criteria or consistent measures that participants used to assess the success or achievements of the MPHP.

Factors contributing to the success or failure of the MPHPs

Study 2 sought to identify the factors and processes that contributed to the MPHP's success. Some of the factors reported by participants as contributing to the successful development and implementation of MPHPs were: the provision of adequate resources, including funding, staffing levels and expertise; adequate timelines; and the implementation of a collaborative, coordinated and integrated approach to the MPHP involving stakeholders from different parts of the system. As the planner at Council Y commented, without involvement by the local community the MPHP failed. Others

described the plan as being effective when interventions targeting the social and economic conditions identified as contributing to a problem were implemented, and when influential decision makers within council and the community were actively involved in the MPHP to drive organisational change and compliance with the MPHP. This is consistent with the findings of Study 1, which found that although influential leaders were *involved* in the MPHP, senior people such as the council CEO were not described as being directly *accountable* for the MPHP outcomes.

Participants also described a range of barriers impeding the success of these plans, including a lack of organisational systems and processes within council to support the MPHP. Participants described the MPHP as being undertaken within a complex system, characterised by multiple planning requirements, a lack of alignment between existing plans and the MPHP, competing and multiple demands and planning requirements, limited staffing and a requirement to act within existing resources. Council staff in particular reported this as affecting their capacity to do little more than develop the MPHP.

In some cases participants commented that delivery of the MPHP depended on the availability and expertise of individual staff, rather than wider organisational systems and responses. When individual officers left the organisation or were required to respond to other priorities, the MPHP and particular MPHP priorities were reported as "going off the boil" – a response that indicates a lack of institutionalisation of the MPHP into the wider public health response of either state government or council.

A lack of funding, limited resources, competing priorities and multiple and complex planning environments and lack of support by the state government were all reported as significant barriers to the successful delivery of the MPHP. Several participants commented that while agreeing with the social model of health, it increased the level of complexity in responding to local public health issues. Participants commented that local councils and communities had a limited mandate, and limited resources and capacity within which to respond to the social and economic conditions affecting health, and argued for a more coordinated and integrated approach involving all levels of government, and the community, as well as business.

Participants commented that particular issues were more likely to be supported when the problem was widespread and affecting the majority of the population. The more mainstream an issue, the more likely it was to get support within council and the wider community. Others described the characteristics of the local area, including rapidly

changing demographics and inequities between LGAs, as having an adverse effect on the capacity of some LGAs to respond.

Participants were also concerned that there was a requirement for local councils to develop and implement the MPHP without additional funding, and within existing capacity. They described an environment characterised by competing priorities, multiple planning requirements, and limited and inequitably distributed resources and capacity. Many raised concerns about competing demands and the inequities that existed between local government areas in terms of health issues and capacity to provide a coordinated and integrated response to local health needs and issues within the context of the MPHP. Several participants expressed concern that while councils met the legislative requirement to develop a MPHP, a lack of resources meant that the plan wasn't implemented, or evaluated.

Alignment between the analytical framework and participants' views

The analytical framework for this thesis sets out eight elements of an effective plan. When participants' responses were analysed according to the eight elements, the results showed an alignment between their views and the framework, apart from two indicators: targets and leadership. This result suggests that the analytical framework for this thesis is useful as a mechanism to inform the development of MPHPs and to assess the effectiveness of future MPHPs.

Differences between the plans at the three case study sites

While none of the three plans was assessed as being likely to lead to sustainable change, two plans (councils Y and Z) were assessed as heading toward change and one plan, the plan from Council X, was assessed as unlikely to lead to change. Study 2 findings are generally consistent with these results. Overall, participants expressed diverse views about the level of influence of the MPHP, its achievements and its impact on health outcomes. There was not a clear or consistent view that the MPHP had led to sustainable change, or about the factors and conditions affecting health outcomes or about health outcomes more specifically.

In considering likely explanations for differences between the three plans as determined in Study 1, comments by participants from Council X indicate that the MPHP sat very much within the realm of the one department responsible for its delivery rather than within the wider organisational context. Comments revealed a reliance on an individual staff member to drive the MPHP and to secure across-council

involvement in the delivery of the plan, suggesting that the MPHP was not embedded in organisational structures and processes.

CHAPTER 7 – DISCUSSION OF FINDINGS AND CONCLUSION

This chapter presents a discussion of the research findings and the conclusion. The chapter describes the thesis context and research questions, and provides a brief summary of the analytical framework for the thesis. It then provides a summary of the major findings against the framework. This is followed by a discussion of the alignment between study findings and the analytical framework for this thesis and the usefulness of the analytical framework in relation to the research findings and the literature. The implications for the use of local planning for health improvement and the future of strategies like the MPHP are then discussed. The chapter concludes with a discussion about the limitations of the study and future research that may be useful, and a discussion of the implications of the study for health planning as a form of social action.

Thesis context

The focus of this research is on planning as a particular form of social action to achieve better health outcomes within the context of MPHPs in Victoria. MPHPs are a widely used social planning strategy intended to improve health outcomes. They have been in place in Victoria for over twenty years, and it is important to learn from that experience.

This thesis sought to investigate local public health planning as a form of social action within the context of MPHPs in Victoria between the years 2003 and 2008.

Eight elements that the literature suggests are indicative of an effective plan that will lead to sustainable change were developed, and these formed the bases of the analytical framework for this thesis, which also drew on the social model of health, and Swerissen and Crisp's (2004) approach to achieving sustainable change within the context of health promotion.

The contention of this thesis is that action to achieve improved health outcomes within the context of health promotion requires coordinated social planning to prevent and reduce institutional, organisational and individual risk factors affecting population health outcomes. Local public health planning provides a mechanism through which this can be achieved. It draws on social capital and is the means through which local communities manage local problems. MPHPs are grounded in that idea.

An effective MPHP is one that leads to sustainable changes in local social and environmental conditions that have an adverse effect on health outcomes, and to the establishment of institutional and organisational rules, norms and practices that promote health and support individual change. To achieve this requires coordinated action targeting institutional, organisational and individual levels of society and the use of interventions including institutional and organisational incentives and sanctions such as council by-laws, funding and taxation policies and enforcement strategies that encourage compliance with new rules, laws and practices that create health-promoting environments.

A MPHP is likely to be effective in achieving this level of change when it is integrated into, and sustained within, a council organisation and when it responds to and leads to the establishment and reinforcement of institutional and organisational rules, norms and practices that lead to and sustain healthy behaviours. A MPHP that incorporates each of the eight elements as listed in chapters 1 and 3 and as discussed in chapters 3 and 5 of this thesis is likely to achieve sustainable change. When a MPHP incorporates each of the elements, it is more likely that new “rules of the game” will be established and sustainable change achieved.

Summary of the major findings against the framework

This thesis sought to test the analytical framework for this thesis within the context of MPHPs in Victoria. The research was conducted using case study design. Data was collected from three Victorian LGAs in two studies.

The thesis sought to identify the key elements of an effective MPHP, whether these were evident in MPHPs from three case study sites and what factors and processes affected whether MPHPs demonstrated these elements. Study 1 involved a content analysis of each plan to assess the extent to which the plans aligned with the eight elements. The plans were categorised into one of three levels of change:

- Level one: change unlikely
- Level two: heading towards change
- Level three: sustainable change.

Study 2 involved in-depth semi-structured interviews with key stakeholders from each of the three case study sites. Participants’ views were sought about the role and effectiveness of MPHPs in driving local responses to improving health and wellbeing and about the factors and processes that contributed to the successful development and implementation of these plans. Participants’ responses were analysed for possible

explanations about the differences between the three plans identified in Study 1. The barriers and facilitating factors identified by participants were checked for consistency with the analytical framework of this thesis and the factors and processes influencing whether or not the plans incorporated these elements were examined. The implications for the use of local planning for health improvement and the future of strategies such as MPHPs were then considered.

The extent to which MPHPs incorporated the key elements

The study found that while MPHPs provide an important strategy for achieving improved health outcomes in Victoria the MPHPs examined for this thesis were unlikely to achieve sustainable change. As such, the opportunity afforded by local public health planning as a form of social action to achieve sustainable change is yet to be fully realised.

Study 1 and Study 2 found that MPHPs only partially aligned with the key elements of successful local public health planning, and that none of the plans was likely to achieve sustainable change. Two plans were assessed as incorporating the majority of elements at a level indicative of a plan that was heading toward change and one plan was assessed as including the majority of elements at a level of a plan not likely to lead to change. The overall results are set out in Table 2.

Study 1 found that the three plans examined fully aligned with only one key element: communication. There were varying levels of alignment between the three MPHPs and the other elements.

Two plans (councils Y and Z) were assessed as being partially aligned with element one: conceptual and analytical framework that included some analysis of the available evidence, some analysis of the local context and in collaboration with key stakeholders. However this was not consistently applied and was apparent for only some priority areas. The third plan (Council X) was assessed as meeting a level of alignment for this indicator that was not likely to achieve change in that it was assessed as not providing a rational basis for priorities or selected interventions. This was because it is difficult to establish a logical link between the priorities identified for action, the selected interventions, the problems to be addressed, and the evidence for effectiveness.

The second element relates to organisational integration. A plan that is integrated into the council organisation and that is based on a conceptual framework that is underpinned by the social model of health is likely to deliver coordinated action targeting the social, built, economic and natural environments for each priority area.

Two plans (councils Y and Z) were assessed as providing some evidence that some departments in the council were responsible for the delivery of some of the actions set out in the MPHP. However there were instances in both plans where one department was recorded as being primarily responsible for the delivery of the plan. One plan (Council X) provided more of a departmental plan rather than a whole-of-council plan, with one department having responsibility for the plan's implementation. This plan was assessed as meeting level one for this element.

Whilst it could be assumed from the information included in each of the three plans that resources had been, or were more than likely to be, allocated to the MPHP, only one plan included specific information about the level of funding available for the delivery of two actions (Council Y). This plan was therefore assessed as having some resources aligned to delivery. The plans for councils X and Z were assessed as providing little or no resources for implementation due to the lack of specificity about funding. The plans were therefore assessed as meeting level 1 for this criterion: little or no resources allocated to delivery.

None of the plans incorporated specific and measurable targets that were aligned to each priority and all had limited if any accountability measures. Rather the type and level of change was not specified and not measurable. Each plan was assessed as meeting level 1 for this criterion.

Study 1 found that two plans (councils Y and Z) incorporated some interventions that targeted institutional, organisational and behavioural actions for some priority issues, and were assessed as meeting level 2 for this criteria. Council X was assessed as primarily targeting local organisations in the form of information provision and sharing, and was therefore assessed as meeting level 1.

There was limited evidence in two plans (councils Y and Z) and no evidence in the third plan (Council X) that institutional incentives were systematically used as a mechanism to drive change. The plans of councils Y and Z included some instances of institutional incentives, including tying funding to the MPHP priorities, and the development of council policies to provide healthy food options at council functions for some priorities. However, incentives were not systematically applied to each priority issue in either plan and there appeared to be limited if any use of the variety of institutional incentives such as council by-laws, enforcement regimes, and taxation and funding policies that are available to local councils, which the evidence shows lead to sustainable change.

Whilst influential leaders were assessed as being *involved* in each of the three plans, there was limited evidence to show that senior people such as the CEO were directly *accountable* for the MPHP's outcomes. The three plans were therefore assessed as meeting level 2 for the indicator related to leadership.

The likelihood of MPHPs achieving sustainable change

The plans analysed in Study 1 were assessed as being unlikely to achieve sustainable change. This finding is consistent with the results of Study 2 where participants expressed diverse and at times conflicting views about the overall effectiveness of MPHPs as a mechanism through which sustainable change was likely to be achieved. Participants had different views about the extent of the MPHPs' influence within council and the wider community and about whether the plans would lead to improved health outcomes. Participants were either unsure, or did not have a view, about the effect of the MPHP on overall health outcomes, apart from one participant who described MPHPs as having made little if any impact on population health outcomes since they were first introduced in Victoria over twenty years ago. This is a serious issue given the purpose of local public health planning is to achieve improved health outcomes.

At one site (Council Z), participants described the MPHP as becoming more influential across the organisation over recent years. This was largely a result of systemic changes to the organisation's planning systems and processes. This accords with the findings of Study 1, which assessed the Council Z plan as heading toward change. At Council X, several participants described a level of confusion about exactly which council document formed the MPHP, which goes some way to explaining the differences between the Council X plan and the plans from councils Y and Z.

Factors and processes affecting the inclusion of the key elements

This research identified a range of factors and processes affecting whether MPHPs included the key elements of an effective plan and whether they were likely to lead to sustainable change. Study 1 findings accord with the findings of Study 2 with participants identifying a range of factors and processes that they described as affecting the successful development and delivery of MPHPs. The majority of factors identified by participants were generally consistent with the key elements. Participants attributed achievements occurring as a consequence of the MPHPs to multiple and interconnected factors rather than any one factor in isolation – a view that is consistent with the literature on organisational change and achieving sustainable change within the context of health promotion (Eagar et al., 2001; Kotter, 1995, 2009; Shediac-Rizkallah & Bone, 1998).

Participants described the level of resources allocated to MPHPs and the capacity of the organisation and local community to adequately participate in, plan for and manage local health priorities. Several described their capacity to undertake all stages of the planning cycle as being limited by existing and competing priorities and planning requirements. Several commented that limited access to relevant and appropriate data had affected their capacity to monitor local health issues and track the progress of the MPHP. Others commented that in some cases existing council processes did not adequately support the MPHP planning process. Participants said there was a need for a more coordinated and integrated approach by the state government in addressing public health issues and supporting local efforts in responding to local health issues through the MPHP.

Participants described the involvement of elected council officials and key stakeholders in all stages of the planning process as contributing to a plan's achievements. Several commented on the nature of the priorities to be addressed through the MPHP and suggested that the extent to which the community and key stakeholders identified an issue as being a major problem affected whether an issue was likely to get funding. Finally and also important was the inclusion of strategies that targeted different aspects of a problem and that involved different council departments in the plan's implementation.

Alignment between the analytical framework and study findings

Overall the findings of Study 1 show little alignment between the three plans and the elements whilst the findings of Study 2 are consistent with the analytical framework developed for this thesis and with the literature. The factors identified by key stakeholders as contributing to or impeding the successful delivery of MPHPs were either aligned or partially aligned with the eight elements of an effective plan. The major discrepancy between participants' responses and the framework was in relation to targets and leadership. None of the participants talked about specific and measurable targets for MPHP priorities, or referred to the need for senior people such as CEOs to be directly accountable for MPHP outcomes (leadership). This is consistent with the findings of Study 1: none of the plans was assessed as including specific or measurable targets, or as having senior people accountable for the MPHP outcomes, although they were supported by influential leaders. Participants' comments were aligned or partially aligned with the remaining elements. Below I discuss each of the elements from the perspective of the participants' comments and the findings of Study 1.

Evidenced based conceptual and analytical framework

Participants described an approach to the MPHP that was consistent with the conceptual and analytical framework argued in this thesis as being indicative of an effective plan. They described factors related to an approach based on the use of available evidence, balanced against local constraints, including existing commitments, priorities and resource availability. The involvement of key stakeholders in the planning process was also a key factor.

Participants said that efforts to establish the MPHP as an influential council plan were constrained by limited capacity, in part caused by conditions in the local social, economic and organisational environment, political imperatives and actions by the state government. Participants also commented that the MPHP planning process occurred within a complex environment characterised by competing and existing priorities, limited resources, and multiple planning requirements. These were described as reducing their capacity to deliver all stages of the planning cycle, particularly the plan's implementation. Participants also described limited evidence and data to monitor local trends, health needs and issues.

Organisational integration

Participants also described a variety of factors that were consistent with the key element of organisational integration. Participants commented that having different departments take responsibility for the implementation of the MPHP was important. They described the benefit of actions targeting different elements of a problem, including responses targeting the social and built environments identified as contributing to poor health outcomes. However, participants also observed that efforts to secure across-council involvement in the MPHP were not always effective, and that responsibility for the delivery of the MPHP sat with one department.

Resources

Participants commented that resources, including staffing and funding, were needed to ensure that the plan was implemented and monitored – a factor that is consistent with the framework. Participants commented that additional funding and staff enhanced their capacity to provide a long-term response to the priorities identified in the MPHP. Inadequate resources were reported as undermining the capacity to deliver all stages of the planning cycle, particularly implementation and evaluation. Interviewees described a range of factors and processes affecting the level of resources allocated to the MPHP including the level of influence attributed to the MPHP within the council

organisation, the level of support by influential individuals, and the extent to which priorities aligned with already existing priorities.

Several participants noted that the state government had a responsibility to ensure that local councils and communities had the resources necessary to develop and implement the MPHP, and argued for a more coordinated approach by local councils and the state government and access to data to monitor local trends, health needs and issues.

Targets and accountability measures

Study 1 found that the three plans did not include specific or measurable targets. This contributed to a level of ambiguity and a lack of accountability in each plan, and also meant that there was limited information about the level and type of change that was expected to result from the implementation of the MPHP

There was also limited reference in the *Environments for Health* framework (DHS 2001) and recent evaluations of the MPHPs about the need for and value of incorporating specific and measurable targets into a MPHP. For instance de Leeuw et al. (2006) in their evaluation of the MPHP reported on the need for additional monitoring processes and incentives to encourage local councils to meet specified targets, but the evaluation made limited reference to the value of including targets in MPHPs or to information about what these targets could encompass or to the extent to which the MPHP or the framework incorporated these.

Interventions: type and incentives

Two of the key elements of an effective plan are related to interventions: that they target institutional, organisational and individual actions related to identified priorities and that incentives are included to encourage local institutions and organisations establish health-promoting rules, and practices that support individual change. Study 1 identified a limited use of incentives, a finding that was consistent with the findings of Study 2. There were instances, however, where participants described the value of actions that were designed to encourage organisational change, such as tying council funding to MPHP priorities and establishing council policies to drive practice.

Communication

Several participants described the importance of reporting the success of the MPHP and local health issues to the local community. This is consistent with the evidence, which shows that securing stakeholder involvement in planning processes is critical to

success and that the implementation of a range of communication strategies contributes to this support.

Leadership

Kotter (2009), Eagar et al. (2001), Shediac-Rizkallah and Bone (1998) and Duck (1998) all agree that successful change efforts are underpinned by senior people with decision-making authority. While most respondents described elected council officials as fulfilling this function, including chairing the MPHP advisory committees, no one talked about the role of the CEO or other senior people as being directly accountable for MPHP outcomes. This is consistent with the findings of Study 1, which found that while influential individuals were involved in the MPHP there was no evidence to indicate that the CEO or other senior people had direct responsibility for MPHP outcomes.

The usefulness of the analytical framework in relation to the findings and the literature

Benefits

Overall the analytical framework developed for this thesis and the eight indicators of an effective plan provide a useful tool to inform the future development of MPHP planning processes. It is consistent with the evidence for achieving sustainable change for health promotion, and with the findings of Study 1 and Study 2 of this thesis, and addressed an identified gap in the literature.

These research findings provide information about the factors and processes needed to ensure the successful delivery of MPHPs as a form of social action to achieve social change. They highlight the need for a consistent set of criteria that can be used to inform the development and evaluation of health promotion plans such as MPHPs. The analytical framework for this thesis with its eight key elements provides a mechanism through which this can be addressed. The data management table (Table 2) provides a useful mechanism to record data so that the results are immediately apparent and so that areas where additional action is needed are highlighted. In doing so it addresses an identified gap in the framework and guidelines for MPHPs.

The analytical framework proved to be a useful mechanism for informing the development of future MPHPs, and for assessing the likelihood that plans would achieve sustainable change. As reported in the last section, the framework is consistent with the majority of factors identified by key stakeholders as affecting the

successful delivery of MPHPs, and with the factors identified in the literature as leading to sustainable organisational change and to achieving improved health outcomes within the context of health promotion and disease prevention.

The elements are consistent with the main tenets of a social model of health, and with Swerissen and Crisp's (2004) framework. The framework aligns with the evidence that shows that long-term changes to health outcomes are more likely to be achieved when individual risk factors adversely affecting health are addressed within the context of the wider social environment. It is also consistent with the need for health promotion programs to strengthen and improve community capacity and social capital, and with the evidence that social and organisational change is needed to create health-promoting environments that support individual change. Institutional, organisational and behavioural action is needed to establish social rules and norms that provide the bases for achieving sustained improvements to health. The elements are also consistent with the approach set out in the state government's framework for MPHPs.

Limitations

Action to achieve social and institutional change is complex and often results in failure. It can be time and resource intensive, and occurs within an environment of existing and competing priorities, and limited resources. And while the framework complies with approaches to social change such as those put forward by Swerissen and Crisp (2004), action at this level is not always feasible. Conditions in the existing political, economic and local environments affect what and how evidence is able to be applied and limits the extent to which plans such as MPHPs can be developed according to a rational approach to planning. As Eagar et al. (2001), Moore and Dietze (2005) and others point out, a lack of evidence, incorrect assumptions, the provision of limited resources, and government policies and political ideologies are realistic limitations to developing plans in a rational way. These factors also present barriers to the capacity of local agencies to develop plans that will lead to fundamental social change, or in setting targets that are measurable and specific. Very often, as the literature and participants in this study highlight, funding is not allocated or known from year to year, and political imperatives demand immediate outputs often at the expense of longer term outcomes.

Furthermore, assessing the extent to which MPHPs are developed based on an assessment of the available evidence about effectiveness of selected interventions and about the local context and capacity requires significant investigation and research prior to assessment. This is not likely to be feasible nor is it realistic as a part of the

MPHP planning process. A focus on the need for evidence-based responses, whilst important, also has the potential to limit the use of new and innovative responses, or acknowledge those already in place and that may, anecdotally, be showing promising results.

In applying the framework it was difficult at times to translate some of the key elements into a useful definition against which plans could be assessed. The descriptions of the elements varied in terms of complexity. For example some elements, such as the element related to resources being aligned to delivery, were straightforward, while the elements related to incentives and intervention types were more complex and risked being open to interpretation. Additional information to clarify the key elements and give examples would enhance the framework.

The implications for the use of local planning for health improvement and the future of strategies such as MPHPs

MPHPs

MPHPs are the designated health promotion and disease prevention planning mechanism for local councils in Victoria. MPHPs provide local councils, in partnership with local organisations, agencies and individuals, with the means to manage local problems and issues affecting the health and wellbeing of local populations. They are enshrined in legislation and the MPHP guidelines, which are underpinned by the social model of health and based on strengthening and developing social capital, and are consistent with the evidence for achieving improved health outcomes.

Victorian local councils, as the level of government with the closest connection to local communities, are ideally placed to develop and implement MPHPs. Local councils have the mandate and the statutory requirements to establish and deliver MPHPs as the means of effectively coordinating the actions of the state, markets and civil society in responding to local health needs and issues and of generating changes to the social and environmental conditions identified as contributing to poor health outcomes. Local councils have a range of mechanisms through which to achieve this, including the provision of funding, services and local infrastructure and the use of regulatory and enforcement regimes such as council by-laws, and funding and taxation policies. These provide the leverage for getting local organisations to comply with and establish health-promoting rules, norms and practices.

However, while the research shows that MPHPs in Victoria provide an important strategy for achieving better population health outcomes within the context of health

promotion and disease prevention, the MPHPs included in this study only partially incorporated the key elements argued in this thesis as being indicative of an effective plan for achieving sustainable social change. Rather the plans were assessed as either being unlikely to achieve change or merely heading toward change, so they are unlikely to achieve better health outcomes.

The findings of this thesis concur with previous evaluations and research into MPHPs. The majority of participants interviewed in Study 2 expressed a view that the MPHP should continue but in a different form, that more state government action was needed in relation to the MPHP, including greater accountability measures, and they argued for greater collaboration between state government departments, and between the state government and local councils in responding to the MPHP.

MPHPs have yet to be recognised as an influential and strategic plan and lack the necessary influence needed to achieve fundamental changes to the rules, norms and practices of society's institutions and organisations that shape public attitudes and behaviours. A critical challenge for state and local government in the future development of MPHPs is to ensure that MPHPs are developed according to the factors and processes identified in the literature as being instrumental to the effective development and implementation of MPHPs.

Whilst significant resources and time have been allocated to MPHPs by the state government, local councils and community agencies and organisations over the years, further action is needed to ensure that MPHPs provide an effective and successful government strategy for achieving improved health outcomes and through which local councils manage local problems. Without continued action and support by all levels of government for the MPHP planning process there is a risk that MPHPs will absorb limited council resources for little end, and local public health planning for health promotion will fail to lead to sustainable change that improves the health and wellbeing of local populations.

The analytical framework

The analytical framework for this thesis provides an important tool for state and local governments for ensuring that local planning for health improvement and strategies such as MPHPs are an effective form of social planning and that they achieve better health outcomes. It provides a mechanism that can be used by the state government, local councils and community organisations and agencies to inform the future development of MPHPs and to evaluate existing plans. It addresses an identified gap in

the literature, and in the current guidelines for MPHPs, and provides an important adjunct to the existing guidelines for MPHPs.

To reiterate, an effective MPHP will focus on action that leads to sustainable change. An effective MPHP is one that leads to the establishment of health-promoting institutional and organisational rules, norms and practices. This is likely to be achieved when a MPHP responds to the social and environmental conditions that lead to and promote individual change. For this level of change to be achieved, local councils need to ensure that the MPHP is integrated into the council organisation, and incorporates the eight elements of an effective plan as set out in this thesis, and as summarised as follows:

- priorities for action and selected interventions set out in the MPHP are developed according to available evidence including effectiveness of the interventions and an assessment of local context and capacity and in collaboration with key stakeholders;
- coordinated action targeting the social, built, economic and natural environment for each priority;
- resources including funding, timelines, personnel, and infrastructure are aligned to the delivery of each priority;
- specific and measurable targets are set for each priority and progress is reported regularly;
- interventions target institutional, organisational and behavioural actions for each priority
- incentives and sanctions drive the establishment of social and organisational rules, norms, and practices that lead to and sustain individual behaviour change;
- a communication strategy designed to report success, local health issues, and that provides a feedback loop into the planning cycle; and
- senior and influential decision makers, including the CEO are directly accountable for MPHPs outcomes.

When a MPHP incorporates these elements, it will most likely be institutionalised into the council organisation, and changes to the social and environmental conditions affecting health will be achieved, and health-promoting rules and practices that support the establishment of healthy attitudes and behaviours will be established. When all this is in place MPHPs are more likely to be effective as a form of social action that leads to improved health. Guidelines that incorporate this type of framework and associated assessment tool are not currently available.

The research shows, however, that it is difficult to achieve systemic change such as that outlined in the analytical framework for this thesis. While the research evidence shows that local councils are ideally placed as the "host agency" for MPHPs, they operate within and are constrained by the local social, political and economic context as well as the actions and policies of the state and Commonwealth governments.

Local councils have diverse and multiple responsibilities and face competing demands for limited resources. Existing priorities, limited resources and political and economic constraints act and interact in ways that affect the extent to which plans such as MPHPs can be delivered to meet specific and measurable targets.

The research also shows that population health outcomes are influenced by a range of factors and conditions beyond the control or mandate of local government and local organisations. Action to achieve improved health outcomes and to establish a MPHP as an effective means through which to act on local health needs and issues therefore relies on the provision of a coordinated and integrated response by all levels of government as well as the community and the individual, and not any one level in isolation. Furthermore, action at this level needs to be sustained over time until new health-promoting rules and systems are established and become the norm.

Implications for state and local governments

A coordinated response involving the state and local governments is therefore warranted to ensure that local councils and MPHPs have the capacity, resources and authority necessary to achieve the level of change argued for in this thesis and to ensure that MPHPs incorporate the key elements that the literature shows will lead to sustainable change. This includes adjusting existing state and council priorities, rules and practices to ensure that accountability measures, incentives and funding are in place to encourage participation and compliance by local councils with the MPHP planning process and that lead to the plans being implemented in ways that lead to sustained change. Without this level of action, MPHPs risk becoming plans with no end point.

To facilitate this process local councils will need to consider and change their existing systems so they can embed the MPHP into their organisation. This includes action related to planning systems and processes, funding allocations and accountability mechanisms, having senior people (including the CEO) being directly accountable for MPHP outcomes, as well as committing to specific and measurable targets for each MPHP priority area. Rationalising the number of MPHP priorities identified for action

may also reduce the breadth of priorities specified for action and in doing so reduce demand on limited council capacity. Another option may be for local councils to focus on a limited number of major priorities each year and align resources and overall council responses to these priorities and use the MPHP to coordinate theses actions.

The *Environments for Health* framework (DHS, 2001) provides the framework and guidelines for the development and implementation of MPHPs in Victoria. While providing a sound overview of the social model of health and planning, it provides limited guidance on the type of analysis needed to determine priorities, or strategies for structuring action for particular types of health issues. It does not articulate specific targets or priorities, which leaves them open to local interpretation.

There is also limited guidance for local government on what targets to set, strategies to employ, or how to measure outcomes in relation to public health issues. There is also limited information about the key elements of an effective plan to inform the planning review and development process. For MPHPs to be effective, the state government needs to rationalise the existing planning context, better align existing plans and public health responses with the MPHP planning process, and develop indicators for an effective MPHP to assist local councils review and develop new plans.

There is limited resource support or sanctions and incentives for local governments to meet performance targets for their MPHP. So from an institutional-level analysis, limited leverage has been applied to get a clear, concrete and sustainable model in place in local government that will improve health outcomes. Implementation depends critically on local advocates in council or the management of local government, because there are few if any state government sanctions and incentives. One way to achieve this is through the Environments for Health framework.

A better model would be for the state to (a) set limits on the focus of MPHPs and establish priorities for action that are linked to overall state and Commonwealth government public health priorities; (b) allocate funding and resources to the MPHP to address identified health priorities; (c) set targets for change and enhance accountability and reporting requirements; and (d) develop indicators of an effective MPHP. The analytical framework for this thesis incorporates these aspects and would enhance local public health planning for health improvement and future of strategies such as the MPHP.

The analytical framework and the findings for this thesis are congruent with the revised guidelines for MPHPs released by the government in 2009 (DoH, 2000a) and provide a

useful adjunct to these guidelines. The revised guide provides more detailed information about planning than the 2001 framework. The guidelines incorporate many of the key elements central to achieving improved health outcomes that are consistent with the indicators set out in the analytical framework for this thesis. This includes reference to action that leads to sustainable change including the need for leaders, adequate resources and involvement by key stakeholders.

The guidelines also include multiple checklists relevant to each stage of the planning cycle. The addition of a tool that encapsulates each of the main components of planning based on the change process, the social model of health and approaches such as that provided by Swerissen and Crisp (2004) and as applied in this thesis as well as a data table to record this information such as that provided in this thesis would provide a useful and succinct adjunct to the revised guidelines.

The limitations of the study and future research options

This study was conducted using a case study design. Data was collected from three case study sites using two interconnected methods: content analysis of the MPHP from each case study site, and semi-structured in-depth interviews with key stakeholders. The study has several limitations, discussed below.

Sample size

MPHPs from three case study sites were examined, and interviews were conducted with a total of fourteen key stakeholders drawn from local council, the state government and community health. The case study sites were also limited to metropolitan Melbourne. This is a small and unrepresentative sample.

However, the selection of three case study sites and the geographical location for each site met a number of the criteria for selecting case study sites as described by Yin (2003). This number was within the resource and time constraints of the study, and provided for an in-depth rather than a broad examination of the issues. Furthermore it is recognised that each LGA in Victoria is characterised by unique social, economic, geographical, built and demographic environments and conditions, but that the framework and requirements for MPHP is consistent for all LGAs across the state.

Future studies would benefit from using more case study sites with an emphasis on rural and regional Victoria as well as growth corridors. This would allow a broader analysis of the issues and a comparison of local public health planning in diverse geographical locations. However, and as Yin (2003) and Gerring (2004) argue, the

value of case study research is in the depth of the material that can be explored rather than its breadth.

Research into different perspectives

The focus of the study was on the development and implementation of MPHP from a local government perspective. And while interviews were conducted with key stakeholders from the state government and community health centres, a more in-depth examination of the state government's approach and policy directions related to local public health planning particularly during the latter years of the Labor Government and now more recently following the change of government in 2010 is warranted. This is important because as highlighted in this thesis, state governments play a key role in local public health planning. Policies and the strategic directions of government change according to differing political ideologies and economic constraints. However, action to build social capital and devolve power and funding to the local context as set out in the third way model of politics is paramount to the success of local public health planning.

Additional interviews with senior state government officials from different government departments as well as from the department responsible for MPHPs would have provided a greater insight into the role state government played in setting the context and rules and policy context in ways that would contribute to the successful development and implementation of MPHPs.

The analytical framework

The analytical framework for this thesis provided a useful tool for assessing existing MPHPs, and to inform their future development. Some of the elements included in the analytical framework were complex and are potentially open to interpretation. There is also some overlap between the indicators for organisational integration, intervention level, and incentives and sanctions. Additional research to test and then modify the eight elements as a tool for evaluating MPHPs would contribute to the further development of the analytical framework.

Health priorities

This research examined MPHPs as a whole, rather than in relation to specific health priorities, such as the audit undertaken by the Victorian Auditor-General (2007) into healthy eating and physical activity. Applying the key elements of an effective plan to specific health priorities could provide for a deeper and more contained examination of local responses to local public health issues through MPHPs.

Timing of the research

This thesis examined MPHPs as implemented in Victoria between 2003 and 2008. The research for this thesis was conducted between 2007 and 2009. The plans that were examined were current for the three years between 2005 and 2010. Since this time the *Public Health and Wellbeing Act 2008* has replaced the *Health Act 1958*, the 2010 state elections resulted in a change of government, an adjunct to the *Environments for Health* framework (DHS, 2001) has been prepared and local councils have developed new MPHPs. Further research into the most recent MPHPs within the context of these changed conditions would provide new insights into the current effectiveness of MPHPs and the likelihood of these plans achieving sustainable change.

Implications for health planning as a form of social action

Action for achieving better health outcomes for health promotion requires social change. Social institutions and organisations, such as schools, sporting clubs and chambers of commerce operate according to rules and norms that in turn govern and shape individual behaviour. They provide an important intervention point for health promotion and disease prevention activities, including planning.

Within the context of health promotion, local public health planning must focus on modifying existing organisational practices and processes so that they provide environments that promote health and support individual behaviour change. However, change at this level is difficult to achieve and sustain. If local public health planning is to be effective as a form of social action, a coordinated and integrated approach involving the Commonwealth, state and local governments, businesses and local communities, as well as the individual, is needed. Each level of society has a role to play in establishing and reinforcing the social rules, norms and practices that affect health. Local health planning by communities and local councils in isolation from the rest of society is likely to be limited in the extent to which it can achieve the level of social change that is needed to secure improved health outcomes.

This thesis shows that future local public health planning, such as the MPHP strategy, is more likely to be effective as a mechanism to achieve better health outcomes when there is coordinated action by the three levels of government, business and the community, and when institutional, organisational and behavioural actions are targeted. The findings of the thesis also support the key elements of Swerissen and Crisp's (2004) framework for achieving sustainable change for health promotion, and are consistent with the main tenets of the social model of health.

Institutional action is needed to ensure that local organisations have the capacity and motivation to comply with, and then subsequently sustain, change. This includes the introduction of policies, legislation and enforcement regimes, and the revision of funding criteria to help support targeted change. This in turn provides the context for the development and delivery of public health plans. Within this context, local public health planning for health promotion provides the mechanism through which the change process is managed and delivered.

Local public health planning for health promotion is grounded in the context of social capital. It provides a mechanism through which local institutions and organisations identify and respond to local problems and manage the change process that is needed to establish and reinforce health-promoting social and environmental conditions that support individual change. Because it provides a mechanism through which local agencies and organisations act, local public health planning is itself health promoting. As commentators such as Marmot and Wilkinson (1999), Kawachi and Berkman (2000), Fukuyama (2001) and Putnam (2000) illustrate, local action builds social capital, which is in turn conducive to better health outcomes.

Local public health planning also takes into account the geographic variations in the social and environmental conditions affecting health and wellbeing outcomes. This allows for the development and delivery of strategies that are tailored to local need, while building social capital.

A consistent and targeted approach to identified public health issues must inform the development of local public health plans to ensure that they lead to sustainable change and, ultimately, better health outcomes. This includes establishing agreed priorities about the public health issues to be included in the plan, the type and level of targets to be set, and the strategies that will be employed to achieve specified change. It also includes the introduction of accountability measures to encourage compliance with the planning process and policies regarding the allocation of funding that align with productivity. This could include establishing performance targets for local public health plans, such as MPHPs, and ensuring that CEOs of relevant organisations, such as local councils, are directly accountable for local public health planning outcomes.

At a broader level, action is needed to redress the social and health inequities between different geographical locations so that local communities have the necessary social and economic capacity and resources to undertake all stages of the planning cycle to achieve sustainable change.

In these ways the future focus of local public health planning needs to be on planning as a form of social action designed to achieve fundamental and sustainable social change, which can in turn support individual change. Without action at this level, and if the emphasis of planning is limited to a single aspect of society or the individual in isolation from the social context, then local public health planning is unlikely to be successful as a strategy for achieving better health outcomes. Specifically, change is unlikely to be sustained, and health improvement unlikely to be achieved. Too often the focus of health planning is on the development of a plan or on action that targets either attitudes or behaviours in isolation from the social context that governs individual behaviours.

The future focus of local public health planning therefore needs to be clearly on planning as a mechanism through which to achieve social change in ways that will lead to the establishment of environments and conditions that promote health and support individual change rather than those that are damaging to health.

Future research

Further research into health planning as a form of social action for achieving improved health outcomes that is relevant to other health promotion plans could be useful. It could also be useful to examine the way in which health promotion and other health promotion planning processes have focused on and achieved sustainable changes to the institutional, organisational and behavioural actions affecting health outcomes. Further research into the application of local public health planning in relation to specific health priorities, such as alcohol and factors contributing to obesity, is also warranted. This could include an examination of the barriers to planning for and implementing action that will lead to sustainable change.

Summary

This thesis examined local public health planning as a form of social action to achieve improved health outcomes within the context of MPHPs in Victoria. I have argued that for MPHPs to be effective in achieving improved health outcomes within the context of health promotion, plans need to be developed according to an analytical framework that research shows will lead to sustainable change.

Drawing on existing research and the framework developed by Swerissen and Crisp (2004) an effective MPHP is one that is embedded into the council organisation, responds to the social and environmental conditions affecting health and drives changes to the rules and norms that lead to and sustain individual behaviour. When

this occurs a MPHP will be effective in driving long-term change to the social and environmental conditions that affect health. It will lead to the creation of environments that promote health and to the establishment of “rules” and norms that support behaviour change, and the local council will have delivered an effective MPHP. For this to be achieved a plan needs to incorporate the eight elements set out in this thesis as indicators of an effective plan.

However, this kind of enterprise is complex and subject to a range of processes and factors that limit effective planning. Political, economic and social constraints, competing priorities and demands, multiple planning requirements and limited resources were identified by research interviewees in this study as barriers to effective MPHP planning. Other key factors affecting whether a plan is likely to be effective are the capacity of an organisation to deliver all stages of the planning cycle, the presence of influential leaders and accountability measures that create the incentives and sanctions necessary to ensure the compliance of the council organisation with the planning process and the compliance of the local organisations and institutions with the strategies set out in a plan. Underlying this is the need for clear criteria and definition for what constitutes an effective MPHP that is based on a perspective of achieving sustainable change.

This thesis addresses this gap and provides a tool that can be utilised by state and local governments alike to both review existing plans and inform the development of future plans.

APPENDICES

Appendix A: Ethics approval

Appendix B: Consent form and participant information sheet

Appendix C: Interview schedules

Appendix D: Summary of original themes and categories for Study 2

Appendix A – Ethics Approval

La Trobe University
Faculty of Health Sciences
MEMORANDUM

TO: Professor Hal Swerissen School of Public Health

SUBJECT: *Reference:* **FHEC07/170**

Student or Other Investigator: Diane Edwards

Title: **The role of Municipal Public Health Plans in achieving long term improvements to community health and wellbeing outcomes**

DATE: 29 October 2007

The Faculty Human Ethics Committee (FHEC) has considered and approved the above project. You may now proceed.

Please note that Informed Consent forms need to be retained for a minimum of 7 years. Please ensure that each participant retains a copy of the Informed Consent form. Researchers are also required to retain a copy of all Informed Consent forms separately from the data. The data must be retained for a period of 5 years.

Please note that any modification to the project must be submitted in writing to FHEC for approval. You are required to provide an annual report (where applicable) and/or a final report on completion of the project. A copy of the progress/final report can be downloaded from the following website:
www.latrobe.edu.au/rgso/forms-resources/forms/ethic-prog-final.rtf.

Please return the completed form to The Secretary, FHEC, Faculty of Health Sciences Office, La Trobe University, Victoria 3086.

A copy of this memorandum is enclosed for you to forward to the student(s) concerned.

3

I
Secretary
Faculty Human Ethics Committee
Faculty of Health Sciences

La Trobe University
Faculty of Health Sciences

MEMORANDUM

TO: Professor Hal Swerissen School of Public Health

SUBJECT: *Reference:* **FHEC07/170**

Student Name/ Other Investigator: Diane Edwards

Title: **The role of Municipal Public Health Plans in achieving long term improvements to community health and wellbeing outcomes**

DATE: 12 October 2007

The Faculty Human Ethics Committee (FHEC) has considered the above project and has minor queries. FHEC needs to receive the following information/or modifications:

Section 5

Ethics approval cannot be granted for a project which has already started. Please amend the start date. Specifying the start date as 'date of approval' is acceptable

Participant information sheet, consent form and withdrawal of consent form.

Please provide a copy of these documents on letterhead.

Please change all occurrences of A/Dean to Acting Dean

Complaints section: please amend the La Trobe contact details to refer to the Secretary of the Faculty Human Ethics Committee, Faculty of Health Sciences, La Trobe University, Victoria, 3086, Telephone 9479 3573.

Please provide your amendments in a memorandum. It is not necessary to resubmit the entire application again.

A copy of this memorandum is enclosed for you to forward to the student(s) concerned.

Natalie Humphries
Secretary
Faculty Human Ethics Committee

MEMORANDUM

TO: Natalie Humphries
Secretary, Faculty Human Ethics Committee, Faculty of Health Sciences

SUBJECT:

Reference	**FHEC07/170**
Student's Name:	**Diane Edwards**
Title:	**The role of Municipal Public Health Plans in achieving long term improvements to community health and wellbeing outcomes.**

DATE: 16 October, 2007

Section 5

The start date has been amended to 'date of approval'.

Participant information sheet, consent form and withdrawal of consent form

All occurrences of A/Dean have been revised to Acting Dean.

Complaints section: The contact details for the Secretary of the FHEC have been amended accordingly.

The information sheet, consent form and withdrawal of consent form have been amended as required and as attached. Hard copies on letterhead are have been resubmitted.

Professor Hal Swerissen
School of Public Health
Acting Dean, Faculty of Health Sciences

Appendix B – Consent Form and Participant Information Sheet

LA TROBE UNIVERSITY

School of Public Health
Faculty of Health Sciences

CONSENT FORM

Project Title:	The role of Municipal Public Health Planning in achieving long term improvements to community health and wellbeing outcomes.
Senior Investigator:	PROFESSOR HAL SWERISSEN ACTING DEAN FACULTY OF HEALTH SCIENCES LA TROBE UNIVERSITY
Researcher:	DIANE EDWARDS PROFESSIONAL DOCTORATE STUDENT FACULTY OF HEALTH SCIENCES LA TROBE UNIVERSITY

I ..... have read and understood the information above, and any questions I have asked have been answered to my satisfaction. I agree to participate in this project, realising that I may withdraw at any time. I agree that research data collected during the project may be included in a thesis, presented at conferences and published in journals, on condition that my name is not used.

NAME OF PARTICIPANT (in block letters): .....

Signature: ..... Date: .....

NAME OF SENIOR INVESTIGATOR (in block letters): PROF HAL SWERISSEN

Signature: Date 26.11.07

NAME OF RESEARCHER (in block letters): DIANE EDWARDS

Signature: ... 21/11/07

La Trobe University
Victoria 3086, Australia
Tel: +61 3 9479 1750
Fax: +61 3 9479 1783
Email: sph@latrobe.edu.au
Web: www.latrobe.edu.au/publichealth
ABN 64 804 735 113

LA TROBE UNIVERSITY

School of Public Health
Faculty of Health Sciences

Withdrawal of Consent for Use of Data Form

Project Title: The role of Municipal Public Health Plans in achieving long term improvements to community health and wellbeing.

I, ...(the participant), wish to WITHDRAW my consent to the use of data arising from my participation. Data arising from my participation must NOT be used in this research project as described in the Information and Consent Form. I understand that data arising from my participation will be destroyed provided this request is received within four weeks of the completion of my participation in this project. I understand that this notification will be retained together with my consent form as evidence of the withdrawal of my consent to use the data I have provided specifically for this research project.

Participant's name (printed):

.....

Signature:

.....

Date:

La Trobe University
Victoria 3086, Australia
Tel: +61 3 9479 1750
Fax: +61 3 9479 1783
Email: sph@latrobe.edu.au
Web: www.latrobe.edu.au/publichealth
ABN 64 804 735 113

LA TROBE UNIVERSITY

School of Public Health
Faculty of Health Sciences

Participant Information Sheet

RE: THE ROLE OF MUNICIPAL PUBLIC HEALTH PLANS IN ACHIEVING LONG TERM IMPROVEMENTS TO COMMUNITY HEALTH AND WELLBEING.

This research project aims to examine the translation of Victorian State government policy into local government planning frameworks for health. It focuses on the Municipal Public Health Planning process as currently conceived by the Victorian State Government and implemented by local government, and examines the factors and processes that impact on municipal public health plans achieving improved and lasting changes to community health and wellbeing.

The study will examine:

- the contribution municipal public health plans make to community health and wellbeing;
- the influence of the plans in achieving sustainable change at an organisational, community and institutional level; and
- the factors and processes that impact on plans achieving improved and lasting changes to community health and wellbeing.

By focusing on municipal public health plans as a process for change, this study examines the complexities involved in municipal public health planning as a mechanism to facilitate change and achieve long-term improvements to health and wellbeing.

It is envisaged that the research findings will provide additional insights into municipal public health planning frameworks as an enabling framework for health and as a process of change, as well as clarify the factors and processes contributing to municipal public health plans achieving sustainable improvements in health and wellbeing outcomes within an organisational, community and institutional context.

The project is particularly interested in testing existing theory of change and sustainability relevant to planning frameworks such as the municipal public health plans. As such it is hoped that the research findings will provide information which will assist in strengthening existing public health planning frameworks.

The research will be undertaken using case study methodology, with three local government sites selected for study. Case study sites have been selected for consistency and comparability based on socio-demographics and geographical location. The study is not an evaluation of individual Councils, nor is it a study of local government, but rather a study which tests existing theory of how and why planning frameworks such as municipal public health plans shift from being a static plan to an enabling framework leading to change. Findings will be generalised from the particular local government context to a broader framework.

This research is being conducted as part of the requirements for Ms Diane Edwards' Professional Doctorate Thesis in Public Health. Professor Hal Swerissen, Acting Dean Faculty Health Sciences is supervising the project.

If you agree to participate in this project, you will be asked to participate in an individual, semi-structured interview at a venue convenient to you (such as your workplace). Interviews will take between 45 and 60 minutes. Questions will focus on changes (within Council and the broader community) that have occurred as a result of the municipal public health plan, the sustainability of these changes, and the factors impacting on plans achieving sustainable change. Your professional opinion and perspective will be sought on the factors and processes that have impacted on municipal public health plans achieving long term change and which have supported the translation of the municipal public health plans from a process of planning to one of implementation.

La Trobe University
Victoria 3086, Australia
Tel: +61 3 9479 1750
Fax: +61 3 9479 1783
Email: sph@latrobe.edu.au
Web: www.latrobe.edu.au/publichealth
ABN 64 804 735 113

Victorian local, and state government, and community health employees who are involved with the municipal public health planning process and who have responsibility for, and/or experience in and knowledge of municipal public health plans will be invited to participate in this research project. Approximately 12 people will be interviewed.

Participation is voluntary and your confidentiality will be maintained; personal information will not be collected. A copy of the consent form for the study is attached.

Notes will be taken during the interview and your approval to record the interview will be sought prior to interview. Upon approval, tapes of the interview will be transcribed and the researcher will take further notes while listening to the tapes at the completion of the interview.

Your approval will be sought at the outset of each interview and again at the completion of the interview, to include direct quotes in the thesis report and subsequent publication, and if your approval is provided, whether you require the researcher to obtain your further approval prior to the inclusion of direct quotes in the written report. All quotes used in the thesis will be anonymous.

Tapes, notes and hard copies of transcripts will be stored at the research student's home in a locked filing cabinet during the course of the study. Upon finalising the study, tapes and transcripts will be stored in a locked filing cabinet at La Trobe University by the supervisor; according to University policy these records will be destroyed after five years.

The results of this research will be made available through the thesis to be written by Ms Diane Edwards, in journal articles and in presentations at conferences; it will not be possible to identify you in any of these reports.

You have the right to withdraw from active participation in this project at anytime and, to demand that data arising from your participation are not used in the research project, provided that this right is exercised within four weeks of the completion of your participation in the project. There are no disadvantages, penalties or adverse consequences for not participating or for withdrawing prematurely from the research. If you wish to withdraw you are asked to complete the 'Withdrawal of Consent Form' or to notify the investigator by email or telephone and advise that you wish to withdraw your consent for your data to be used in this research project.

If you have any questions or to indicate your willingness to participate please contact Diane Edwards at your earliest convenience by phone on 0408962771 or email: d2edwards@students.latrobe.edu.au.

Any further questions regarding this project may be directed to the Investigator Professor Hal Swerissen, Acting Dean Faculty of Health Sciences, La Trobe University on (03) 9479-1743.

If you have any complaints or queries that the investigator has not been able to answer to your satisfaction contact the Secretary of the Human Ethics Committee, Faculty of Health Sciences, La Trobe University, Victoria 3086, Telephone 9479-3573.

Sincerely,

Diane Edwards
(Student Researcher)
dianeedwards@studentslatrobe.edu.au

Professor Hal Swerissen
(Research Supervisor)
hswerissen@latrobe.edu.au

Appendix C – Interview Schedules

Office Use Only [Reference No: HEC /]
Date Received:

Interview questions : for Council staff and governance role

Introduction: I am interested in understanding the way in which municipal public health plans influence community health and wellbeing outcomes and in the factors and processes that impact on the implementation process. It is not an evaluation of the Municipal Public Health Plans or local government, recent evaluations have been completed and found that the plans are an important enabling process for local government and for state to achieve its priority policy of achieving improved community health and wellbeing.

Rather I am interested in understanding the way in which municipal public health plans influence community health and wellbeing outcomes and in the factors and processes that impact on the implementation process.

Outcomes and change resulting from Municipal Public Health Plans

Municipal public health plans have been in place for a number of years now with the current plan for this local government now in place *(or being revised).*

1. Would you describe one or two outcomes which have occurred as a result of the most recent municipal public health plan and which illustrate the way in which the plan has influenced change within the community and or Council?

   (What was the problem? What interventions were agreed to redress the problem? How were the strategies determined? What were the outcomes? Was the resulting change sustainable? What were the benefits? Was the resource commitment acceptable and (did it need to be) able to be maintained?)

The plan and the planning process - initiation

2. In terms of the most recent municipal public health plan, would you describe the process that took place to develop the plan? *(How was the plan developed, what was the process, who was involved, how were problems (interventions) identified and priorities set)*

3. To what extent does the current plan include objectives and strategies that are not specific to the municipal public health plan but are rather included in other plans?

   (To what extent does the Municipal Public Health Plans set priorities compared with other plans or is it a summary of other plans?)

4. What resources are specifically allocated to this plan?

Outcomes

5. What impact do you see this plan as having on Council ?
   (in relation to outcomes, changing the way Council works, and views health and wellbeing, what about priority setting, decision making, funding allocation, policy? To what extent and how? Do you think the Municipal Public Health Plans and community health and wellbeing Is institutionalised within Council).

6. What impact do you think this plan has or is having on community organisations and the broader community? *(Do you think the outcomes and strategies would have occurred regardless of the Municipal Public Health plan?)*

7. What factors and processes do you think have contributed to the Municipal Public Health Plans influencing change, and impacting on the factors or risk conditions that impact on health and wellbeing outcomes in the long term and which are sustained over time?

   Did the plan have a 'champion' ?
   (a person with decision making power, authority and knowledge of the plan?)
   Was there a communication strategy developed for the plan?

Was there an assessment of the impact of the plan on organisational and community capacity?
What about organisational capacity - staff training, changes to council and community infrastructure, funding?
Was there support from the community for this plan -how was this achieved?
What about resistance to the plan? From within council, external to council
How was this managed?
What about competing priorities – how was this managed?
What benefits did the community, Council staff and management understand the plan to have?
What about monitoring and evaluation strategies and processes? How did you know outcomes resulting from the municipal plan were achieved ? What monitoring and review processes were in place?
How are outcomes measured?
Program logic – do the desired outcomes relate to the strategies, and needs and issues and evidence?

Changes over time

The Municipal Public Health Planning process has been in place for a number of years now.

8. To what extent do you think the plan has led to change over time? (Within the last three years)
   (Are there outcomes that have occurred as a result of the plan and that are now permanent ? Do you think this change would have occurred regardless of the Municipal Public Health Plans?)

9. Do you think based on your overall experience that municipal public health plans should continue? Why do you think that? *(If no)* What would you do instead?

Office Use Only [Reference No: HEC /]
Date Received:

Interview questions : for external reference point (DHS / community health)

Introduction: I am interested in understanding the way in which municipal public health plans influence community health and wellbeing outcomes and in the factors and processes that impact on the implementation process. It is not an evaluation of the Municipal Public Health Plans or local government, recent evaluations have been completed and found that the plans are an important enabling process for local government and for state to achieve its priority policy of achieving improved community health and wellbeing.

Rather I am interested in understanding the way in which municipal public health plans influence community health and wellbeing outcomes and in the factors and processes that impact on the implementation process.

Outcomes and change resulting from Municipal Public Health Plans

1. To what extent are you familiar with the (council) Municipal Public Health Plans and planning process? *(Would you describe your involvement in the Municipal Public Health Plans)*

2. What do you think have been some concrete examples of change and outcomes resulting from the most recent plan? *(Within Council, within the community, within your organisation ?)*

The plan and the planning process - initiation

3. In terms of the most recent municipal public health plan, would you describe the process for developing the plan? *(How was the plan developed, what was the process, what was your / community level of involvement?)*

4. To what extent do you think the current municipal public health plan includes objectives and strategies that are not specific to the Municipal Public Health Plans but are covered in other plans? *(To what extent does the Municipal Public Health Plan set priorities compared with other plans or is it a summary of other plans? And what influence has the plan had on community health / your organisation and its planning process?)*

5. What resources are specifically allocate\d to this plan?

Outcomes

6. What impact do you see this plan as having on Council *(in relation to outcomes, changing the way Council works, and views health and wellbeing, what about priority setting, decision making, funding allocation, policy? To what extent and how?)*

7. What impact do you see this plan as having on community organisations and social institutions community? On changing factors at an institutional level which impact on health and wellbeing? (*On your own organisations? What about allocation of funding, program design and delivery? what about priority setting, decision making)*

8. What factors and processes do you think have contributed to the Municipal Public Health Plans influencing change, and impacting on the factors or risk conditions that impact on health and wellbeing outcomes?

Did the plan have a 'champion' ?
(a person with decision making power, authority and knowledge of the plan?)
Was there a communication strategy developed for the plan?
Was there an assessment of the impact of the plan on organisational and community capacity?
What about organisational capacity - staff training, changes to council and community infrastructure, funding?
Was there support from the community for this plan -how was this achieved?
What about resistance to the plan? From within council, external to council
How was this managed?
What about competing priorities – how was this managed?
What benefits did the community, Council staff and management understand the

plan to have?
What about monitoring and evaluation strategies and processes? How have you assessed or known that the plan has achieved change? What monitoring and review processes were in place?
How are outcomes measured?
Program logic – do the desired outcomes relate to the strategies, and needs and issues and evidence?

Changes over time

Municipal Public Health Plans have been in place for a number of years now.

9.To what extent do you think the plan has led to change over time? (Within the last three years) *(Are there outcomes that have occurred as a result of the plan and that are now permanent ? Do you think this change would have occurred regardless of the Municipal Public Health Plans?)*

10. Do you think based on your overall experience that municipal public health plans should continue? Why do you think that? *(If no)* What would you do instead?

11. Is there anything else you would like to add?

Appendix D – Summary of original themes and categories for Study 2

The original themes and sub-categories for the qualitative analysis are as follows:

- The MPHP as a driver of change

Factors and process contributing to the MPHP success

- The local council context
    - Funding
    - Timelines
    - Staffing levels, relevant experience, and expertise
    - Existing organisational processes and systems
- Key stakeholder involvement in the MPHP planning cycle
- The MPHP alignment with existing priorities and functions
- The state government context
    - Unrealistic expectations
    - The legislation
    - The Environments for Health framework
    - Across-government responses to health
    - The state and local governments working together
- The existing planning and policy environment
- The existing characteristics of the local area
    - “Inequitable playing field”
- Factors related to the individual
    - Influential individuals
- The individual plan
    - The plan met an identified gap
    - Monitoring progress and evaluating outcomes
    - Interventions targeting different aspects of built, social, economic and physical environments
    - The provision of incentives
- The health issue identified for action
- Factors concerning the whole system
- An integrated, coordinated and collaborative approach to the MPHP between state, local governments and the community – “we all have a stake in it”
- The future.

The original category list was reviewed, modified, tested and text re-assigned several times. In some instances text was assigned to more than one category. At the final stage of analysis the categories were reviewed and then tested against the indicators that were applied to assess the three municipal public plans in Study 1. The final themes, categories and sub-categories used to report on Study 2 are as follows:

- MPHP: influence and achievements
    - Influence
        - The MPHP: a driver of change
        - The MPHP: heading toward change
        - The MPHP: a reflection of already existing priorities
    - Achievements
        - Enhanced planning capacity and the development of an integrated response to public health
        - Enhanced capacity and expertise
        - Improved service delivery
        - Partnerships
- Factors contributing to the successful development and implementation of MPHPs
    - Resources and organisational capacity
    - Staffing levels and expertise
    - Local area characteristics: “an inequitable playing field”
    - Buy-in and support by key stakeholders: “we all have a stake in it”
        - The provision of an integrated and coordinated action underpinned by a collaborative approach by key stakeholders
        - Factors that contribute to key stakeholder support for the MPHP
            - “it is seen as a human services plan”
            - Competing demands
            - The issue itself
            - Processes and systems to generate key stakeholder support
            - Limited resources
            - “the experience, almost the personality, of the officer responsible”
- Involvement in and endorsement by influential decision makers
- Measuring and “celebrating success”
    - Barriers
        - Defining and monitoring success
        - The planning cycle
        - Access to and availability of relevant data

- Theoretical framework: the social model of health
- Systems and processes to support across Council X and community involvement
    - Competing planning processes and requirements
- The changing environment and competing priorities
- Legislation governing the MPHP
- The future.

BIBLIOGRAPHY

Aspin, C., Jowsey, T., Glasgow, N., Dugdale, P., Nolte, E., O'Hallahan, J. & Leader, S. (2010). Health policy responses to rising rates of multi-morbid chronic illness in Australia and New Zealand. *Australian and New Zealand Journal of Public Health, 34*(4), 386–393.

Adams, D., & Hess, M. (2001). Community in public policy: Fad or foundation? *Australian Journal of Public Administration, 60*(2), 13–23.

Atkinson, R., & Kintrea, K. (2001). Disentangling area effects: Evidence from deprived and non-deprived neighbourhoods. *Urban Studies, 38*(12), 2277–2298.

Australian Broadcasting Commission. (2007). *Australian health map*. Retrieved from http://www.abc.net.au/health/healthmap/vic/

Australian Bureau of Statistics. (2002). *Social capital and social wellbeing: Discussion paper*. Canberra: Commonwealth of Australia.

Australian Bureau of Statistics. (2006). *Information paper: An introduction to socio-economic indexes for areas (SEIFA), 2006*. (Cat. no. 2039.0). Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/mf/2039.0/

Australian Institute for Primary Care. (2003). *An evaluation of the Primary Care Partnership strategy 2003* (No. 3). Melbourne, Australia: La Trobe University.

Australian Institute for Primary Care. (2005). *An evaluation of the primary care partnership strategy 2005*. Melbourne, Australia: La Trobe University. Retrieved from http://www.health.vic.gov.au/pcps/evaluation/index.htm

Australian Institute of Health and Welfare. (2010). *Australia's health 2010* (Cat. no. AUS 122). Canberra, Australia: AIHW.

Bagley, P., Lin, V., Sainsbury, P., Wise, M., Keating, T., & Roger, K. (2007). In what ways does the mandatory nature of Victoria's municipal public health planning framework impact on the planning process and outcomes? *Australia and New Zealand Health Policy, 4*(4). Retrieved from http://archive.biomedcentral.com/1743-8462/4/4

Baum, F. (1995). Researching public health: Behind the qualitative–quantitative methodological debate. *Social Science & Medicine, 40*(4), 459–468.

Baum, F. (1997). Public health and civil society: Understanding and valuing the connection. *Australian and New Zealand Journal of Public Health, 21*(7), 673–675.

Baum, F. (1999). Social capital: Is it good for your health? Issues for a public health agenda. *Journal of Epidemiology & Community Health, 53*(195–196).

Baum, F. (2002). *The new public health* (2nd ed.). Melbourne, Australia: Oxford University Press.

Baum, F., Bush, R., Modra, C., Murray, C., Cox, E., Alexander, K., & Potter, R. (2000). Epidemiology of participation: An Australian community study. *Journal of Epidemiology & Community Health, 54*(6), 414–423.

Baum, F. E., Ziersch, A. M., Zhang, G., & Osborne, K. (2009). Do perceived neighbourhood cohesion and safety contribute to neighbourhood differences in health? *Health & Place, 15*(4), 925–934.

Berkman, L. F., & Kawachi, I. (Eds.). (2000). *Social epidemiology*. New York, NY: Oxford University Press.

Blacher, Y. (2005). Changing the way government works. *Public Administration Today,* October–December, 38–42.

Bush, R., & Baum, F. (2001). Health, inequities, community and social capital. In R. Eckersley, J. Dixon & B. Douglas (Eds.), *The social origins of health and well-being* (pp. 189–204). Cambridge, England: Cambridge University Press.

Butler, G. (2005). *Sustainable communities: The important role of local government in building social capital.* Paper presented at the 2nd Future of Australia's Country Towns Conference, La Trobe University, Bendigo, Australia. Retrieved from http://www.latrobe.edu.au/csrc/fact2/refereed/butler.pdf

Commission on Social Determinants of Health. (2005). *Towards a conceptual framework for analysis and action on the social determinants of health* Discussion paper for the Commission on Social Determinants of Health (Draft). Geneva, Switzerland: World Health Organization.

Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health.* Final report of the Commission on Social Determinants of Health*.* Geneva, Switzerland: World Health Organization.

Cox, E. (1995). *A truly civil society*. Sydney, Australia: ABC Books.

de Leeuw, E., Butterworth, I., Garrard, J., Palermo, J., Godbold, T., & Tacticos, T. (2006). *Evaluation of the environments for health framework*. Melbourne, Australia: Deakin University.

Department of Planning and Community Development. (2010a). *Guide to local government*. Melbourne, Australia: Victorian Government. Retrieved from http://www.dpcd.vic.gov.au/localgovernment/guide-to-local-government

Department of Planning and Community Development. (2010b). *What councils do*. Melbourne, Australia: Victorian Government. Retrieved from http://www.dpcd.vic.gov.au/localgovernment/guide-to-local-government/what-councils-do

Department of Premier and Cabinet. (2005). *A fairer Victoria: Creating opportunity and addressing disadvantage*. Melbourne, Australia: Victorian Government.

DHS (2000). *Municipal public health plan questionnaire: Summary report*. Melbourne, Australia: Department of Human Services, Victorian Government. Retrieved from http://www.health.vic.gov.au/archive/archive2004/index.htm#localgov

DHS (2001). *Environments for health: Promoting health and wellbeing through the built, social, economic and natural environments. Municipal public health planning*

framework. Melbourne, Australia: Department of Human Services, Victorian Government.

DHS (2008a). *Avoidable mortality in Victoria: Trends between 1997 and 2003*. Melbourne, Australia: Public Health Branch, Rural and Regional Health and Aged Care Services Division.

DHS (2008b). *Victorian Tobacco Control Strategy 2008–2013*. Melbourne, Australia: Department of Human Services, Victorian Government.

DHS (2008c). *Your health: A report on the health of Victorians 2007*. Melbourne, Australia: Department of Human Services, Victorian Government.

DHS (2009). *Fair health facts 2009*. Melbourne, Australia: Department of Human Services, Victorian Government.

DHS (2010). Neighbourhood renewal. Melbourne, Australia: Department of Human Services, Victorian Government. Retrieved from http://www.neighbourhoodrenewal.vic.gov.au

Dibley, G., & Gordon, M. (2002). *Leading the way: Councils creating healthier communities*. Melbourne, Australia: VicHealth.

DoH (2007a). Local government planning for health and wellbeing. Melbourne, Australia: Department of Health, Victorian Government. Retrieved from http://www.health.vic.gov.au/localgov/mphp.htm

DoH (2007b). Municipal public health planning update July 2007. Melbourne, Australia: Department of Health, Victorian Government. Retrieved from http://www.health.vic.gov.au/localgov/links/newsletter.htm

DoH (2008). *Victorian Population Health Survey 2008*. Melbourne, Australia: Department of Health, Victorian Government.

DoH (2009a). *A practical guide to municipal public health planning: A resource for public health and social planners in local councils in Victoria*. Melbourne, Australia: Department of Health, Victorian Government.

DoH (2009b). Municipal public health plans: New requirements. Melbourne, Australia: Department of Health, Victorian Government. Retrieved from http://www.health.vic.gov.au/phwa/downloads/municipal_health_plan.pdf

DoH (2010). Life expectancy at birth: Victoria 2003–2007. Melbourne, Australia: Department of Health, Victorian Government. Retrieved from http://www.health.vic.gov.au/healthstatus/admin/life-expectancy/le0307.htm

DoH (2011). Primary care partnerships. Melbourne, Australia: Department of Health, Victorian Government. Retrieved from http://www.health.vic.gov.au/pcps/community/index.htm

Duck, J. D. (1998). *Managing change: The art of balancing.* In Harvard Business Review on Change (pp. 55–81): Boston, MA. Harvard Business School Press.

Eagar, K., Garrett, P., & Lin, V. (2001). *Health planning: Australian perspectives*. Crows Nest, NSW, Australia: Allen & Unwin.

Flyvbjerg, B. (2006). Five misunderstandings about case study research. *Qualitative Inquiry, 12*(2), 219–245.

Fukuyama, F. (2001). Social capital, civil society and development. *Third World Quarterly, 22*(1), 7–20.

Gerring, J. (2004). What is case study research and what is it good for? *American Political Science Review, 98*(2), 341–354.

Giddens, A. (1998). *The third way: The renewal of social democracy*. Cambridge, England: Polity.

Graham, H. (Ed.). (2000). *Understanding health inequalities* (2nd ed.). Buckingham, England: Open University Press.

Green, A. (1999). *An introduction to health planning in developing countries* (2nd ed.). Oxford, England: Oxford University Press.

Green, L. W., & Kreuter, M. W. (1991). *Health promotion planning: An educational and environmental approach* (2nd ed.). Mountain View, CA: Mayfield.

Hancock, L. (2000). Women's policy interests and the Third Way? *Southern Review, 33*(2), 196–211.

Hay, A., Frew, R., & Butterworth, I. (2001). Environments for health: Public health planning. *Environmental Health, 1*(3), 85–89.

Li, J., Mattes, E., Stanley, F., McMurray, A., & Hertzman, C. (2009). Social determinants of child health and well-being. *Health Sociology Review, 18*(1), 3–11.

Kalucy, E. (2008). Ian Webster oration – Inaugural Ian Webster “Health for all” Oration. Delivered by Associate Professor Elizabeth Kalucy. Retrieved from http:/notes.med.unsw.edu.au/CPHCEWeb.nsf/resources/Forum+11-15/$fileLibby+Kalucy+Oration.doc

Kanter, R. M., Stein, B. A., & Jick, T. D. (1992). *The challenge of organizational change: How companies experience it and leaders guide it*. New York, NY: The Free Press.

Kawachi, I., & Berkman, L. (2000). Social cohesion, social capital, and health. In L. Berkman & I. Kawachi (Eds.), *Social epidemiology* (pp. 174–190). New York, NY: Oxford University Press.

Kemenade, S. Van. (2003). *Social capital as a health determinant. How is it defined?* Health Policy Research Working Paper Series. Working paper 02-07. Ottawa: Population and Public Health Branch, Health Canada.

Klein, H. (2004). Neighbourhood renewal: Revitalising disadvantaged communities in Victoria. *Public Administration Today,* Sept–Nov (1), 20–29.

Kotter, J. P. (1995). Leading change: Why transformation efforts fail. *Harvard Business Review* March–April, 59–67.

Kotter, J. P. (2009). Leading change: Why transformation efforts fail. In D. Price (Ed.), *The principles and practice of change* (pp. 113–123). New York, NY: Palgrave Macmillan.

Kotter, J. P., & Schlesinger, L. A. (2009). Choosing strategies for change. In D. Price (Ed.), *The principles and practice of change* (pp. 161–174). New York, NY: Palgrave Macmillan.

Liamputtong, P. (2009). *Qualitative research methods* (3rd ed.). Melbourne, Australia: Oxford University Press.

Lupton, D. (1999). Content analysis. In V. Minichiello, G. Sullivan, K. Greenwood & R. Axford (Eds.), *Handbook for research methods in health sciences* (3rd ed., pp. 449–461). Frenchs Forest, NSW, Australia: Pearson Education.

Macintyre, S., & Ellaway, A. (1999). Local opportunity structures, social capital and social inequalities in health: What can central and local government do? *Health Promotion Journal of Australia, 9*(3), 165–170.

Macintyre, S., Ellaway, A., & Cummins, S. (2002). Place effects on health: How can we conceptualise, operationalise and measure them? *Social Science & Medicine, 55*(1), 125–139.

Marmot, M., & Wilkinson, R. G. (Eds.). (1999). *Social determinants of health* (8th ed.). New York, NY: Oxford University Press.

Mendes, P. (2004). Empowering the aspirational poor: Mark Latham on the welfare state. *Social Alternatives, 23*(3), 38–41.

Moore, D., & Dietze, P. (2005). Enabling environments and the reduction of drug-related harm: Re-framing Australian policy and practice. *Drug and Alcohol Review, 24*(3), 275–284.

National Preventative Health Taskforce. (2009). *Australia: The healthiest country by 2020*. Canberra: Commonwealth Government of Australia.

National Primary Care Research and Development Centre. (2000). *The national tracker survey of primary care groups and trusts: Progress and challenges 1999/2000*. Manchester, England: Manchester University.

National Public Health Partnership Group. (2000). *Background paper on integrated public health practice: Supporting and strengthening local action*. National Public Health Partnerships. Retrieved from http://www.nphp.gov.au/publications/strategies/integph-bground.pdf

Neuman, W. L. (2003). *Social research methods. Qualitative and quantitative approaches* (5th ed.). Boston, MA: Allyn & Bacon.

Nutbeam, D. (1997). Creating health-promoting environments: Overcoming barriers to action. *Australian and New Zealand Journal of Public Health, 21*(4), 355–359.

OECD. (2001). *The well-being of nations: The role of human and social capital.* Paris: Centre for Educational Research and Innovation, OECD.

Owen, J. M. (1993). *Program evaluation: forms and approaches*. St Leonards, Australia: Allen & Unwin.

Perakyla, A. (2005). Analyzing talk and text. In N. K. Denzin & Y. S. Lincoln (Eds.), *The sage handbook of qualitative research* (3rd ed., pp. 869–886). Thousand Oaks, CA: Sage.

Petersen, A., & Lupton, D. (1996). *The new public health: Health and self in the age of risk*. London, England: Sage Publications.

Pridmore, P., Thomas, L., Havemann, K., Sapag, J., & Wood, L. (2007). Social capital and healthy urbanization in a globalized world. *Journal of Urban Health, 84*(1), 130–143.

Putnam, R. (1993). The prosperous community: Social capital and public life. *The American Prospect, 13*, 35–42.

Putnam, R. (2000). *Bowling alone: The collapse and revival of American community*. New York, NY: Simon & Schuster.

Reddel, T. (2004). Third way social governance: Where is the state? *Australian Journal of Social Issues, 39*(2), 129–142.

Secretariat on Social Determinants of Health. (2004). *Commission on social determinants of health: Note by the Secretariat*. Geneva, Switzerland: World Health Organization.

Shaw, M., Dorling, D., & Davey Smith, G. (1999). Poverty, social exclusion and minorities. In M. Marmot & R. G. Wilkinson (Eds.), *Social determinants of health* (pp. 211–233). New York, NY: Oxford University Press.

Shaw, M., Dorling, D., David, G., & Davey Smith, G. (2000). *The widening gap: Health inequalities and policy in Britain* (2nd ed.). Bristol, England: The Policy Press.

Shediac-Rizkallah, M. C., & Bone, L. R. (1998). Planning for the sustainability of community-based health programs: Conceptual frameworks and future directions for research, practice and policy. *Health Education Research, 13*(1), 87–108.

Stake, R. E. (2005). Qualitative case studies. In N. K. Denzin & Y. S. Lincoln (Eds.), *The sage handbook of qualitative research* (3rd ed., pp. 443–466). Thousand Oaks, CA: Sage.

Subramanian, S. V., Lochner, K. A., & Kawachi, I. (2003). Neighborhood differences in social capital: A compositional artefact or a contextual construct? *Health & Place, 9*(1), 33–44.

Swerissen, H. (2007). Understanding the sustainability of health programs and organisational change. A paper for the Victorian Quality Council. La Trobe University, Melbourne, Australia. Retrieved from http://www.health.vic.gov.au/qualitycouncil/downloads/sustainability_paper.pdf

Swerissen, H., & Crisp, B. R. (2004). The sustainability of health promotion interventions for different levels of social organization. *Health Promotion International, 19*(1), 123–129.

Szreter, S., & Woolcock, M. (2004). Health by association? Social capital, social theory, and the political economy of public health. *International Journal of Epidemiology, 33*(4), 650–667.

Victorian Auditor-General. (2007). *Promoting better health through healthy eating and physical activity*. Melbourne, Australia: Victorian Auditor-General's Office.

Victorian Quality Council. (2009). Successfully implementing change. In D. Price (Ed.), *The principles and practice of change* (pp. 147–155). New York, NY: Palgrave Macmillan.

Vinson, T. (1999). *Unequal in life: The distribution of social disadvantage in Victoria and New South Wales*. Melbourne, Australia: Jesuit Social Services.

Vinson, T. (2004). *Community adversity and resilience: The distribution of social disadvantage in Victoria and New South Wales and the mediating role of social cohesion*. Melbourne, Australia: Jesuit Social Services.

Vinson, T. (2007). *Dropping off the edge: The distribution of disadvantage in Australia*. Melbourne, Australia: Jesuit Social Services.

Vinson, T., & Baldry, E. (1999). *The spatial clustering of child maltreatment: Are macro-social environments involved*? Canberra, Australia: Australian Institute of Criminology.

Wakefield, S. E. L., & Poland, B. (2005). Family, friend or foe? Critical reflections on the relevance and role of social capital in health promotion and community development. *Social Science & Medicine 60*(12), 2819–2832.

Wilkinson, R., & Marmot, M. (Eds.). (2003). *Social determinants of health: The solid facts* (2nd ed.). Copenhagen, Denmark: World Health Organization.

Yeatman, H. (2008). Action or inaction? Food and nutrition in Australian local governments. *Public Health Nutrition, 12*(9), 1399–1407.

Yin, R. K. (2003). *Case study research: Design and methods* (3rd ed.). Thousand Oaks, CA: Sage Publications.