Evaluation of the *Environments for Health* Framework

Final Report

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in association with

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Acknowledgements

Abbreviations

ABS	Australian Bureau of Statistics
CCT	Compulsory Competitive Tendering
CEO	Chief Executive Officer
CHP	Community Health Plan
CP	Council Plan (or Corporate Plan)
DHS	State Department of Human Services
DOI	State Department of Infrastructure
DSE	State Department of Sustainability and Environment
DVC	State Department of Victorian Communities
EHO	Environmental Health Officer
HIA	Health Impact Assessment
LGA	Local Government Authority
MAV	Municipal Association of Victoria
MPHP	Municipal Public Health Plan
NGO	Non-Government Organisation
NHF	National Heart Foundation (Victorian Division)
MSS	Municipal Strategic Statement
PAG	Program Advisory Group
PCP	Primary Care Partnership
PIA	Planning Institute of Australia
SEIFA	Socio-Economic Indexes for Areas
VicHealth	Victorian Health Promotion Foundation
VLGA	Victorian Local Governance Association
WHO	World Health Organisation

EXECUTIVE SUMMARY

Environments for Health, Five Years On…

The *Environments for Health* Municipal Public Health Planning Framework has had a major impact on local government health planning since its launch in 2001.

The Framework has influenced the conceptualisation of health in local government, as demonstrated by the incorporation of its principles and guidelines in the large majority of MPHPs. This awareness includes:

- an increased understanding within local government that 'health' incorporates multiple aspects of wellbeing that go beyond 'health service delivery';
- increased awareness of the multiple determinants of health (the four environments that influence health – social, economic, natural and built environments); and consequently
- recognition of the intersectoral nature of health and the importance of incorporating health planning into whole-of-council planning, and across council departments.

The *Environments for Health* Framework has been well received by the local government sector and beyond. The Framework has been adopted by a range of other state government areas including Municipal Early Years Plans, Neighbourhood Renewal, and Emergency Management. For example in emergency management recovery the Framework has extended planning past welfare relief (i.e. blankets and shelter) to look at people's wider needs.

Full compliance in the development of MPHPs has been achieved in Victoria – an increase of 15 per cent since 2000. This figure endorses the value of MPHPs to local government and is well in excess of the state benchmark of 80 per cent.

This impressive result compares favourably with experience reported in other countries to date. Examples of similar programs in the US, UK and The Netherlands report limited progress in implementing local area health planning based on the social model of health at multiple sites state-wide.

The implementation of the *Environments for Health* Framework has generated additional capacity in the sector and has been well supported by DHS and other programs, such as the Good Practice Program and *Leading the Way*.

For such a modestly resourced program, the return has been significant. For example, through the support of the Good Practice Program, one Local Government Authority (LGA) has received a government commitment to build seven kilometres of bike/walking path (at a cost of $1.7 million) through a new residential area in a rural growth corridor. Total funding on the Good Practice Program over the past four years only amounted to $1.5 million.

In its first five years*, Environments for Health* has raised awareness, allowed the trial of existing tools and resources, and generated considerable momentum for further change. Through consultation with, and input from, the local government sector and other stakeholders, this evaluation has identified the strengths and weaknesses of the Framework and supporting resources, the local and state-level barriers preventing further progress, and a series of practical and strategic recommendations.

The evaluation itself has provided the opportunity for reflection and in so doing generated enthusiasm for a new edition of *Environments for Health* and support for its continued implementation over the next five years and beyond. It is recommended that a new *Environments for Health and Wellbeing* forms part of a suite of integrated health promotion

initiatives. The revised Framework together with complementary initiatives, such as the Integrated Health Promotion Resource Kit, recently endorsed statewide Health Promotion Priorities, Chronic Disease Prevention framework and policy focus on addressing health inequalities, will contribute to the ongoing development of health promotion and public health in Victoria.

Introduction

Environments for Health, which was launched in 2001, was designed to provide an integrated planning approach for Municipal Public Health Plans (MPHPs) in Victoria. It aimed to make public health a central focus for local government and to increase its capacity to prevent ill health and increase wellbeing.

Environments for Health is based on a social view of health which recognises the impact of the social, built, economic and natural environments on community health and wellbeing. The Public Health Branch of the Department of Human Services, Victoria, commissioned the evaluation to assess the framework's usefulness and impact, and to make recommendations for future directions. An external evaluation team from Deakin and Melbourne Universities was appointed to undertake the study over a period of approximately six months beginning in April 2006.

The evaluation **objectives** were to assess the extent to which the *Environments for Health* Framework had:

- Been incorporated by local governments in their policies and practices;
- Contributed to greater consistency and quality in the scope and approach of municipal public health planning across the state;
- Led to the integration of municipal public health plans (MPHPs) with other council plans;
- Increased the level of understanding among appropriate local government staff of the impact of the social, economic, natural and built environments on health and wellbeing;
- Created additional opportunities for health gain through strengthened intersectoral partnerships to address the social determinants of health; and
- Been supported effectively by the Department of Human Services and other stakeholders.

The evaluation also aimed to provide direction for future developments in supporting Municipal Public Health Plans.

Evaluation design

The evaluation design and data collection methods were developed in consultation with the DHS Local Government Partnerships Team and the Project Advisory Group (18 members representing key stakeholder organisations in municipal public health planning).

The multi-method evaluation design incorporated following four components.

- Document analysis of Victorian Local Government Authorities' (LGAs) MPHPs (62 plans were available for analysis).
- Individual and group interviews with key stakeholders in municipal public health planning (73 interviewees).
- Online survey of individuals involved in municipal public health planning (councillors, council staff, non-council organisations and community members) (108 survey respondents).
- Community forums (five) to present preliminary evaluation findings and obtain input from additional stakeholder groups.

Key findings

Content and structure of MPHPs (document analysis)

Findings in this section are derived from the first component of the evaluation (document analysis of MPHPs).

All councils in Victoria now comply with the requirement of the Health Act (1988 and 1991 amendments) to develop a MPHP. Most MPHPs are in the implementation phase (61), with a small number under review (17).

The majority of the MPHPs showed evidence of extensive use of *Environments for Health* in terms of:

- defining 'health' broadly (encompassing multiple aspects of health and wellbeing) rather than narrowly (absence of disease) (84 per cent);
- incorporating the multiple environmental determinants of health (social, economic, natural and built environments) (84 per cent);
- using a consultative committee (often with broad council and community representation) to assist in developing the plan (57 per cent);
- employing a range of community and agency consultation processes (90 per cent);
- drawing on appropriate sources of data and evidence (94 per cent) to frame objectives in the context of state and national health priorities (75 per cent); and
- linking MPHPS with a wide range of other council and community plans (90 per cent).

Most MPHPs mentioned links to the Council Corporate Plan (79 per cent) and the Municipal Strategic Statement (MSS) (61 per cent), often in the form of a diagram similar to the one contained in *Environments for Health*. The extent to which these references represented substantive links was difficult to judge from the documents. Specific mechanisms to review and evaluate MPHPs were less apparent.

These findings from the MPHP document analysis indicate a generally high level of incorporation of *Environments for Health* principles and guidelines in MPHPs, though ownership and application of the principles is difficult to assess in the written documents. There was considerable variation in the processes undertaken to develop the plans, as well as in their length, content and structure. There was good evidence in the documents of links to other council and community plans, and of consultative processes used to develop MPHPs. Organisational and agency consultation was more prevalent than engagement with residents.

Impacts of *the Environments for Health MPHP Framework* (key informant interviews)

Evidence for the impacts of the *Environments for Health* Framework on individual and organisational awareness, knowledge and practice comes primarily from the second component of the evaluation (key informant interviews).

Interviewees reported that the *Environments for Health* Framework has contributed to (but not been solely responsible for):

- an increased understanding within local government that 'health' incorporates multiple aspects of wellbeing that go beyond 'health service delivery'
- increased awareness of the multiple determinants of health (the four environments that influence health – social, economic, natural and built environments); and consequently
- recognition of the intersectoral nature of health and the importance of incorporating health planning into whole-of-council planning, and across council departments.

These changes have been facilitated by consistent messages from the *Environments for Health* Framework and support activities, other DHS and non-DHS sources, and from the simplicity and memorability of the 'four environments' platform for promoting them.

While these impacts were consistently referred to, it was also evident that the changes were not uniform either across or within councils. The extent to which these changes were embraced and acted on by councils was dependent on many factors. Demographically, size and location of the LGA did not necessarily predict impact, though some rural and regional LGAs were constrained by difficulties recruiting experienced health and social planners.

Council 'culture', priorities, resources, and organisational capacity were considered more important, including the influence of individual councillors and senior managers. *Leading the Way* was considered an important influence at councillor and senior manager levels, with interviewees reporting some moments of illumination among participants in the program. However, individual 'conversions' were considered insufficient to bring about and sustain wide-scale organisational change.

Ongoing workforce development of councillors, senior management and other council staff was considered important for building capacity for sustained organisational change. Staff turnover within councils means that staff training needs to be embedded both within the organisation and the wider local government sector. Awareness raising, tools and practical assistance are also required. A range of approaches, supports and strategies are needed at different levels within councils.

Traditionally 'health' tends to be compartmentalised within councils, with responsibility for the MPHP residing with one health or planning officer. The word 'health' contributes to this isolation – 'wellbeing' is a more inclusive term that is more widely recognised as the business of the whole council. Health promotion 'jargon' is a constraint on intersectoral cooperation to improve health. Resources and activities that speak the language of other sectors, and communicate effectively with all levels within council (councillors, senior managers and officers) are required.

Care needs to be taken that promoting intersectoral action to improve health is not seen as shifting responsibility for health to other sectors without adequate resourcing. There was also a concern that integrated planning might lead to the 'homogenisation of issues, populations and voices', running the risk of marginalising diverse views and needs in the community. A lack of focus on health inequalities and marginalised groups was seen to be a gap in the *Environments for Health* Framework.

Developing a MPHP was seen as one thing, implementation another. Whilst development of the plan is mandated, its implementation is not, and there is little accountability for implementing, reviewing or evaluating proposed actions. In some cases, the planning phase of the MPHP was considered to be an end in itself. The key to implementation was considered by some interviewees to be increasing ownership of the MPHP and partnership development.

It was also noted that having a committee responsible for overseeing the implementation of the plan (rather than disbanding the committee when the MPHP had been developed) would improve implementation of the plan. At the same time, it was acknowledged that there is a risk of consultation and meeting 'fatigue' for both internal and external stakeholders, particularly in light of the plethora of local government plans.

Support for MPHP development and implementation, and for integrated health planning, was also needed at senior levels within the Department of Human Services (DHS). Interviewees stated that there was often closer and better liaison between agencies and government departments at the local level than within the same agencies at the central level.

Partnerships between DHS and Non Government Organisations (e.g. Municipal Association of Victoria (MAV), Victorian Local Governance Association (VLGA), Planning Institute of Australia (PIA), VicHealth, National Heart Foundation (NHF), etc) were considered important for

supporting *Environments for Health,* as was having a senior 'champion' within DHS for the *Environments for Health* Framework.

Impacts of the *Environments for Health MPHP Framework* (online survey)

Respondents were familiar with the *Environments for Health* Framework (93 per cent), with fewer respondents familiar with *Leading the Way* (75 per cent). Open-ended comments were generally very positive, but one respondent noted that the different names of the two resources could cause confusion.

The *Environments for Health* document was considered by most respondents to be easy to understand (87 per cent agreement), and to have good links to supporting documents, research and websites (94 per cent). Part A reportedly provided a sound theoretical base for health planning (88 per cent), and Part B provided practical planning tools (87 per cent). The *Environments for Health* Framework had a moderate to substantial influence on councils' MPHPs for approximately two-thirds of participants.

There was less agreement about *Environments for Health*'s influence on other plans, especially those unrelated to 'health' in the traditional sense. Over 60 per cent of participants agreed that *Environments for Health* had a moderate to substantial influence on the Primary Care Partnerships (PCP) Community Health Plan. Slightly less agreed that *Environments for Health* had a moderate to substantial influence on their Community Health Service Health Promotion Plan, Access and Inclusion Plan, and Alcohol and Drug Strategy.

In relation to the Corporate Plan, only 34 per cent of participants believed that *Environments for Health* had had a moderate to substantial **influence**. Even fewer participants indicated that *Environments for Health* had influenced their Municipal Strategic Statement (MSS) (19 per cent). Levels of influence of the *Environments for Health* Framework on LGAs' planning schemes in general were perceived to be relatively low or unknown. These findings suggest that there may be a lack of mainstreaming of the MPHP planning initiatives in the main planning schemes of council.

There was also a perceived lack of **integration** between MPHPs and Corporate Plans. Just over 37 per cent of participants suggested that their MPHP was moderately or substantially integrated with their Corporate Plan (16.2 per cent of respondents indicated 'don't know'). Integration with the Municipal Strategic Statement was less common with only 21 per cent of participants indicating that the MPHP was moderately to substantially integrated (27.9 per cent of respondents indicated 'don't know' or 'not applicable').

This finding contradicts statements about integrated planning in the MPHPs themselves as reported above from the content analysis of MPHPs. Perhaps rhetoric or intention has not been realised in the implementation of these plans in the context of the overall planning scheme within local government.

A range of additional activities and resources were reported to be useful by the majority of respondents who were familiar with them (Good Practice Program, *Leading the Way* (VicHealth), Municipal Public Health Planning Conferences, DHS Local Government Planning for Health and Wellbeing website, DHS Municipal Public Health Planning Newsletters). 'Face-to-face' activities were more highly rated than the print and web-based resources.

The majority of participants who answered an item about support and resources provided by DHS regional offices reported finding them useful (ranging from 50 to 65 per cent). This was particularly true for participation in MPHP steering committee and regional network meetings (65 per cent rated quite to very useful), other funding resources (64 per cent), Good Practice Program (62 per cent), provision of data (58 per cent quite to very useful), and Training Program (56 per cent rated quite to very useful). Across this and all other questions related to support and resources, 'other funding resources' was the item with the highest proportion of respondents indicating 'very useful'. A number of open-ended, uncued comments related to the need for the state government to invest more resources in integrated council and community health planning.

In terms of the five strategy areas of the Ottawa Charter for Health Promotion, the *Environments for Health* Framework was perceived to have contributed most to improved health public policy (66 per cent agree) and creating supportive environments (63 per cent), and least to strengthening community involvement in the LGA (35 per cent) and developing personal skills of community members (21 per cent).

Organisational capacity is important for innovation and sustained change in policy and practice. Respondents to the online survey tended towards agree/neutral that councils worked in ways that encouraged partnerships (mean score 3.7), knowledge transfer (3.6), leadership (3.3), and workforce development (3.2). Respondents tended to neutral/disagree that councils provided adequate resources for health and wellbeing planning (2.7). Generally lower scores for resourcing issues were a consistent finding from the evaluation.

Impacts of the *Environments for Health MPHP Framework* (community and stakeholder forums)

Participants at the council and stakeholder forums expressed general agreement with the preliminary evaluation findings. Change was evident to participants at organisational and inter-organisational levels. Numerous other governmental plans and policies were seen as connected to *Environments for Health*.

Forum participants suggested a range of improvements and initiatives to further the implementation of the Framework in MPHPs. Participants particularly expressed the need for practical examples: case studies, methods of measuring community participation, specific examples applying to rural/regional councils; and action plans that correspond to core council operations. In general it was felt that Part B of *Environments for Health* needed to be made more prescriptive to enable further use of the Framework and that it needed to include electronic links to new resources at departmental and local levels.

In summary, the evaluation findings suggest that for local government staff and other stakeholders, the development and implementation of *Environments for Health* has been significant in their immediate setting in terms of:

- increasing awareness and knowledge of the four environments of health;
- organisational policies;
- inter-organisational networks and collaborations; and
- enhanced capacity across the broader local government sector.

Programs similar to the *Environments for Health* Municipal Public Health Planning Framework indicate very limited, if any, success for the wide-scale development of local health plans elsewhere. Therefore, findings of this study can be regarded as positive.

Conclusions and recommendations

Conclusions and recommendations in relation to the objectives listed earlier are presented in the following sections.

Incorporation by local governments in their policies and practices

The findings of this study demonstrated that *Environments for Health* has had a significant influence on local government policy and practice. This was evident from participants' perceptions about the impact of the Framework on improved and 'healthier' public health policy, and its contribution to improvements in plans that impact on the four environmental domains.

In spite of the relative success of *Environments for Health*, this study also revealed barriers and factors blocking its further effective dissemination. These factors are not intrinsic to the current format of the Framework: rather, this evaluation has found future work should focus

on enhancements in communication, on the provision of further support mechanisms for the dissemination and sustainability of current achievements.

The following recommendations could encourage the further incorporation and implementation of the Framework by local government:

a) Revise, re-badge and re-issue as *Environments for Health and Wellbeing.*

b) Consolidate *Leading the Way* with *Environments for Health,* linking the two more consistently through, for instance, co-branding of already available and newly developed resources and nomenclature.

c) Communicate sector-specific messages about the four domains to groups traditionally outside the health field via practical examples and guides for developing communication strategies. Develop guidelines that avoid health promotion industry-related language.

d) Develop funding incentives and opportunities for implementing *Environments for Health* including more specific support for rural regions.

Level of understanding about the four environmental domains

Environments for Health has had a significant impact on the change in understanding of the many determinants of health. The social model of health is now being used widely in the formulation of Municipal Public Health Plans in Victoria. This change has taken place alongside other initiatives supporting the social model of health.

Despite the significant achievement in relation to changing understandings, this study demonstrated that there may have been less reach of these understandings in areas not traditionally associated with health. In particular the economic and natural environments may still require targeting in relation to raising awareness and understanding of their inter-relationships with other environmental domains. The social environment also would benefit from further strengthening and the explicit incorporation of cultural features. Findings suggested that community representatives and councillors were often less likely to realise the benefits of resources that support the Framework. The following recommendations address these gaps:

e) Develop tools like *Healthy by Design* for the economic environment with the economic development sector as the audience.

f) Encourage better use of existing resources. For example, consider ongoing *Leading the Way* training in councillor orientation programs and consolidate MAV councillor/senior officer *Leading the Way* training module as a permanent offering in local government training.

g) Develop links with Health and Social Impact Assessment tools and resources;

h) Compile a community participation guide containing lists of resources and examples for local governments with multiple access points.

Consistency and quality in the scope of MPHPs

The document analysis conducted as part of this study showed a wide variation in the content of MPHPs, which in itself may be most appropriate for local governments dealing with diverse populations and geographies. All councils had a MPHP. This represents a 15 per cent improvement on the 2000 evaluation survey where 11 councils did not have a plan. The majority of plans in 2006 mentioned *Environments for Health* and referenced the four environmental domains and social determinants for health model in their introductory sections.

Despite this improvement, a consistent theme that emerged from interviews and survey results was the variability of capability and capacity for planning in general within councils. Future work should focus on disseminating best practice models in relation to planning, rather than health planning specifically. There was little information in plans about how these plans would be implemented, monitored and reviewed, and many participants indicated confusion about whether the MPHP was a strategic statement or an operational plan.

Many participants suggested the need for training and specific tools in relation to planning, and in particular, how to integrate plans. Recommendations specific to addressing this gap include:

i)   Confirm the status of the MPHP as a high-level, overarching strategic document within the broader planning arena and across local government areas, with operational plans cascading down from it.

j)   Develop tools and resources focused on implementation that are sourced from general planning literature and practice. For example, provide models of linked or cascaded plans and guidelines to implement the social model of health that include access to data, including key performance indicators that are not just illness and disease measures, best practice examples and intervention points under each environmental domain.

k)   University training of planners needs to be multidisciplinary to equip planners with intersectoral skills and understandings. This may develop the ability to work across sectors and divisions, use the language of other disciplines, and the ability to describe 'health' from multiple perspectives.

Integration of MPHPs and other plans

Contradictory findings across different levels of data collection in this study suggested that while many MPHPs refer to their links to other plans, this may not reflect actual practice. The document analysis suggested that a majority of MPHPs were linked to the council's corporate plan, and to a lesser degree the MSS. Participants expressed strong intentions to practice integrated planning; however, they appeared frustrated with barriers faced including lack of capability in relation to how to achieve this, as well as some technical barriers, particularly in relation to statutory requirements of the MSS.

The interviews with key stakeholders confirmed this finding, with themes emerging around barriers to integrated planning: silo mentality, language issues, workforce capability and capacity and the complexity of planning requirements within councils.

Future work should focus on the establishment of conceptual consistency between *Environments for Health* and other planning parameters. This could also involve the establishment and maintenance of an inter- and intra-governmental policy perspective on whole-of-government approaches at all levels of governance.

It is recommended that a program of work be conducted to simplify planning requirements for councils:

l)   Use the findings of the recent mapping exercise, the Joint State/Local Government Planning Review led by the Department of Victorian Communities (DVC), to clarify and help integrate the range of statutory and other planning requirements relevant to MPHPs and the *Environments for Health* Framework.

m)   Develop guidelines for integrated planning that could be developed along with practical tools and templates to integrate the plethora of existing plans. This work could utilise the expertise of planners, ensuring that plans contain links to business plans and the budget process.

n)   Strengthen the strategic and operational links between PCP Community Health Plans and the MPHPs.

o)   Develop and disseminate specific examples of how the Corporate Plan, the MSS, MPHPs and other local government plans can be integrated.

p)   Consider a benchmarking project in relation to integrating planning. Benchmark partners may not necessarily be in health or government, and could include other industries that need to address the needs of a range of stakeholders.

The following strategies may provide a way forward to a more integrated approach at the state level:

q) Promote the MPHP as the strategic higher-order health plan from which other health and wellbeing plans (e.g. PCP Community Health Plans) would cascade down across regional and sub-regional settings.

r) Investigate linking the key local government plans at the legislative level including MPHPs.

s) Build on existing partnerships and understandings between DHS, DVC, Department of Sustainability and Environment (DSE), VLGA and VicHealth where appropriate and possible. University partnerships with DHS and all relevant local government stakeholders could be to be explored and extended to facilitate mutual teaching and learning.

t) Develop a state-integrated local government policy statement based on *Environments for Health* for government departments and state partners to adopt.

u) Promote the use of the *Environments for Health* Framework across DHS and other state government departments in developing policies and any funding programs for local government, and in conceptualising the MPHPs.

v) Raise the profile and leadership role of the Public Health Branch of DHS in strategic health planning, not just in service delivery. This can be done by:

- identifying and nurturing champions who support this approach;

- encouraging regional offices to promote, market and resource local government recognising the key role local government plays in health planning;

- ensuring entry points and contact details for the local government resources located within Public Health Branch of DHS and other departments are highly visible and accessible.

Additional opportunities for health gain

Although it is difficult to attribute outcomes to *Environments for Health* alone, findings of this study suggested that *Environments for Health* had significantly:

- increased the level of understanding of the impact of the four environmental domains on health and wellbeing;
- contributed to improving public health policy;
- contributed to policies and plans that impacted on the four domains; and
- helped create supportive environments in local government.

There was less agreement that the Framework had: contributed to addressing different needs in local government; encouraged services to be more health promoting; strengthened community involvement; or developed personal skills of members of the community.

An analysis of different group responses to these outcome measures suggests that there were no differences according to geographic locations, or job role (management versus staff and community). However there were some differences between council and non-council staff in their perceptions. As expected, council employees tended to be more familiar with the Framework and attribute outcomes related to increased level of understanding, contribution to planning and addressing the needs of disadvantaged population groups to the Framework. This finding may suggest that future opportunities for health gain in relation to *Environments for Health* should focus on community needs and strengthening partnership involvement.

Strategies in relation to strengthening community and partner involvement in the Framework could include:

w) Tools and resources to identify the benefits of community engagement, and help increase the level of engagement.

x) Extending the understanding of the social model of health to identify and address health inequalities through a recognition of the social determinants of health.

Support provided to the Framework

Participants appeared to be satisfied with many of the supplementary initiatives that support the implementation of *Environments for Health*, especially *Leading the Way* and the Good Practice Program, as well as *Healthy by Design* (Heart Foundation) and Planning for Health (PIA). However, findings in this study clearly showed that barriers to implementation of the Framework included gaps in workforce capability and resources. Participants strongly supported ongoing training for a range of stakeholders including councillors.

Confirming conclusions of the evaluation report for the 2002-2004 Good Practice Program, this study also found that organisational culture and leadership were key to acceptance of the social determinants of health model and the level of intra- and inter-organisational collaboration. In particular, correlations with outcome measures in the online survey showed that organisational capacity, and in particular leadership, was a significant factor for successful integration of the MPHP with other plans.

However it also found that, apart from leadership, other organisational capacities were more likely to impact on the achievement of demonstrated health gain in relation to *Environments for Health*. These include workforce development (in relation to professional development for staff); knowledge transfer (in relation to evidence-based planning and meaningful stakeholder consultation); partnerships (in relation to proactively working in a cooperative and inclusive manner and having available networks); and resources (in relation to appropriate human and financial resources).

The following recommendations address the need to raise the capability of various sectors.

y) Provide an integrated training and workforce development program which operates regularly and involves planning partners as well as other resources and expertise.

z) Revisit and revitalise existing training models and resources for new health planners with appropriate peer-learning and support mechanisms along the lines of the Good Practice Program. This might require:

- inclusion of materials and guidance in councillor training handbooks;

- use and strengthening of existing forums and networks, such as local government networks, regional management forum, Fairer Victoria regional forum, Health Promotion Short Course;

- training using *Environments for Health* with regional public health teams;

- provision of state government incentives for senior level demonstrated commitment; and

- development of information and learning exchanges with universities and other relevant research bodies.

Directions for the future development of Municipal Public Health Plans

As described above, the findings of the study have been positive for all the study objectives evaluated. The *Environments for Health* Framework has been implemented successfully in terms of the installation of a broad social model of health in local government health plans. This is reflected in the incorporation of the Framework into local government planning and in the achievement of additional opportunities for health gain. These achievements should be applauded.

Five years on, the Framework itself requires revision. A new edition is needed to incorporate new developments in the field, to address the shortcomings identified in this study, and to permit a more sophisticated use of the social model of health at the local government level. Tools, templates and resources require revision and updating, and new materials included.

A series of practical, 'on the ground' recommendations has been proposed above to further the implementation achieved to date. However in order to truly sustain this accomplishment, three strategic recommendations must be added.

1. Respondents in the different elements of the evaluation have expressed a concern that, if local authorities are to adopt a **whole-of-government approach**, this should be modelled and exemplified at the state level. The need to align and integrate the local government planning roles of DHS and DVC, in particular, was identified as an immediate priority. It is therefore recommended that the existing initiatives and processes in train that provide a consistent whole-of-government approach be strengthened and extended. These initiatives need to be more visible, have a strong local government planning focus and an accessible point of contact. The local government field needs to be well-informed of the deliverables expected and their achievement so that the planning benefits may be experienced immediately.

2. The second strategic recommendation is to implement the outcomes of the above whole-of-government initiatives, such as the findings of the recently completed Joint State/Local Government Planning Review, led by DVC. The need to map and review the different local government planning requirements in terms of governance, decision-making, organisational collaboration, capacity development, legal context, and resourcing has been well recognised. This process will allow for the identification of opportunities for **coordination, integration and streamlining** of health planning requirements. The strategic development of integrated planning mechanisms and processes at state, regional and local level has already occurred to some extent. The Department for Victorian Communities' role in this area should be actively supported across government departments and state partners.

3. Taking full advantage of these opportunities hinges heavily on further **capacity and resource development**. Such development calls for visible and high level commitment in the Victorian Government to the role of local government in promoting health and wellbeing. Capacity and resource development must be structured and benchmarked with long-term objectives in mind. The NSW capacity-building framework and California Community Capacity Building framework may guide this effort in the following areas:

    ▪ *Community capacity building*. This was perhaps is the weakest area identified in the study. Intersectoral efforts are required to sustain and build further community development.

    ▪ *Workforce and organisational capacity building*. From the highest level, the need to embed awareness, implementation processes and resource allocations is required to be put high on social and political agendas. Priority areas include targeting training for different audiences i.e. councillors, planners, community developers etc, ensuring training resources are ongoing (due to high staff turnover) and make better use of existing resources.

    ▪ *Review mechanisms*. Increase requirements for review, evaluation and accountability compliance measures which are needed not just for developing MPHPs but for implementing and reporting on the achievements or outcomes of these plans.

    ▪ *Appropriate resourcing*. This evaluation showed that respondents appreciate the existing tools and support mechanisms, but that they are not always experienced as accessible, transparent, or appropriate. The continued review, marketing and redevelopment of these should be a prime priority. Any review should also include an economic evaluation of the first stage of the Framework, and recommend resource requirements for the subsequent planning and implementation cycles. Finally, it is recommended that funding in the second stage needs to equal or exceed the investment already made to develop and implement the Framework. This funding would best be used in conjunction with direct grants and the creation of opportunities for local government to generate additional resources in partnership with key players in the four environments for health.

EVALUATION OF *ENVIRONMENTS FOR HEALTH* FRAMEWORK

PART A – BACKGROUND

1.1   Introduction

Environments for Health was launched in 2001 to provide a state-wide policy framework for Municipal Public Health Plans (MPHP) in Victoria. Designed to provide an integrated planning approach for MPHPs, *Environments for Health* is based on a social view of health which recognises the impact of the social, built, economic and natural environments on community health and wellbeing. The Framework has sought to provide both a theoretical and practical guide for understanding and implementing this new public health paradigm. It aimed to make public health a central focus for local government and to increase its capacity to prevent ill health and increase wellbeing, particularly amongst those most disadvantaged.

Environments for Health was developed as a leading-edge approach to quality health planning at the local government area. Significant changes have occurred in local approaches to MPHP planning over the past five years. The contribution attributable to the *Environments for Health* Framework and supporting resources is the subject of this evaluation study.

The Public Health Branch of the Department of Human Services, Victoria, commissioned the evaluation to assess the introduction of the *Environments for Health* Framework to municipal public health planning and to make recommendations for its future direction. An external evaluation team from Deakin and Melbourne Universities was appointed to undertake the study over a period of approximately six months beginning in April 2006.

This section describes the origins, the Victorian history, and the international and theoretical context of the *Environments for Health* Framework.

1.2   Origins

The Ottawa Charter and Healthy Cities Program

The origins of *Environments for Health* can be traced directly back to the Ottawa Charter and the concurrent launch of the Healthy Cities Program by the World Health Organisation (WHO) in 1986. Healthy Cities is a long-term development project that seeks to place health on the agenda of cities and municipalities around the world, and build a constituency of support for public health at the local level (Tsouros, 1995). Such initiatives are characterised by a broad-based, intersectoral political commitment to health and wellbeing in its broadest ecological sense, and a commitment to innovation. Democratic community participation is an essential component, as is the resultant healthy public policy (WHO, 1997).

The Healthy Cities movement is based on the recognition that city and urban environments affect citizens' health, and that healthy municipal public policy is needed to effect change (Ashton, 1992). Since the concept was embraced by WHO in 1986, the movement has produced more than 10,000 initiatives worldwide. The concept is evolving to encompass healthy villages and municipalities, and has a close relationship to municipal public health planning (National Civic League, 1998). The capacity-building approach of Healthy Cities is central to the WHO definition of health – 'the process of enabling people to increase control over and improve their health' (Trevor Hancock, cited in the National Civic League, 1998, p. 288).

The Healthy Localities Project

Between 1989 and 1993, six Healthy Localities initiatives were funded in Victoria. These three-year funded projects attempted to implement the Healthy Cities framework at local community level, on the assumption that local community acted as mediator between the level of the city and the level of the individual (Garrard, Hawe, & Graham, 1995a & b). The project was auspiced through the Municipal Association of Victoria (MAV), and managed through a Healthy

Localities Project Management Committee consisting of representatives from local government, VicHealth, MAV and the Victorian Health Department. The Healthy Localities Project aimed to promote: (i) the social model of health; (ii) a range of health promotion strategies, drawing fully on the Ottawa Charter, and placing particular emphasis on community participation; (iii) collaborative planning between local government and their communities; (iv) evaluation of these strategies' effectiveness in creating supportive environments and changing behaviours; (v) innovation; (vi) all councils and their communities to engage in similar systemic health promotion. Garrard et al.'s (1995) evaluation indicated that project aims had been ambitious and insufficiently defined, and emphasised process over desired outcomes. Nevertheless, shifts in community capacity were identified in many of the sites that could be attributed to the initiatives. The projects highlighted the importance of local governance, and the need to focus on structural change (organizational policies or structures) as much as micro-level change (awareness, attitudes and behaviours).

1.3 Historical Development

Local government

As the closest tier of government to the community, local government is often perceived to be in the best position to generate health gains through integrated public health planning and implementation at the local level. Apart from councils' responsibilities in environmental health, they have typically delivered services in areas such as immunization, emergency management, home care and facilities management.

The emphasis is now to extend their roles in health promotion and to develop links and partnerships with other service providers and the community to facilitate this. Through *Environments for Health*, DHS acknowledged that local governments are a distinct sphere of government with the authority and responsibility for providing leadership, working with citizens to create vision and goals for their communities, promoting integrated planning, fostering community participation and community development, advocating for local needs, establishing structures to ensure intersectoral partnerships, and facilitating local change (Department of Human Services, 2001, p. 10). Local governments, with their clearly identified populations and geographic boundaries, are ideally placed to plan for and act upon goals and issues relating to municipal health and wellbeing.

Implementing change at this level, however, is not without political and organisational issues. Although local councils are elected with a mandate to constituent voters, they are not recognised as separate legal entities under the Australian constitution; instead they reside under the direct authority of state governments (Smith 1995). State governments have tended to oscillate between prescribing and imposing reforms through legislation and encouraging the adoption of new directions through guidelines, education and support mechanisms. Over the past decade, there has been a shift away from prescriptive legislation to the provision of frameworks which allow local government greater autonomy in the interpretation and implementation of state-wide policies (Blau & Mahoney, 2005).

The implementation of Municipal Public Health Plans (MPHPs) in Victoria has been shaped by both of these approaches from successive state governments**.**

The introduction of Municipal Public Health Plans

The advent of Healthy Localities initially coincided with a drive to legislate for municipal public health planning across Victoria using the principles of Healthy Cities/Healthy Localities Projects. Municipal Public Health Plans (MPHP) were introduced via the Health (General Amendment) Act 1988, and an amendment of the Victorian Health Act in 1991. The introduction of MPHPs aimed to remove a number of restrictive regulatory controls and give councils greater freedom to determine their own priorities. Under the Health Act, Section 29B, every council must prepare a MPHP and revise it every three years. The plan must identify and assess actual and potential public health dangers affecting the municipal district and outline programs and strategies which council intends to pursue. The council must review the plan annually and, if appropriate, amend the plan. A range of resources were developed to support the 210 local governments that existed across Victoria at this time.

During the 1990s there was considerable upheaval in Victorian local government. Major reforms were introduced to restructure the size and culture of local government. In 1993, the state government amalgamated the 210 Victorian councils into 78 (currently there are 79). This process resulted in the replacement of the elected councillors with Commissioners appointed by government.   Compulsory Competitive Tendering (CCT) was also introduced during this time requiring local government to 'market test' 50 per cent of their expenses (Blau & Mahoney, 2005). The CCT process and outcomes represented the antithesis of the collaborative development of partnerships and integrated planning intended to accompany the initial introduction of MPHPs.

Restructuring also occurred at the state government level, with the Department of Health and Community Services amalgamating with the Department of Housing and Disability Services, Office of Aboriginal Affairs and Office of Youth to form the Department of Human Services (DHS). Despite these challenges, some key personnel associated with the introduction of MPHPs in 1991 remained at the new DHS, and continued to support local government health planning efforts.

Formation of the Local Government Partnership Team, DHS

MPHPs regained priority status with the election of the state Labor Government in 1999. A commitment to reinvigorate civic democracy and the planning role of local government was included in Labor's election campaign platform. The independent Review of Primary Health Redevelopment in 1999 also supported the need for greater consistency and quality of MPHPs across the state and recommended the development of a template or framework for MPHPs.[1]

The Local Government Partnerships Team (LGPT) was established in early 2000 with a view to scoping the potential for developing a state-wide municipal public health planning policy framework to guide and support all local governments. Situated in the Partnership Development Section of the Public Health Division of DHS, the LGPT consciously adopted all tenets of the Ottawa Charter, namely: creating supportive environments; developing personal skills; enhancing community action; reorienting health services; and creating healthy public policy (WHO, 1986). The stated aims of the team were to:

- Provide leadership, support and co-ordination on municipal public health planning to the local government sector and all stakeholders, and to
- Strengthen public health infrastructure and capacity by: sharing information, identifying and encouraging best practice, stimulating research, developing collaborative relationships, and developing and implementing public health policy.[2]

The work of LGPT members[3] included strategic planning, team building, partnership development and research. They also developed the MPHP framework, securing endorsement of the final draft, releasing the Framework, and created multi-sectoral links between policy makers and practitioners in public health and urban planning.

A comprehensive implementation program for *Environments for Health* was also devised.

Development of the Environments for Health Framework

As a foundation for developing *Environments for Health*, the LGPT embarked on a systematic program to develop partnerships with key internal and external stakeholders, including various program teams within the Public Health Group, other divisions within the Department of Human Services; the Municipal Association of Victoria (MAV); Victorian Local Governance Association (VLGA); local governments and other stakeholders. A Steering Committee, made up of 18 key stakeholders was established, co-chaired by the DHS and the Municipal Association of Victoria. This served to create a sense of collective ownership of the process, ensure external political support, and encourage a commitment amongst council senior management, councillors and practitioners to use the Framework.

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[1] "Report of the Review of Primary Health Redevelopment", Principal Reviewer: Adjunct Professor Hayden Raysmith, December 1999, page 26.
[2] From Local Government Partnerships Team archives, April 2001
[3] The team comprised Ms Andrea Hay, Mr Ron Frew and Dr Iain Butterworth, who together brought local government, urban planning and health planning experience to the project.

MPHP Survey, 2000

In August 2000 the Local Government Partnerships Team sent a questionnaire to all Victorian local governments. It sought information about the status and content of current MPHPs, and sought to identify issues requiring consideration in the development of a new framework. The questionnaire was intended to provide information on good practice, and model planning processes that could be incorporated into a planning framework. Sufficient data was received to enable detailed analysis of all questionnaire items for 59 of the 78 Victorian local government areas, representing 76 per cent of Victorian Councils. Additional information was provided by public health staff at DHS Regional Offices, to whom councils were required both to submit and report on the status of their MPHP.
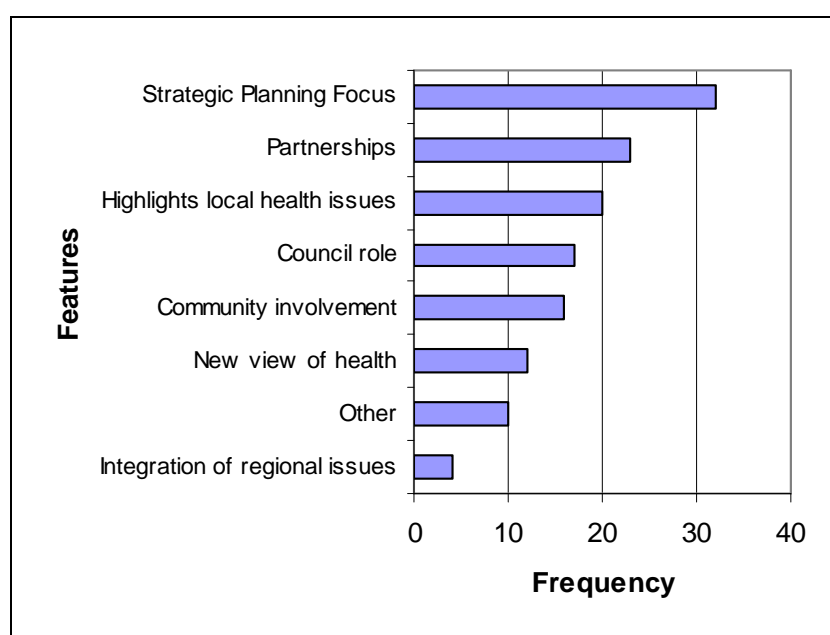
Figure 1 Positive Features of MPHPs identified in DHS 2000 Survey (DHS, 2000, p.12)

The survey determined that over 52 per cent of the 78 new councils were implementing a plan, 18 per cent were developing a new plan, and 15 per cent were under review. As shown in Figure 1, a wide range of positive processes was reported in the areas of strategic planning, partnership development, community involvement, management and working relationships to implement plans, and a whole-of-council commitment to public health (Department of Human Services, 2000).

In addition to the positive processes identified, many significant barriers were uncovered (see Figure 2). From the 150 responses received, resource constraints emerged as the main barrier to effective MPHP implementation, with 55 specific references made to this issue. Key resource constraints, in descending order of magnitude, were funding issues, limited human resources, and insufficient time (DHS, 2000).
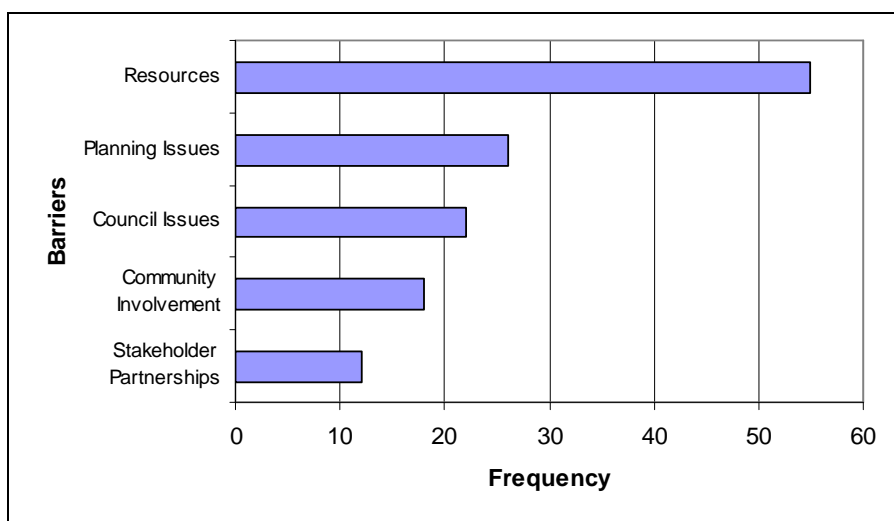
Figure 2 Perceived Barriers to Effective MPHP Development (DHS, 2000, p. 24)

The 2000 Survey identified several interconnected elements of an effective MPHP framework which formed the basis for the first draft of *Environments for Health.* These were the need for*:*

- strategic plans containing clear goals, objectives, strategies, intended outcomes, timelines, performance indicators and evaluation strategies
- specific focus on local health issues
- community involvement in identifying, prioritising and acting on local issues
- the adoption of new public health principles (social model of health)
- whole-of-council involvement in health planning
- integration of MPHP with local, state and national health issues
- fostering of effective partnerships and networking between agencies by MPHPs
- establishment of steering committees and working groups to ensure successful planning.

Development of draft MPHP Framework

The first draft of what was to become *Environments for Health*[4] was developed through several iterations by the LGPT, in close collaboration with the MPHP Reference Group. The draft was distributed for comment in May 2001. Several hundred people attended consultation workshops held in five locations across the state. Still others returned comments via email and fax. Feedback and outcomes were circulated via the LGPT website, via a special newsletter, and by email. DHS released the final version of *Environments for Health* in September 2001.

Implementation and supporting resources

A comprehensive implementation program began in early 2002. The implementation program was designed to build on two consistently recurring issues that consultations identified during development of the Framework. These were:

- the need for best practice/good practice examples and stories to illustrate components of the Framework, with particular emphasis on the built environment and integrated planning; and
- workforce development/skills development for practitioners and other officers in local government about the Framework: in particular, matters pertaining to data collection, community participation, and evaluation.

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[4] http://www.health.vic.gov.au/localgov/

Components that supported the initial implementation of *Environments for Health*, and its adoption, included:

- a 'Local Government Planning for Health and Wellbeing' website;[5]
- workforce development seminar program;
- the comprehensive Good Practice Program (2002 – present);
- Provision of on-site consultancy to local governments;
- Conferences;
- *Leading the Way* (VicHealth) - a package directed to senior managers and councillors; and the Good Practice conferences held in 2003 and 2004.

These implementation initiatives were supported by a longer-term program that included consultation, needs analysis, strategic planning, evaluation, review and publishing. Several of these initiatives are described in more detail below.

Workforce Development Seminars

In partnership with VicHealth and the Planning Institute of Australia, a series of workshops was conducted throughout Victoria in 2002 on the theme 'Planning and Health: Building Sustainable Links'. Given that a major thrust of *Environments for Health* was in integrating better council planning around urban planning and public health, a key aim of the workshops was to promote understanding of the relationship between the built environment and health/ wellbeing. The workshops also aimed to improve collaboration between council urban planners, architects, engineers, environmental officers, corporate planners, health planners and social planners. Workshops were held at four locations around Victoria: (i) City of Maribyrnong at Footscray; (ii) Warrnambool; (iii) City of Casey at Narre Warren, and (iv) Churchill, in Gippsland. Regional DHS Public Health staff worked with the LGPT to identify local government practitioners who could showcase their expertise in promoting healthy urban design and innovation in integrated planning. Given the close collaboration between VicHealth, PIA, DHS central and regions, and the local government sector, it might be argued that these became community building activities in their own right. These seminars were well attended; feedback at the time indicated that they had helped to stimulate new thinking and build intersectoral networks. Proceedings from many of these events are still available via the DHS Local Government Planning website.[6]

Good Practice Program

The objectives of the Good Practice Program, established in 2002, were to:

- support application of the new *Environments for Health* Framework, with explicit involvement of the four environmental domains across council functions;
- encourage integration of planning effort (both within and beyond local government);
- support quality municipal public health planning practice;
- support models of good practice and support their broader application;
- encourage good practice through action learning.

The first two rounds of the program provided direct funding to 40 of the 79 local governments across the state. These one-off funded projects developed a number of innovative approaches to municipal public health planning. The third round of the program distributed funding through the Department's regional offices, allowing regions to focus on particular issues associated with municipal public health planning in their local government areas. Annual funding has continued to be managed and distributed by DHS regions. Since 2002, almost all councils have received funds to explore the implementation of key aspects of *Environments for Health*.

The small pool of funding (approximately $1.5 million) available to the program over the past four years has led to significant outcomes in terms of creating further investment in healthier communities. For example, due to the support of the GPP one LGA has received a government

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[5] http://www.health.vic.gov.au/localgov/
[6] http://www.health.vic.gov.au/localgov/conf.htm

commitment to build seven kilometres of bike/walking path (at a cost of $1.7 million) through a new residential area in a rural growth corridor (Baw Baw Shire, pers. comm.).

Evaluation of Good Practice Program - Rounds 1 and 2

The Program Evaluation Unit at the University of Melbourne conducted an evaluation of the Good Practice Program (rounds 1 and 2). This included a program of planning and evaluation training and support for each individual project, and an overall review of the Good Practice Program.

Findings from the Final Evaluation Report of the 2002-2004 Good Practice Program are available from the Local Government Partnership website, Public Health Branch, DHS[7]. Key findings from the report were as follows:

- The *Environments for Health* Framework provided a platform to consider council activities within a broader social health model. However, the achievement of Good Practice Projects seemed to depend on the culture and pre-existing corporate understanding and commitment to the social model of health. Reports suggested that the higher the level of management involved, the higher the corporate understanding and acceptance of the social model of health, and the greater the extent of organisational support for the project. Where there was not the culture of cross-council departmental cooperation, significant resources were expended on promoting the benefits of working collaboratively.
- Some councils experienced considerable staff, management or councillor changes which led to delays. Shifting organisational structures and policies also impacted on the progression of projects.
- *Leading the Way* training seemed to have had the most impact where training was part of an overall agenda linked to the Good Practice project, rather than a separate, one-off initiative.
- Suggestions for improvement to the *Environments for Health* Framework were based on increasing the capacity of councils to implement the Framework, and including more local level data for each of the four environments. Requests were also made for government to strengthen the linkages and positioning with other documents e.g. the Municipal Strategy Statement (Tacticos & Jordan, 2005).

These findings are reiterated in those that have emerged from the current evaluation study. The similarity of themes is discussed further in Part D.

MPHP State Conferences

As a condition of receiving Good Practice funding, grant recipients were required to present their findings at conferences and other workforce development seminars organised by DHS. State conferences were held in 2003 and 2004.

The 2003 conference was organised collaboratively with the DHS Primary Care division, which enabled the Primary Care conference and MPHP conference to be run at the same venue on consecutive days. The 2004 conference was co-ordinated by the Partnership Development Section of the Department of Human Services and assisted by conference partners Planning Institute Australia (Victoria), Municipal Association Victoria, VicHealth and National Heart Foundation (Victorian Division).

> *The [2004] program highlighted leading edge work undertaken by Victorian local governments in planning for healthier environments and scoped current activities with the World Health Organisation (WHO) Healthy Cities program. In the spirit of the Year of the Built Environment, a special focus of the program was on the role of urban design and the built form in contributing to active, healthy communities. Over 180 delegates attended from a mixture of disciplines, including health planning, social and corporate planning, urban design, urban and regional planning, engineering, private sector planners and consultants, and researchers. The conference was an opportunity for fourteen Victorian local governments involved in the second round of Good Practice*

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[7] http://www.health.vic.gov.au/localgov/goodprac/evaluation.htm

> *funding to share their experiences and present the findings of their projects.*
> *Topics included indicators of sustainability and health, integrated planning,*
> *collaborating with other councils and external partners, and community*
> *participation (DHS, 2004, p.1)*

To many organisers and participants, the ebullient mood amongst delegates and the high quality of applied research shared at these conferences provided tangible evidence of (i) restored and enhanced individual and collective capacity and confidence amongst practitioners within the local government sector; (ii) restoration of trustful relations between the state and local government sectors; and (iii) evidence that the intersectoral, collaborative approach adopted by the LGPT, DHS regions and allied partners had achieved outcomes across the community capacity spectrum expounded by Kegler et al. (2003).

DHS Regional Public Health Team support

Public Health teams in DHS regional offices provide direct support to local governments in public health planning. Support activities vary from region to region, and include:

- facilitating regional networks for local government health planners;
- conducting workshops on particular topic areas;
- providing input to the development, implementation and review of MPHPs;
- participating in MPHP steering committees or advisory groups;
- establishing and/or supporting links with other planning processes; and
- regular liaison with senior management in local governments.

Complementary strategies: *Leading the Way*

VicHealth's *Leading the Way* program was developed in partnership with DHS and the Municipal Association of Victoria. The program was designed as a supplementary resource to support the *Environments for Health* Framework to help councillors and senior managers seek opportunities to positively affect the health and wellbeing of their communities.

Through the program, a *Leading the Way* Resource Pack was developed to provide information and tools to assist councils in planning for healthier communities. The resource was supported by MAV seminars and training sessions for councillors and senior management at each council. These sessions were conducted in a number of ways, depending on councils' preferences.

In 2002 Public Health Branch, DHS provided additional funding to VicHealth for a *Leading the Way* 'train the trainer' program, video, and set of case studies.

1.4   International Context

The specific empirical and value base to municipal public health planning in Victoria, supported by the *Environments for Health* Framework, can be seen to be embedded in an international culture shift in local health planning. Since the adoption and implementation of the Ottawa Charter in 1986, increasing numbers of governments around the world are endeavouring to include a broader social and environmental model for health with varying degrees of success. Especially at the local level, government authorities are encouraged to take up such models.

Despite the evident culture shift, and the institutionalising of such culture in extensive programs such as Healthy Cities, few international examples exist of municipal authorities taking up the challenges of implementing the new paradigm.

One large evaluation of twenty programs (funded through the Californian Healthy Cities and Communities program) conducted by Kegler et al. (2003) sought to obtain results through analysis of program documentation, participant surveys and in-depth interviews, a highly informative model which this evaluation has adopted. No other useful experience can be identified in the United States, where society 'focuses more on the individual that on the community and … has a service delivery system heavily slanted to individual remedial care rather than to community-based prevention' (Wolff, 2003, p. 106).

In The Netherlands, the statutory requirement very closely resembles that of Victoria. In 1989 the national government accepted legislation requiring the 400-odd municipalities in the country to develop local health policy on the premises of the Ottawa Charter and a social model of health. By the late 1990s, however, only a handful of municipalities had accomplished this mission. Hoeijmakers (2005) attributes this failure to a lack of local planning capacity, absence of ownership of 'health' at the local level, the perception by local actors of 'health' as a fuzzy domain (Goumans & Springett, 1997) and competing planning requirements.

In the United Kingdom the Health Action Zones (HAZs) mirror the value system of MPHP and *Environments for Health*. However, there is no legal requirement for local governments to develop and implement integrated health plans, but they are instead invited to make a bid for additional resources to support such approaches. HAZs were initiated in 1997 by the Labour government. In total 26 HAZs were designated, which received £4-5 million annually. The evaluation of the program (Bauld et al., 2005) revealed existing barriers similar to those in The Netherlands. Inexperience with community-based initiatives, a lack of collaborative governance opportunities and difficulties addressing complex health problems (such as health inequities) are also mentioned. However, the authors also say that time has not allowed for the full deployment and maturation of the HAZ value system, and they claim that the program has made 'a good start'. This claim reinforces the view that implementing change of this magnitude, and at this level, is a task that must be treated as a long-term one.

In our assessment of the use and implementation of the *Environments for Health* Framework and Municipal Public Health Planning in Victoria we might thus anticipate similar barriers.

How do some sectors acquire 'ownership' of public problems and become responsible for their solutions, whereas others are secured against such ownership? Gusfield (1981,1989) maintains that this happens through manipulation and attribution of meaning. He sees playing with words, metaphors and symbols as the main tool in the allocation of ownership of public problems. The point to be made is that the usage of language allows the discussion to be reframed in terms applicable to and comprehensible by the various stakeholders and to address their differing orientations and values.

Goumans (1998) has affirmed these mechanisms in her study of ten Healthy Cities in The Netherlands and Britain. She found that in spite of an existing 'standard definition' of Healthy Cities, each Healthy City allocated ownership of urban health promotion to actor's unique to their own socio-cultural environment: sometimes it was the Mayor's Office, in other cases the Public Health Service, and in yet other settings it was a community-based responsibility.

This obvious uniqueness of local contexts would suggest that there is no 'one size fits all' in local health planning, and that we may anticipate a wide diversity of findings across local governments.

Looking at the findings of broad-based health planning evaluations (from The Netherlands and England) such an analysis would suggest the following insights:

1. upstream health promotion and the application of a social model of health were not regarded as relevant policy problems at the local level

2. the national authorities, requiring the development of local healthy public policy, did not offer frameworks to enable local authorities to develop these

3. community groups were not sufficiently engaged and thus not pressuring local government to take appropriate action.

Environments for Health sought to address the constraints identified in the international experience.

PART B – THE EVALUATION STUDY

2.1   Study Objectives

The evaluation aimed to assess the implementation and impacts of the *Environments for Health* Framework, and to determine how to best to support future planning in this area. The study objectives were:

To determine the extent to which the *Environments for Health* Framework has:

- Been incorporated by local governments in their policies and practices;
- Contributed to greater consistency and quality in the scope and approach of municipal public health planning across the state.
- Led to the integration of municipal public health plans (MPHP) with other council plans.
- Increased the level of understanding among appropriate local government staff of the impact of the social, economic, natural and built environments on health and wellbeing.
- Created additional opportunities for health gain through strengthened intersectoral partnerships address the social determinants of health.
- Been supported effectively by the Department of Human Services and other stakeholders.

To provide direction for future development in supporting Municipal Public Health Plans.

2.2   Approach

The evaluation was planned to draw on the collaborative, iterative approaches employed in the development and implementation of *Environments for Health*.

The study involved broad participation from key stakeholders, including:

- Local Government Partnerships Team, Public Health Branch, Department of Human Services;
- all local governments within Victoria, with attention paid to the impact of the allocation of Good Practice Program funds;
- Regional Public Health Teams, Department of Human Services
- other program areas across DHS, including Public Health, PCP and Housing;
- Departments of Sustainability and Environment, Victorian Communities and other state government departments;
- MAV, VicHealth, VLGA, NHF, Parks Victoria and other relevant peak organisations;
- other key stakeholders.

Fundamental to the development of the study was the formation of a Project Advisory Group (PAG), co-chaired by the Department of Human Services and the MAV. To facilitate stories of change and draw on tacit knowledge, the Project Team recommended that the Project Advisory Group comprise, as much as possible, the initial members of original *Environments for Health* Steering Group. The group met at key stages to advise on the methodology, comment on the draft report and draft recommendations. In addition, members of the PAG were invited to contribute to the study as key informants. A list of PAG members is in Appendix 1.

All stages of the evaluation process, including data generation and analysis, were guided by the evaluation team in consultation with the Project Advisory Group.

The study also utilised a number of capacity building frameworks: the NSW Department of Health Organisational Capacity Building Framework (NSW Health, 2001) and the Californian Healthy Cities and Communities Evaluation Framework (Kegler, Norton & Aronson, 2003). Specifically the NSW framework formed the basis for some items in the online survey questionnaire, and the Californian model shaped the group activities in community stakeholder forums.

2.3   Data Collection Methods

The evaluation design, which incorporated both qualitative and quantitative methods, comprised four components: document analysis, key informant interviews, online survey, and council and stakeholder forums. These are described in detail in the following sections.

2.3.1 Document analysis

This component of the evaluation aimed to determine the number of Municipal Public Health Plans available and assess the use of the *Environments for Health* Municipal Public Health Planning Framework in the plans.

The document analysis involved a review of existing MPHPs across Victoria. Collection of the documents involved searching Local Government websites for available plans, using the DHS Local Government Planning for Health website current MPHP database, then follow-up phone calls and emails requesting a copy of the plan when no plan was available on line.

A document analysis template was designed, drawing on key aspects from the *Environments for Health* framework. Information was elicited on the following documented features:

- Did the plan explicitly use or reference the *Environments for Health* Municipal Public Health Planning Framework?
- Were the four environments for health evident?
- Was the social model of health evident?
- What data sources were used?
- What types of community consultation took place?
- What was the range and diversity of representation on Advisory Committees?
- How did the MPHPs relate to the Corporate Plan and the Municipal Strategy Statement?
- What evidence of intention to implement, monitor and evaluate proposed actions was displayed?

Limitations of the MPHP document analysis

As there is no consistent structure or format for reporting of the MPHP, the diversity of the plans in terms of structure, layout and content is substantial. Consequently the MPHP might not include all details (e.g. community consultation, advisory committee). Therefore, the absence of documentation of a particular feature does not necessarily mean that the activity was not undertaken, simply that it was not recorded.

2.3.2 Key informant interviews

Face-to-face and telephone interviews were conducted with 73 key informants across Victoria. To ensure a wide range of perspectives, purposive and snowball sampling techniques were used. Over thirty interviews with individuals and small groups took place across the relevant sectors.

The interviews ran for between thirty minutes and one hour, and consent was gained for participation in, and recording of the interviews. Transcripts and notes of the interviews were coded to ensure anonymity of participants.

The interview format covered the following topics:

- changes in local governments over the past five years (in relation to municipal public health planning and health and wellbeing in general)
- supports and barriers to councils working within an *Environments for Health* approach
- perceptions of the effectiveness of the *Environments for Health* Framework in improving approaches to municipal public health planning
- perceptions of increased opportunities for achieving health gain
- sustainability of *Environments for Health* and future directions
- specific questions relating to an interviewee's work, eg, historical understanding of the development of *Environments for Health*.

See Appendix 2 for a copy of the interview format.

2.3.3   Online survey

The third component of the study comprised an anonymous online survey of municipal public health planners, social planners, health promotion staff, urban planners and a range of stakeholders within councils, state agencies and the wider community. An emailed invitation to complete the online survey was sent to 600 individuals listed in a database developed by the DHS Local Government Partnerships Team. The database was established by contacting all councils in Victoria requesting contact details for individuals involved in developing their MPHP, Municipal Strategic Statement, and the Council or Corporate Plan (these names were used interchangeably by respondents). Individuals on the database also included members of the reference/steering/advisory group overseeing the development and/or implementation of the MPHP (which may also include councillors, external stakeholders and community representatives) and members of an overarching council Health and Wellbeing Reference Group if one existed.

The survey questionnaire was developed in consultation with the Project Advisory Group. A pilot survey was sent to 20 people who were identified by the Local Government Partnerships Team as having been involved in local government health planning, either as an employee of local government or from another organisation that works with local government. The questionnaire included closed-ended and open-ended questions covering the following topics:

- familiarity with *Environments for Health* Framework;
- usefulness of *Environments for Health* Framework and support initiatives;
- level of influence and integration of *Environments for Health* Framework; and
- outcomes directly linked to the *Environments for Health* Framework including health gain.

See Appendix 3 for a copy of the survey questionnaire.

The questionnaire was administered to individuals on the database via an email requesting their participation in the anonymous online survey. The questionnaire remained open for one month between August and September 2006. Follow-up procedures included a reminder from the evaluation team two weeks after the initial invitation was sent out, and a reminder in the Municipal Public Health Plan *Environments for Health* Update (electronic newsletter), Issue August 2006. Follow-up emails were sent to councils that had not responded encouraging then to do so. This was done via email by the Local Government Partnerships Team.

Completed questionnaires were submitted by 108 individuals. The response rate (18 per cent crude response rate; 20 per cent adjusted for estimated levels of non-working, dormant and infrequently accessed email addresses) was relatively low, though common for online surveys.

Despite low response rates, online surveys can result in representative samples of respondents (Bethell et al. 2004; Koch & Emrey, 2001). Nevertheless, caution needs to be used in generalising the findings. In order to obtain basic demographic and organisational information about survey respondents, the questionnaire asked respondents where they worked (council or other organisation) and their role in the council/organisation. This was done to track the range of locations, organisations and roles of respondents, but may have contributed to a low

response rate due to concerns about potential identification (despite assurances that this information would only be used for monitoring purposes, and that individuals and organisations would not be identified). In addition, the database contained contact details for a large number of non-council employees and community members who may have considered that the survey was not relevant to them.

Some of the questions prompted participants to comment on frameworks, plans and activities with which they may not have been familiar. As a consequence, there was a large proportion of missing or 'don't know' responses to questions such as those about council plans (other than health-related plans).

Data from the completed anonymous surveys were aggregated at the geographic level to prevent the identification of individuals or municipalities.

2.3.4 Council and stakeholder forums

The fourth component of the study involved conducting group discussions at five council and stakeholder forums conducted in selected areas of Victoria. The type and locations of the five forums were negotiated with the DHS Local Government Partnerships Team and DHS regional offices, and comprised:

- four general forums (one inner metropolitan, one interface (including city fringe), one rural city, one rural LGA)
- one primary care-specific forum (which could include one to four councils).

Forums included representatives from state and local government, practitioners, MPHP citizen advice panel members, and interested members of the general community. Held over a half-day, forums included presentations of preliminary findings from previous stages of the evaluation in order to gather feedback from participants.

In addition, because building community capacity (including organisational capacity) is a key philosophical component of *Environments for Health*, and a key social determinant of health (Wilkinson & Marmot, 2002), group discussions were conducted to explore participants' reflections of the impact of *Environments for Health* on community capacity.

In their evaluation of 20 Healthy Cities' initiatives in California, Kegler, Norton and Aronson (2003) identified community capacity as including:

- measures of civic participation;
- mechanisms for community input and for the distribution of community power;
- skills and access to resources;
- sense of community and social capital/trust;
- social and inter-organizational networks;
- community values and history; and
- capacity for reflection and learning.

Changes in community capacity were assessed by Kegler et al. (2003) according to a range of criteria grouped across five levels: (i) changes in individuals; (ii) changes in civic participation; (iii) organizational development; (iv) inter-organizational activity; (v) community level changes (see Figure 3).
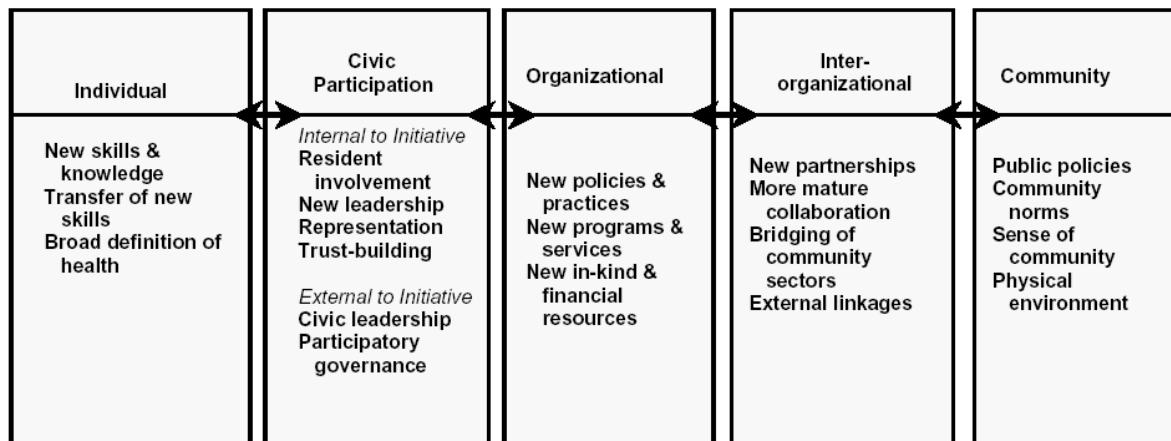
Figure 3 California Healthy Cities and Communities Evaluation Framework

(Kegler et al., 2003, p.17)

Discussion groups provided the opportunity to elicit perceptions from a wide range of people involved in, and affected, as a consequence of planning outcomes. The two group discussions covered the following topic areas:

- in which of the five areas of the community capacity framework had the most change occurred (individual, civic participation, organisational, inter-organisational, community), and which areas presented the biggest challenges?

- feedback on the preliminary findings, which included discussion around findings that 'rang true' for participants, acknowledgement of differences that were perceived, and perceptions of areas not covered in the evaluation findings.

The forum agenda is included in Appendix 4. Notes and group summaries from the small group discussions were analysed to identify emergent themes.

Data from the four components of the evaluation were analysed using descriptive and inferential statistics for the quantitative components of the evaluation (MPHP document analysis and online survey) (using Microsoft Excel and SPSS for Windows v 12.0.1), and thematic analysis for the qualitative components (key informant interviews and community forums).

Findings from the four components of the evaluation are presented in the following chapter.

PART C – THE EVALUATION FINDINGS

3.1   Document Analysis – Municipal Public Health Plans

This section of the evaluation aimed to determine the number and status of Municipal Public Health Plans available and assess the impact of the *Environments for Health* Municipal Public Health Planning Framework on the documentation in these plans.

3.1.1 Municipal Public Health Plan status

The current status of MPHPs for the 79 councils throughout Victoria was assessed by accessing MPHPs through the DHS Local Government Partnerships Team, the Local Government Planning for Health website, council websites, and follow-up phone calls to councils where no plan was available from the above sources. MPHPs were categorised according to whether they were in the process of being implemented, being developed or redeveloped or were under review (see Figure 4). Four rural councils and two regional cities were currently implementing two joint sub-regional plans, and four rural councils and one regional city were working towards a joint sub-regional plan.
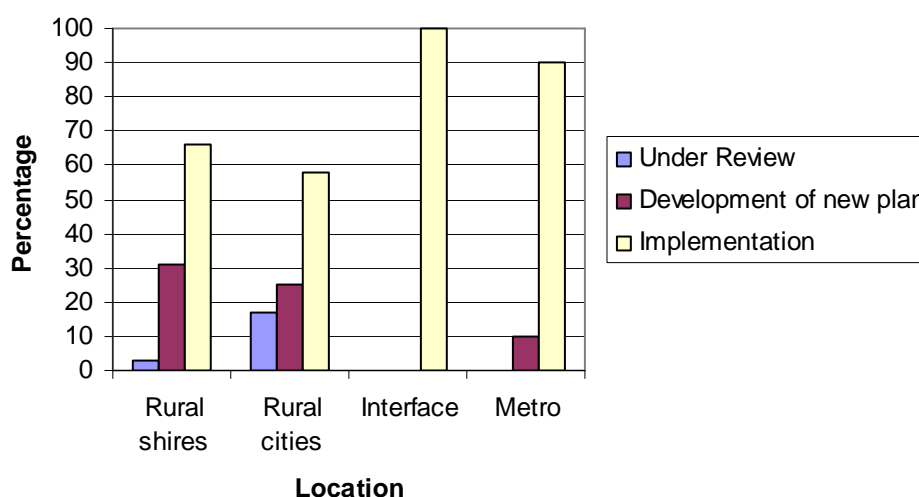

Figure 4 MPHP Status 2006

All councils in Victoria have developed a MPHP, and 61 councils were currently implementing the plan. Fourteen councils were currently developing a new plan. Where available the previous MPHP was analysed for these councils. Three councils indicated that they were currently reviewing their MPHP.

When compared to survey data collected by the Department of Human Services on the status of MPHPs in 2000, it is evident that the number of Councils with MPHPs has increased. The 2000 survey indicated 11 Councils had not developed a MPHP. The shift from 14 per cent non-compliance in 2000 to full compliance in 2006 is a substantial achievement, and well above the state government's compliance benchmark of 80 per cent.

Sixty-two MPHPs were analysed for this evaluation. Approximately 74 per cent of plans stated that they were developed by the council. Thirteen per cent stated that they were developed by a consultant, three per cent by a Primary Care Partnership and 10 per cent did not state by whom they were developed.

3.1.2 Use of the *Environments for Health* Municipal Public Health Planning Framework

The *Environments for Health* Municipal Public Health Planning Framework was mentioned in 84 per cent of plans, most frequently in defining 'health' and as the reference used in framing objectives, actions and strategies. The four environmental domains outlined in the *Environments for Health* Framework - built, social, economic and natural - were addressed consistently in the introductions and rationales to these plans. Seventy-four per cent of plans

explicitly referred to the four environments for health, 10 per cent mentioned a combination (e.g. social, cultural, environmental, biological, political and economic or economic, environmental and social) and the remaining 16 per cent of plans did not have any specific reference to the four environmental domains.

The social model of health conceptual framework was consistently referred to throughout the introduction and background of 75 per cent of the plans. The majority of plans defined health within the social model of health, demonstrating an understanding of the multiple determinants of health, and used the social model of health as a conceptual underpinning for developing the actions and strategies addressed in the plan.

3.1.3 Linking MPHPs and Municipal Planning

Corporate Plans, MPHPs and the Municipal Strategic Statement (MSS) are all required by statute, and are key statements for articulating strategies about community wellbeing and health within the governance responsibility of local governments. The *Environments for Health* Framework emphasises that planning for health and wellbeing should be afforded the same level of prominence as the MSS by clearly expressing links with the Corporate Plan and ensuring that concern for community health and wellbeing is integrated into the MSS. Seventy-nine per cent of the analysed MPHPs expressed links to the Corporate Plan. Most commonly this was demonstrated through diagrammatic representation as presented in the *Environments for Health* Framework and in the plan's introduction. The inclusion of council visions and drawing the links between the Corporate Plan's health and wellbeing actions and goals was also consistently referenced.

Approximately 61 per cent of MPHPs made reference to the MSS. Once again this was most commonly expressed diagrammatically and in the introduction. The MSS was also linked to the MPHP through the action areas of the plans.

Aside from linking the three legislated plans of local governments, there was consistent evidence that MPHPs are drawing on a number of other council and non-council plans. This was evident in approximately 90 per cent of MPHPs.

Most commonly MPHPs drew links to the Primary Care Partnership Community Health Plan, particularly in relation to using the plan as a source of data and setting priorities for issues to be addressed in the MPHP. A wide variety of council plans was mentioned, particularly in the action areas of the plan. Indication of the utilisation of existing plans and strategies most commonly included those concerning community and road safety, housing, open space, recreation, transport, drug use, health promotion, disability access, and environmental management. Council plans referred to included:

- Municipal early years plan
- Community safety strategies
- Road safety strategies
- Housing plans
- Open space strategies
- Disability access plans
- Health promotion plans
- Recreation strategies
- Transport strategies
- Local drug strategies
- Environmental management strategies.

The apparent involvement of numerous departments of councils, and their relevant plans, in MPHPs is evidence, albeit of a modest kind, of intersectoral collaboration in the development of MPHPs.

3.1.4 Use of Steering Committees

More than half (57 per cent) of MPHPs had a consultative committee to guide the development of the plan. For those plans the number of members ranged from eight to thirty-eight people. Steering committees involved a wide range of council and non-council staff (Primary Care Partnerships, Community Health Services, Department of Human Services and Divisions of General Practice). The remaining 43 per cent of plans did not mention a consultative committee, but this did not necessarily mean that they did not have one.

3.1.5 Community consultations

Community participation is a critical input into the MPHP planning process. The majority of MPHPs (90 per cent) described a wide range of consultation processes, people/ organisations/agencies consulted, and specific inputs into the MPHP.

Most commonly MPHPs described that they had undertaken a community and service consultation. The range of people and organisations consulted included: council staff, local health service/agencies, the general community, community groups, government agencies, businesses, schools, police, and private providers. Types of consultation included: identification and prioritisation of health issues, comments/submissions on draft plans, community profiles, and strategy development. The different forms of consultation included: resident/community surveys, agency/service consultations, reference groups, community forums, focus group discussions, telephone interviews, and planning workshops.

Three per cent of MPHPs identified that they had trained local community members for community consultation purposes. Five per cent of MPHPs did not mention any form of community consultation. Another five per cent mentioned that 'consultation' was undertaken but did not describe with whom, how or the specific purpose of the consultation.

3.1.6 Data sources

Along with community consultation, collecting information from a range of data sources enables a community profile to be built which identifies the major health issues and needs to be addressed as priorities in the MPHP.

The majority of plans (94 per cent) used data sources in the development of the plan. In providing a picture of local health needs, 34 per cent of the MPHPs mentioned that they had used a health and wellbeing demographic profile or health status report that was produced by a consultant or by the council itself. The remaining 66 per cent of plans described a range of data sources. However this was variable, with some listing just one or two data sources and others listing over thirty.

The three most common sources were the Department of Human Services Victorian Burden of Disease Study, the Australian Bureau of Statistics Census data including Socio-Economic Indexes for Areas (SEIFA), and the Primary Care Partnerships Health Plan and Data Set. Other common sources of data included: Jesuit Social Services research, Australian Institute of Health and Welfare, Victorian Population Health Survey (Department of Human Services), Cancer Council of Victoria research and service access/use data.

Approximately 75 per cent of plans had considered national and state priorities in the development of the MPHP. While the remaining 25 per cent did not explicitly refer to national and state priorities there was evidence within the action plans that they were being addressed.

3.1.7 Review, monitoring and evaluation strategies

The *Public Health Act (1958)* states that councils must review MPHPs annually and evaluate them after three years. In assessing the intent to review, monitor and evaluate MPHPs the document analysis found that nearly a quarter of plans (23 per cent) did not mention an intention to review, evaluate or monitor the implementation of the MPHP. Approximately half (48 per cent) mentioned that they would review the plan annually but did not give an indication of process (how, when or by whom). Twenty-nine per cent of plans however described a range of review process that would be undertaken such as the establishment of a review and implementation committee, when the review would occur and specific elements of

the plan that were going to be reviewed. Linked to the intention to review the plan is the approach to monitoring the implementation of the plan's strategies and actions.

Evidence of monitoring was found in 60 per cent of the MPHPs. This included the establishment of an implementation committee, descriptions of persons responsible, reporting details and the development of indicators and timelines.

Of those that described an intention to review the plans annually 30 per cent also mentioned an intention to evaluate the plan at the end of three-year implementation period.

3.1.8 Discussion

All councils are currently compliant with the legislative requirement of the Act to develop a MPHP. MPHPs contained extensive references to the *Environments for Health* Framework and the four environmental domains, as well as the social model of health, indicating that MPHPs are incorporating current public health principles. The four environmental domains were mentioned consistently in the introduction/background/rationale, actions and strategies of the plan. Integration of MPHPs with local, state and national health issues was also consistently high.

The nature of the plans is very diverse, as demonstrated, for example, through the use of variable numbers and types of data sources. Various forms of community consultation were apparent in the development of the majority of plans. Most plans addressed national and state health priorities. Operational features of the MPHPs are also diverse. The intention to review and evaluate MPHPs was substantial, however very few plans gave any indication of when, how, what and by whom.

Summary of findings

- The number of MPHPs available has increased since 2000.

- All councils in Victoria have developed a MPHP, and 62 councils are currently implementing a MPHP.

- The *Environments for Health* Framework was mentioned in 84 per cent of plans, most frequently in defining 'health' and as the reference used in framing objectives, actions and strategies.

- Seventy-nine per cent of the analysed MPHPs expressed links to the Corporate Plan.

- Approximately 61 per cent of MPHPs made reference to the MSS

- Approximately 90 per cent of MPHPs drew on other plans.

- Most commonly MPHPs drew links to the Primary Care Partnership Community Health Plan, and a wide variety of council plans – strengthened connections to PCPCH plans

- More than half (57 per cent) of MPHPs had a consultative committee to guide the development of the plan.

- The majority of MPHPs (90 per cent) described a wide range of consultation processes.

- The majority of plans (94 per cent) used data sources in the development of the plan.

- Approximately 75 per cent of plans had considered national and state priorities in the development of the MPHP.

- Nearly a quarter of plans (23 per cent) did not mention an intention to review the plan, and approximately half mentioned they would review the plan but did not give an indication of process

- Approximately half intended to review the MPHP, but only one third intended to evaluate it.

- Thirty per cent also mentioned an intention to evaluate the plan at the end of three-year implementation period.

3.2   Key Informant Interviews

Members of the Evaluation Team conducted individual and group interviews with 73 key informants from a range of sectors. Interviews were mainly face-to-face, with a small number conducted by telephone when necessary (see Table 1).

Table 1 Key informant interviews by sector

Sector	Number of interviewees
Local Government Partnerships Team, Department of Human Services	2
DHS Public Health senior management	8
Other program areas across DHS central and regions, including Public Health, PCP and Housing	41
Local governments within Victoria targeted according to their geographical status – e.g. inner city, interface council, rural city, and remote rural.	11
Departments of Sustainability and Environment, Department of Infrastructure, Victorian Communities, Parks Victoria	3
MAV, VicHealth, VLGA, NHF, and Sunsmart	6
Consultants, Universities and Academics	5
TOTAL PARTICIPANTS	73

Questions sought responses on: the impact of *Environments for Health* on changes in understanding the links between health and the environment; internal factors which either supported or presented barriers to implementation, external factors which had an influence, the health impact and sustainability of the new Framework, and future directions for *Environments for Health* and municipal public health planning. To preserve anonymity and yet also to provide some context for responses, interviewees were identified only by their sector, as outlined in Table 2. Interviews were recorded and a thematic analysis was conducted.

Table 2 Coding used for interviewees

Sector/ Informants	Code
Local Government	LG
All state government departments eg Departments of Human Services, Sustainability and Environment, Department of Infrastructure, Victorian Communities, Parks Victoria	GOV
Non Government Organisations e.g. MAV, VicHealth, VLGA, NHF, Sunsmart	NGO
Universities and Academics	UNI

3.2.1 Changes in Conceptual Understanding

Respondents reported that there has been a significant shift in awareness and understanding of the nature of health and the determinants of health over the last five years. Respondents acknowledged that there has been a significant shift in understanding of the social model of health over the last five years. However, it was also acknowledged that whilst the improvement has been significant, the low starting base means that there is a considerable way to go before understanding and application are embedded and consistent, not only between different local governments, but within the same organisation.

The four environmental domains

There was a consistent view across interviewees that the four domains or environments (respondents used the terms environments and domains interchangeably) was a useful way to conceptualise the social model of health. The four domains provided a way to identify potential stakeholders and engage them as well as identify action areas. This provided an accessible way to broaden thinking beyond service delivery and individuals and on to populations, environments and the consideration of more upstream factors.

> *[There has been a] significant shift in the understanding of health, so we are not just focussing on individuals, but encouraging councils to consider health and prevention and promotion in community care. NGO2*

> *Having a broad framework such as Environments for Heath enables councils to look beyond service system. GOV1*

Nevertheless, respondents also recognised that there was considerable variability in understanding, not only between different local governments, but within the same organisation, which is further discussed in section 3.2.3. Whilst acknowledging the training and support provided, others felt further work was still needed to broaden people's understanding of the determinants of health; highlighting the relevance and potential of different areas of local government to influence health. More concrete examples were needed and suggestions were made to adapt the language to suit different audiences rather than using health promotion terms (jargon).

> *It has helped public health planners to broaden their understanding of LGA work. Shifts in the public health plans, focus of the health issues. …you've got to go out and talk to them on their turf, in their language. UNI1*

> *Health promotion is still not fully understood, and is still seen to be bit fluffy within other sectors of council. GOV1*

The four environments were highly valued as an entry point for collaboration and integration with a range of Non Government Organisations (NGOs) and other government departments, which is discussed further below in section 3.2.5.

There was also acknowledgement of the long time-frame and multiple strategies required to bring about the change in orientation needed to fully implement the *Environments for Health* Framework.

> *Although a start has been made, a lot more work is needed to change cultures. UNI1*

3.2.2 Implementation shortfalls

The Framework

There was substantial support and affirmation of the theoretical aspect (Part A), but more practical information and guidance was requested on how to implement the Framework (Part B).

> *Provided a lot of references in one body of work from international sources and credibility... Provides a physical document to start conversations. UNI1*

Further information was sought to assist with the implementation of actions under each of the four domains, including access to data, examples of work undertaken, and possible intervention points under each of the four domains. The economic and social domains, in particular, required further information to tease out and unpack actions and boundaries.

> *Some organisations struggle to see where they fit in terms of the social determinants approach. [You need to] provide a framework that demonstrates to*

> *people at what entry point they can affect the determinants of health, rather than have them thinking that there are [only] big things, e.g. transport and development. GOV3*

> *Brochure was useful, the actual guidelines were very good in giving a sense of what it was all about to convince non-public health players. GOV2*

There was considerable support for the document being a framework rather than a prescriptive template, but more assistance was needed on implementation, practical tools, and action implementation points. Other suggestions on improving the document included: more practical information and guidance on web links, data sources in a format that usefully relates to their municipality, links with other sectors; showcasing best practice examples; evidence that the integrated approach is cost-effective and leads to a better result; and being clear on the links between plans both within council and also with other state government departments.

> *Need to be able to say that the integrated approach makes a difference – evidence, stories, and leads to value-adding. Economic arguments are important for councils. NGO8*

Finally, a number of interviewees identified gaps in MPHPs that were not addressed in the *Environments for Health* Framework, namely, a lack of focus on health inequalities and marginalised groups. Although the social determinants of health were being acknowledged both in the Framework and in MPHPs, no real action was being taken to reduce inequalities. In addition, whilst there was consistent praise for the usefulness of the Framework to identify and engage in partnerships (internal and external), community engagement with residents was not thought to be well done. The unsatisfactory nature of community engagement was considered to be the result of resource constraints, low consideration of the value gained from engagement, and a lack of skills required to undertake meaningful engagement.

3.2.3 Internal council challenges

Variable implementation

Although all local governments are mandated to have a MPHP, the extent of implementation is inconsistent across councils. Variable MPHP implementation is a problem that predates the *Environments for Health* Framework, although the Framework has assisted with extending the rate of implementation. Frequently it appears that the planning phase of the MPHP is considered to be an end in itself, rather than just the beginning of the process. It was also noted that having a committee specifically charged with overseeing the implementation of the plan (as opposed to disbanding the committee once the MPHP has been formulated) was an important factor in increasing the extent of implementation.

> *Some people think that the plan is the whole work, plan and reviewing, but what is happening in between? This may be where the legislated requirement may influence implementation. …demonstrating that the plan is being done but also someway of reporting/monitoring the actions/implementation that are occurring from that. Plan becomes the means rather than the end. LG6*

> *There has been an increasing commitment to getting the plan done but in terms of the actions that fall out of the plan, probably not as far ahead. LG1*

The key to implementation was considered to be through increasing ownership of the MPHP and partnership development. However, even within one of the more progressive LGAs, there is still the question of the extent to which integrated planning and the social model of health is carried into the implementation. Many alluded to the need to have an understanding and commitment to the social model of health firmly embedded in council's organisational capacity and culture, if integrated planning was to be achieved. A number of barriers to this were identified.

The silo mentality

Narrowly focused departments, a lack of cross-departmental communication and a silo approach were identified as barriers to integrated planning.

> *Within council the broad determinants of health are not 100 per cent embraced or necessarily understood – resistance is due to people still having a narrow portfolio or siloed approach their work. …However this is much less than it used to be, e.g. the library strategic plan has embedded the council's health plan framework with recognition of the different areas for actions are based on the determinants of health from a library services perspective. LG1*

> *It is much easier going when people see the value in complementary approaches rather than competing silos. LG6*

Language issues

There was considerable discussion of the advantages and limitations associated with the use of the word 'health'. In many cases this was very limiting as councils often relegated all responsibility for 'health' matters to their health department, and considered 'health' to be very narrowly defined as service delivery (for example Home and Community Care (HACC) services). A suggestion was made to use the words 'health and wellbeing' rather than just 'health'.

> *VicHealth sent a letter to a CEO in relation to Leading the Way, he did not even read it, saw the word health, it went to the health department.' UNI1*

> *For some people 'health' is hospitals or an individual's responsibility to change their diet or exercise. LG6*

> *The term wellbeing is much more meaningful than health - all partners can be involved in the term wellbeing seeing that it is a council role. GOV4*

Workforce development

There was a consistent view amongst interviewees that the commitment to the social model of health was generally not embedded in an organisation but very much depended upon particular personnel, and champions. This meant that there was considerable vulnerability when staff or councillors changed.

> *Very dependent on the capacity of people/person in the role. Some of councils that are doing some good programs embedding health – funding is a key driver – walking school bus/food security. GOV13*

> *There has been an impact on capacity but staff turnover is a problem. Needs to be embedded, ongoing and involving capacity building. GOV5*

The need for ongoing sustainable workforce development of councillors, senior management and other staff to build capacities was a consistent view across interviewees. There was agreement amongst interviewees that the training and supports provided had made a great contribution to building the understanding and support of the social model of health within local government, but more was needed.

Advocates are also needed at a range of positions within council. *Leading the Way* was considered a valuable resource for senior managers and councillors, but given the extent of turnover, the training needed to be ongoing for each new wave of councillors. This was particularly important as senior support is critical for the organisational change agenda underpinning the social model of health to be successful. Similarly, staff turnover in a range of positions across councils means that training needs to be embedded within the organisation, perhaps as part of the usual staff induction.

However, the main point is that multiple messages need to be delivered in a variety of ways to different levels within the organisation. There is no 'one size fits all' solution, thus it is not only

training that is needed but awareness raising, tools and practical assistance. Similarly the training has to be tailored to different levels within local government, as well as different professions, so that the language and examples could be adapted accordingly.

> *Targeting different levels in particular at the higher level and this needs to be repeated – working with other key stakeholders in other areas. A suite of different products is needed. NGO1*

> *Commitment from the top governance level can be a real driver to change if they understand and have a commitment to change and action. Very hard to implement change in a council if the CEO is not on board – and the political support from the councillors is a key to getting the right councillor and staff. GOV15*

> *Useful for DHS to get with the MAV and run another round of information sessions for councillors and training sessions for councils officers The people at top need to understand it so you don't hit a brick wall*. *LG2*

> *If the links are made clear and there is guidance the councils that are more open to change, innovation and confident and secure in their organisation the change has been greater. Some smaller councils are afraid of new things and may not be interested. UNI1*

> *There is often high turnover within councils and between councils – need to think about how to 'embed' it when people move on. NGO8*

There is also considerable variation in both the professional background and seniority of the person responsible for the MPHP: obviously the more senior the person, the greater organisational support for the MPHP. In smaller rural LGAs, the Environmental Health Officer (EHO) often still manages the MPHP, however in many other LGAs it has moved into the domain of social planners. The shifting of the MPHP away from EHOs was generally seen as a positive (i.e. acknowledgement of social model of health), although was considered problematic by EHOs. On one hand people considered that the EHOs did not have the training or understanding for the social model of health now necessary for the MPHP. Excluded EHOs however saw this as being an unwelcome narrowing of their job, and a 'power grab' now that the MPHP had a higher profile.

> *Rurally, the understanding of the EHO is limited in context of the broader determinants of health. GOV4*

More workforce development was needed at a range of levels to support the social model of health and integrated planning, for example the inclusion in undergraduate courses, staff and councillors induction, short courses, workshops, professional networks and supports.

> *There is training available eg PIA and HIA, Healthy Cities. Regions support networks of local government staff. Policy is not strongly supported at the whole of government level. GOV5*

> *Leading the way – very practical and more of a how to manage the issue – practical tools. GOV2*

> *For those that love Leading the Way it is fantastic document but I feel that it has not brought those hard to reach people on board. GOV4*

> *Leading the Way good, need more for other professions, so it is in their plain language. GOV15*

Staffing was also noted as a particular issue, in both rural and metropolitan Councils, when appropriately qualified staff could not be recruited, and a particular role could not be filled. When there is a staffing problem, it is the MPHP that suffers.

> *If there is no staff then the MPHP is where they drop off on responsibility because even though it is legislated for there are not real repercussions for not doing it. GOV13*

The provision of networks and supports at the regional level was also noted as providing valuable support, training, and sharing of information.

Finally, a number of respondents alluded to the great variation in organisational culture and support for integrated planning which needed to be taken into account when developing appropriate and relevant workforce and capacity building strategies. Some identified this variation as being in two camps: reactive and proactive, others considered there was a continuum. Regardless of the extent of the variation, the key message is that a range of approaches, supports, and strategies are needed at different levels in the organisation: councillors, senior management, and at officer level.

> *There is diversity across different councils in adopting this approach, ranging from committed, to indifferent, to anti. Which group a council falls into is not necessarily a rural/metro or large/small divide, but strongly dependent on council 'culture' including the CEO and councillors, e.g. does the council have a strong community focus, or is it about more traditional council services and traditional environmental health? NGO8*

Priorities and resources

There was a range of views regarding resourcing of MPHP, for example should local government receive additional funding for implementation, or was this simply a matter of the MPHP not having a high enough priority within the organisation and was thus not allocated sufficient funding. This is where the support of the senior management and councillors was important. Others noted the particular difficulties in terms of resource and workforce constraints faced by smaller rural councils, which were perceived to reduce their capacity for MPHP implementation compared to metropolitan councils.

> *There is a difference between rural and metro: different priorities (we would argue that water is health), resourcing constraints, right people with the right skills. Small rural councils are just struggling to keep their normal services going. GOV7*

> *Some of the inner metropolitan councils have got a committee of people who work on MPHP. If you go to some of the rural councils, they are struggling to maintain the roads, never mind anything else. NGO3*

Similarly, a number of councils, particularly rural ones, noted that they do not have a dedicated staff person whose main role is health promotion, or the carriage of the MPHP, which severely limits the capacity and likelihood of MPHP implementation. Any progress was dependent upon receiving additional minor grant funding, although the sustainability of these gains was not guaranteed once the grant was expended.

> *There is no health promotion officer within this council (and this goes for many others) therefore health promotion work is taken up by anyone with an interest or where we get some funding. It is not a core responsibility of any one person. LG4*

Nevertheless, even within councils that have a person dedicated to implementing the MPHP, concerns were expressed that there was limited organisational engagement as the MPHP was considered to just be the responsibility of that staff person. Once again, the key message was about increasing organisational understanding and commitment to the MPHP and the broad social model of health.

Different plans within council

Another area of concern was the range of different plans required within councils and the question of how to bring them together meaningfully.

> *Is the MPHP a strategic document or an action plan? Environments for Heath is a strategic framework, whereas the MPHP is still sitting at action plan level. GOV4*

There were considerable and competing demands for plans to be undertaken at the local level, which resulted in duplication of effort, as the plans may be across slightly different geographic regions, were required in different formats, or had different time-frames.

> *During the Good Practice Program, our large council looked at all the policies and strategies; there were 55 strategies. What is the rationale for all of them? No-one knew the big picture of how they all fit together. Who understands them? A smaller council has no hope. UNI1*

Finally, a number of concerns were noted with integrated planning which are important to address. A potential problem with integrated planning was a 'homogenising of issues, populations and voices' and thereby a risk of marginalising the true diversity of views and needs in the community. A second concern was consultation and meeting 'fatigue' from both internal and external stakeholders, and finally there was the risk that efforts to engage with partners could be interpreted as trying to 'dump' work on people without providing them with funding.

3.2.4 External Factors

It was widely recognised that whilst the development of the MPHP is mandated, its implementation is not. Some respondents noted that both more incentives and penalties were needed to increase the rate of implementation and the allocation of greater council resources to the MPHP.

> *Being pragmatic, because there are so many pressures and demands, unless there is a mandate [for implementation] they won't change. ..Some say if it's mandated you'll get the resources. UNI1*

Collaboration across the four *Environments for Heath* domains

The value of the *Environments for Heath* Framework has been recognised by its adoption by a range of other state government areas including Municipal Early Years Plans, Neighbourhood Renewal, and Emergency Management. The four domains were found to provide a useful framework to focus attention much more broadly and strategically than had been the case in the past. For example in emergency management recovery, it facilitated planning beyond just welfare relief (i.e. blankets and shelter) into looking at people's wider social, health and economic needs when recovering from disaster. The *Environments for Heath* also provided a platform and common language to bring different departments and organisations together, and has also provided a leverage tool for NGOs and other organisations to gain the commitment and support of local government for particular policies such as the provision of shade.

> *The Environments for Heath framework worked because they were using different language but essentially talking about the same thing – helped in identifying common themes and the translation of the language. GOV2*

> *The shade policy has been framed using Environments for Heath and therefore this enables us to work with other key partners that work closely with LG, ...and has helped with leverage. NGO2*

The *Environments for Heath* Framework has been found to be useful in partnership development, firstly by providing a tool to identify potential partners, and secondly as a conceptual tool to ensure that partners have a consistent understanding.

> *DHS, VicHealth, Go for your Life, Sunsmart, Heart Foundation reps all get together and talk about the work that is being done within councils and that they are all on the same page. NGO2*

> *I get a lot of use out of the stakeholder matrix. It is important to constantly review your stakeholders and be looking at whom you are not working with. NGO2*

Communication and collaboration at the state level

Two distinct themes emerged regarding communication and collaboration across the state government and NGO levels. The first was that the four domains of the *Environments for Heath* had been a vehicle for collaboration and had been adopted and adapted by a range of other program areas within DHS and with other government departments. The second was that despite the rhetoric of joined-up or whole-of-government, partnership and integration both within different sections of DHS, and across different government departments was an area where considerable improvement needed to occur. In some cases respondents considered that there was closer and better liaison between agencies and government departments at the local level, than within the same agencies at the central level.

> *DHS needs to model the approach themselves. DHS as a Department of State Government does not talk to the other departments at state government level.*

> *Confusing agendas – state and federal work around different program agenda that have similar outcomes intended but that weaken capacity for really good integrated local area work at a LGA base.. for example PCPs. LG1*

> *A commitment at the state level across the different departments to see Environments for Heath as the kind of framework that should underpin all planning would certainly make life easier. GOV1*

Some respondents referred to tensions in the relationship between state and local governments which influenced their dealings regarding the MPHP. These tensions related to misgivings associated with state imposed local government amalgamations, the sense that state government was attempting to transfer responsibility to local government without a corresponding transfer of funding, and some general resentment that state government was able to impose conditions and duties upon local government.

> *Local government amalgamation are still struggling with this, they are suspicious of State government. Show local government that you are not big brother. UNI1*

> *Real resistance and this around cost shifting – cynicism about the planning process and being dumped with the responsibility. GOV4*

It was also noted that it was important to continue to have a senior champion within DHS for *Environments for Heath* Framework

> *We need a champion at public health level [within DHS], similar to what was there in at the time that Environments for Health was developed. GOV5*

Finally, a number of key partnerships between DHS and NGOs were noted as being particularly important in forwarding the *Environments for Health* agenda, namely with MAV, VLGA, PIA, VicHealth, and Heart Foundation. Both formal and informal agreements were needed to foster and support these relationships.

3.2.5 Contribution of *Environments for Health* to health gain

In determining whether *Environments for Heath* has increased opportunities for heath gain, a number of respondents noted that it has resulted in improved planning and a much broader conceptualisation of the social determinants of health which presumably will result in an improvement in population health in the longer term.

> *The Framework in itself is an effective framework that enabled planning to be done more consistently …It has given a legitimacy across the council and at the especially CEO and councillor level because it has been so clearly endorsed and supported across the state by the state government and DHS this has assisted in the building of capacity because it has been in a central position. LG1*

Environments for Health complements a lot of other resources, so I can't say it is directly responsible for shifting the notion of health, but it certainly has played a part. In particular, it has placed an emphasis on the built environment and has shifted council's role in health out from just being HACC [Home & Community Care] service delivery. GOV8

Environments for Health was the first one out there and instigated change. It is one of the best planning frameworks and has moved local government on to a new way of thinking in a short time, it has created that conversation. UNI2

A range of complementary initiatives all have an effect to broaden the understanding and commitment to the social model of health. It is a complex rather than linear relationship. However, the fact that the *Environments for Health* and the four domains are mentioned by a range of different departments and different areas can be directly attributable to the *Environments for Health* Framework.

A number of respondents noted that the brand name of *Environments for Health* may not be well recognised beyond those with direct responsibility for MPHPs, although it had had a much wider legacy. Whilst the four environments were used in designing the MPHP, the internal and external partners in the MPHP may not have been made explicitly aware of the *Environments for Health* Framework.

3.2.6 Discussion

A number of very clear themes emerged from the interviews. There was a consistent view across the interviewees that the *Environments for Health* Framework has made a significant contribution to integrated planning at the local level. In particular, it was the conceptualisation of the four environments that made the framework appealing to a range of sectors in local government and a range of NGOs, and other government departments.

The adoption of integrated planning and the social model of health, however, is not consistent, and is patchy both within and across local government around Victoria. Whilst the development of the MPHP is mandated, its adoption and implementation is not, and these aspects of the plan are varied. In many local governments the implementation is dependent upon particular personnel or champions, and is thus vulnerable when there are staff changes.

There are also a multitude of plans both within local government and across a range of state government departments. A consistent theme across many of the interviews was that although integrated planning was promoted at the local level, there was little modelling of this approach across state government departments, nor across different sections and divisions within DHS.

Summary of findings

- There was greater recognition of the social model of health and broader definitions of health among interviewees.

- A basic problem identified was that the planning phase of the MPHP was considered to be an end in itself.

- Demand for more targeted language and ownership was expressed.

- There was recognition of long-term implementation timelines.

- Interviewees required more information, and sought a more detailed implementation guide.

- Gaps in MPHPs were identified that were not addressed in the *Environments for Health* Framework, namely, a lack of focus on health inequalities and marginalised groups.

- Community engagement with residents was not thought to be well done (90 per cent of plans did it but not well).

- It was noted that having a committee specifically charged with overseeing the implementation of the plan (as opposed to disbanding the committee once the MPHP has been formulated) was an important factor in increasing the extent of implementation.

- The key to implementation was considered to be increasing ownership of the MPHP and partnership development.

- Barriers to integrated planning included: Narrowly focused departments, a lack of cross-departmental communication and a 'silo' approach recommendation.

- The need for ongoing sustainable workforce development of councillors and senior management and other staff to build capacities was a consistent view across interviewees.

- Staff turnover in a range of positions across council, means that training needs to be embedded within the organisation, perhaps as part of the usual staff induction.

- It is not only training that is needed but awareness raising, tools and practical assistance, including a range of approaches, supports, and strategies at different levels in the organisation.

- Even within councils that have a person dedicated to implementing the MPHP, concerns were expressed that there was limited organisational engagement as the MPHP was considered to just be the responsibility of that staff person. Once again, the key message was about increasing understanding and commitment to the MPHP and the broad social model of health.

- A potential problem with integrated planning was a 'homogenising of issues, population and voices' and thereby a risk of marginalising the true diversity of views and needs in the community. A second concern was consultation and meeting 'fatigue' from both internal and external stakeholders, and finally there was the risk that efforts to engage with partners could be interpreted as trying to 'dump' work on people without providing them with funding.

- It was widely recognised that whilst the development of the MPHP is mandated, its implementation is not.

- Closer and better liaison is required between agencies and government departments at the local level, perhaps even more than within the same agencies at the central level.

- It is important to have a senior champion within DHS for *Environments for Heath* Framework.

- A number of key partnerships between DHS and NGOs were noted as being particularly important in forwarding the *Environments for Health* agenda, namely with MAV, VLGA, PIA, VicHealth, National Heart Foundation, and Sunsmart.

- Whilst the four environments were used in designing the MPHP, internal and external partners in the MPHP may not have been made explicitly aware of the *Environments for Health* Framework.

3.3   Online Survey

As previously described (2.2.1) the online survey questionnaire was anonymous, with results presented here aggregated at the DHS regional level to prevent identification of individuals or municipalities. The survey questions were designed to elicit information about the following issues:

- ▪   familiarity with *Environments for Health* Framework;
- ▪   usefulness of *Environments for Health* Framework and support initiatives;
- ▪   level of influence and integration of *Environments for Health* Framework; and
- ▪   outcomes directly linked to the *Environments for Health* Framework including the opportunity for health gain.

The data were analysed using SPSS and Microsoft Excel. Descriptive statistics were produced, and. multivariate analyses were conducted of some key questions by geographic region. Bivariate correlations were also produced to analyse outcomes by organisational capacity.

3.3.1 Participants

This survey sought to widen the participant pool to a state-wide population of municipal public health planners, social planners, health promotion staff and urban planners. A sample of approximately 600 participants from different stakeholder positions within councils and state agencies was included in this stage of the evaluation. The response rate for the survey was 18 per cent with a final sample of 108 respondents. This response rate is to be expected from online or mail delivered surveys, which often range from 10 to 20 per cent.

The majority of respondents (101 of the 108) to the online survey completed the questions about where they worked. Eighty-one respondents indicated the specific council or organisation they worked for, while the remaining 20 listed the type of organisation they worked for such as council, PCP or NGO. Seven respondents did not provide any information on the council or organisation they worked for.

In total 77 of the responses were from people who worked within local government, and 16 councils had at least two respondents to the survey. Approximately 57 per cent of LGAs in Victoria were represented in the responses. Accordingly, although the overall response rate was low, the online survey obtained information from a reasonable proportion of councils.

Demographic details

More females (71 per cent) than males (29 per cent) responded to the survey. A majority of respondents (65 per cent) were 40 years or older, suggesting that the targeted job roles tended to be filled by older workers. As Figure 5 shows, the sample comprised people with job roles covering the range of roles involved in planning and health promotion in local government.
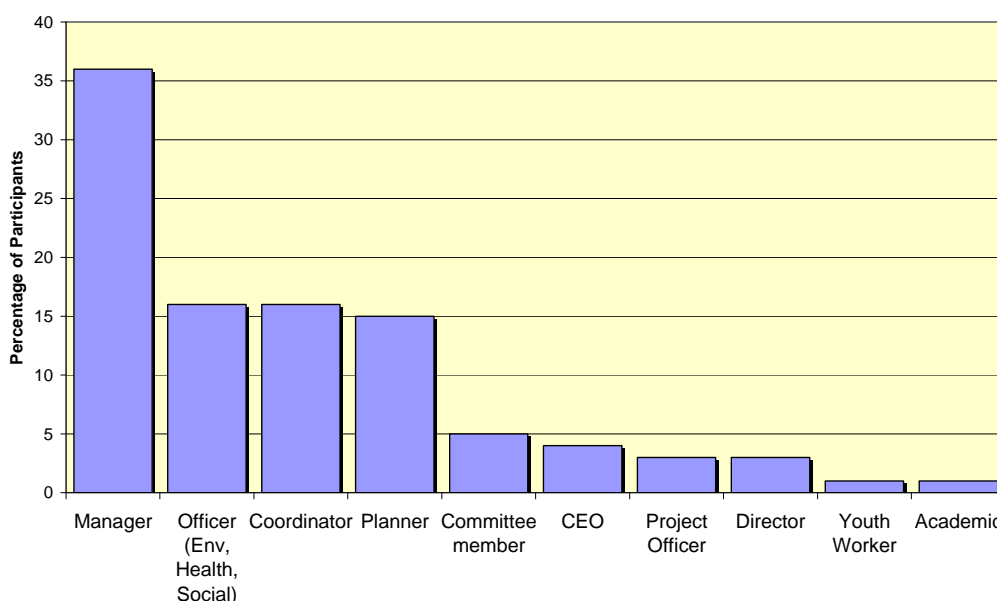
Figure 5 Job roles of participants

The majority of the sample was in management, coordination and planning officer roles. Approximately 75 per cent of participants worked in councils, with the remainder from mainly support services (i.e. health service providers), other local government areas, and the community.

Geographic locations

Respondents were from a range of locations across Victoria, as shown in Figure 6. Approximately half of the sample was from local government areas in the inner metropolitan and interface or city fringe area, whilst the remainder worked in rural and regional areas of Victoria. In addition, most of the organisations where participants worked were also part of a Primary Care Partnership (90 per cent).
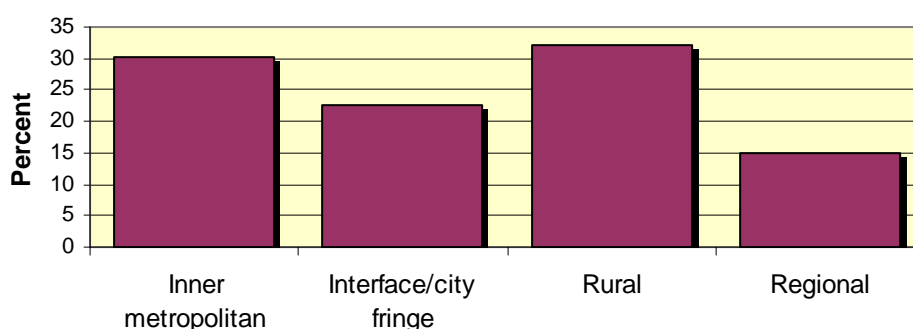
Figure 6 Locations of participants' employment

Organisational capacity

Initiatives that support Municipal Public Health Planning may or may not be useful depending on an organisation's capacity to utilise such resources. Participants were asked to indicate their perceptions of the organisational capacity of their own council or the council they work with against five criteria drawn from the NSW Health Organisational Capacity Building framework (2001): Partnerships, Workforce Development, Knowledge Transfer, Leadership and Resources – see Figure 7. This framework is also used in the Integrated Health Promotion Resource Kit for health promotion planning in the primary health sector.

Partnerships:
- Council works in a cooperative and inclusive way.
- Council initiates and sustains effective involvement with other partners to implement/sustain the MPHP.
- There is a capacity to deliver the MPHP through a network of organisations and groups.

Workforce Development:
- Council provides professional development for staff in skills related to planning heath and wellbeing.
- Planning for health and wellbeing in the community is integrated across departments / divisions in Council.

Knowledge Transfer:
- MPHP planning in council is informed by evidence.
- Council disseminates information about the MPHP within relevant networks.
- Council has meaningful consultation with stakeholders about their needs in relation to MPHP planning.

Leadership:
- Council is committed to planning for health and wellbeing at all levels.
- Senior staff support a multi-disciplinary approach to improving health and wellbeing.
- Different departments incorporate health and wellbeing as a planning priority – "we all speak the same language."

Resources:
- Appropriate human resources are allocated to planning for health and wellbeing.
- Adequate financial resources are allocated to planning for health and wellbeing.

Figure 7 Organisational Capacity Framework

Mean responses for each sub criteria were computed to produce five main organisational capacity dimensions. Overall mean ratings are displayed in Figure 8.
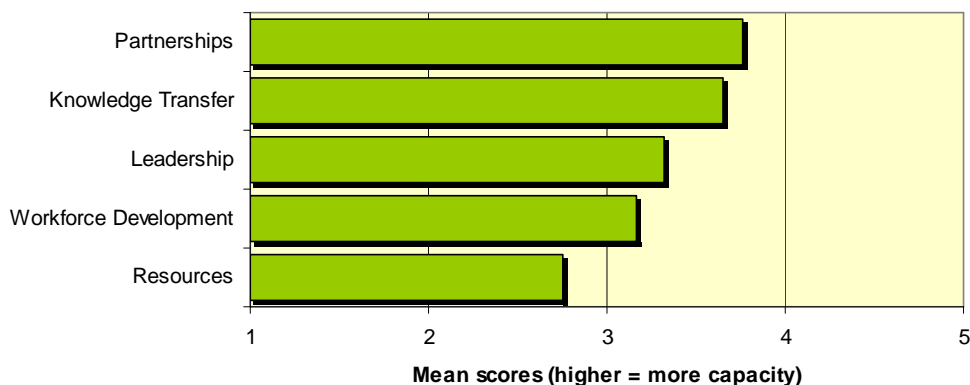

Figure 8 Perceptions of organisational capacity in their council

Results show that participants perceived that their local council was richer in partnerships than in resources and workforce development related to planning for health.

3.3.2 Familiarity with *Environments for Health* Framework

As Figure 9 shows, the majority of respondents indicated that they were familiar with the *Environments for Health* Framework.
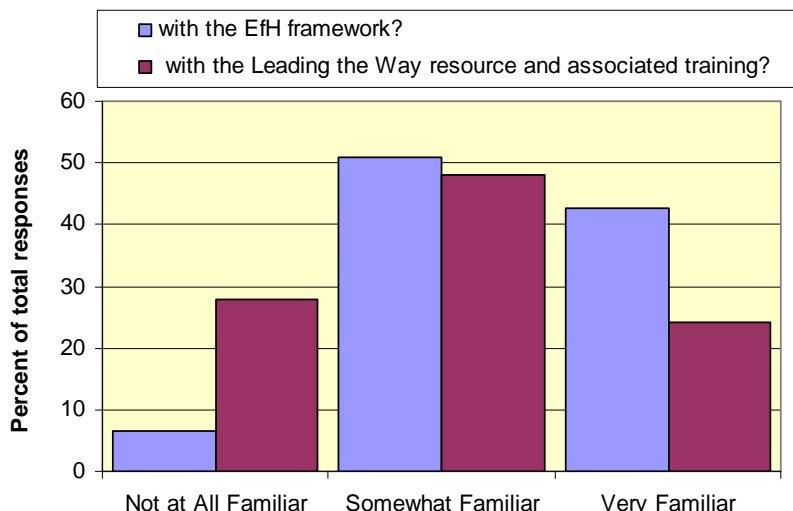
Figure 9 Participants' familiarity with *Environments for Health* and *Leading the Way*

This result is not surprising given that: the sample were people in roles from whom one would expect high familiarity; and the majority of respondents were in implementation phases of the framework, (see Figure 10). Therefore it is not surprising that only 6.5 per cent of participants were unaware of *Environments for Health*, with only just over 27 per cent of respondents unfamiliar with *Leading the Way*.
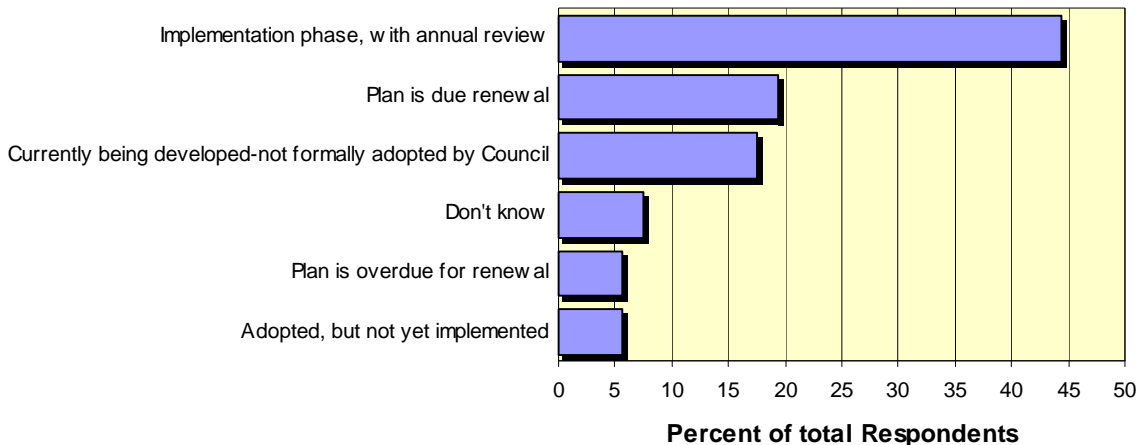

Figure 10 Perceptions of the current status of Municipal Public Health Plan in their Local Government Area

Many participants commented that they had used *Environments for Health* as a resource and tool in health planning:

> *The model gives the ability to think about health and the improvement of wellbeing from a social, cultural, environmental and economic determinants of health [perspective].*

Some suggested that *Leading the Way*, which was being used for training councillors and senior management in councils, could also be extended to community representatives:

> *It is not readily available through local government. Seems to be kept in house rather than distributed to community representatives.*

A few participants also suggested that there may be confusion in having two resources and that ideally these could be re-branded together.

> *A bit confusing for council people having the two resources to get their heads around. Perhaps it should be renamed Environments for Health Resource Guide for councillors, rather than introducing a new name and concept.*

3.3.3 Usefulness of *Environments for Health* Framework and support initiatives

Participants were asked to comment on the content of the *Environments for Health* Framework and its presentation as a document. There was strong agreement amongst participants that *Environments For Health* was presented in a way that made it easy to understand (87 per cent agreed) and that links to supporting materials helped to identify relevant references and models (94 per cent agreement). There was also strong agreement that PART A provided a sound theoretical basis for council to approach planning (88 per cent agreement) and that PART B provided practical planning tools (87 per cent agreement).

Most participants commented positively about the *Environments for Health* Framework.

> *I couldn't imagine a health plan using any other framework. The previous health plan was very short sighted and did not demonstrate any partnership or integrated planning outcomes.*

> *It is an excellent resource - something of a 'bible' to me in my work.*

Participants also were asked to rate the usefulness of a number of supplementary activities and resources that complemented the *Environments for Health* Framework during its implementation. The proportions of participants' responses on a five point Likert-type scale from useless to very useful are presented Tables 3-5. Rating categories were not collapsed in this section, nor was a summary statistic used due to the positive bias of the scale used in this section of the survey. Note that percentages presented do not include missing or non-rated data. Supplementary activities were grouped according to:

- the general supplementary resources for *Environments for Health* (Table 3);
- the resources provided for the implementation of *Environments for Health* (Table 4); and
- the support provided by DHS Regions (Table 5).

Results suggest that most participants indicated that activities/resources had some use. Overall, the following activities appeared to be rated highest in usefulness: Good Practice Program with over 35 per cent of respondents rating it as 'very useful' (Table 3); support from participants' own organisations, other stakeholders (69 per cent rating quite to very useful), and the *Healthy by Design* framework by the National Heart Foundation with around 58 per cent rating it as quite to very useful (Table 4); and participation in MPHP steering group (65 per cent rating as quite to very useful) and other funding resources provided by DHS Regional Public Health staff as rated by just under 58 per cent of respondents as quite to very useful (Table 5).

Table 3 Usefulness ratings of supplementary activities and resources

	Useless	Slightly Useful	Average	Quite Useful	Very Useful	No Resp.
Supplementary Activities and Resources	%	%	%	%	%	
Municipal Public Health Planning Newsletters (Local Governments Partnership team DHS Central Office)	8.20	14.75	24.59	36.07	16.39	61
Municipal Public Health Planning Conference 2003	10.71	10.71	10.71	50.00	17.86	28
Leading the Way (VicHealth)	2.90	13.04	17.39	39.13	27.54	69
Municipal Public Health Planning Conference 2004	9.38	6.25	15.63	50.00	18.75	32
Local Government Planning for Health and Wellbeing website (Local Government Partnerships team DHS Central Office)	3.39	11.86	27.12	40.68	16.95	59
Good Practice Program (Local Government Partnerships Team DHS Central Office and The University of Melbourne)	5.45	5.45	18.18	36.36	34.55	55

Looking more closely at the data presented in Table 3, it is apparent that around 70 per cent of participants judged the Good Practice Program and Leading the Way as useful initiatives. They also suggested that MPHP conferences gained in their usefulness from 2003 to 2004. MPHP newsletters and website were also judged to be useful (quite to very) by over 50 per cent of respondents.

Table 4 Usefulness ratings of support provided for implementation of the framework

Initiatives used to support implementation	Useless	Slightly Useful	Average	Quite Useful	Very Useful	No Resp.
DHS Regional Office	%	%	%	%	%	
Other program areas	36.36	4.55	36.36	18.18	4.55	22
Public Health Team	14.06	17.19	18.75	34.38	15.63	64
DHS Central Office						
Public Health Awards	29.27	19.51	24.39	17.07	9.76	41
Municipal Early Years Plan (Office for Children DHS)	19.05	16.67	26.19	30.95	7.14	42
Evidence based reviews	11.11	22.22	15.56	31.11	20.00	45
Public Health Branch	16.67	11.90	35.71	28.57	7.14	42
Health Promotion and Capacity Building sections						
Health Promotion Short Course	8.51	14.89	14.89	36.17	25.53	47
Local Government Partnerships Team	9.43	13.21	18.87	41.51	16.98	53
Peak Organisations						
Metro-active (VicHealth)	16.67	13.89	8.33	38.89	22.22	36
Food for all (VicHealth)	10.87	17.39	19.57	28.26	23.91	46
Kids - 'Go for your life' (Victorian Government)	6.52	17.39	30.43	28.26	17.39	46
Planning for Health (Planning Institute of Australia)	7.69	11.54	32.69	32.69	15.38	52
Healthy by design (National Heart Foundation)	5.45	9.09	27.27	36.36	21.82	55
Other						
Other support	57.14			14.29	28.57	7
Support within my organisation	3.51	19.30	21.05	33.33	22.81	57
Primary Care Partnerships	9.76	10.98	15.85	39.02	24.39	82
Support from other stakeholders	8.16	4.08	18.37	42.86	26.53	49

Results in Table 4 suggest that as a group, initiatives from peak bodies and other sources were judged useful by more participants than those provided by DHS, with the exception of the Health Promotion Short Course and the Local Government Partnerships Team. Around 60 per cent of respondents judged support from stakeholders, PCPs, *Healthy by Design* and Planning for Health to be useful resources (quite to very useful). Around 30 per cent of respondents indicated that the Public Health Team and Public Health Awards were not useful, with around 20 per cent suggesting that the Municipal Early Years Plan was of no use.

Table 5 Usefulness ratings of support provided by DHS Regions

	Useless	Slightly Useful	Average	Quite Useful	Very Useful	Number Resp.
Support and activities	%	%	%	%	%	
Telephone and support visits	8.00	22.00	18.00	38.00	14.00	50
Individual meetings and support	3.51	19.30	28.07	28.07	21.05	57
Other regional meetings	8.16	14.29	32.65	30.61	14.29	49
Training program (eg evaluation skills)	9.09	11.36	22.73	36.36	20.45	44
Regional local government network meetings	4.84	14.52	27.42	30.65	22.58	62
Other funding resources	6.98	11.63	16.28	23.26	41.86	43
Good Practice Program	3.45	13.79	20.69	39.66	22.41	58
Provision of data/information/evidence	2.94	13.24	25.00	36.76	22.06	68
Participation in MPHP steering committee/reference group	5.17	6.90	22.41	37.93	27.59	58

Results in Table 5 suggest the majority of participants (ranging from 50 to 65 per cent) found services provided by DHS regional offices as useful. This was particularly true for participation in MPHP steering committee and regional network meetings (65 per cent rated quite to very useful), funding programs (64 per cent), Good Practice Program (62 per cent), provision of data (58 per cent quite to very useful), and Training Program (56 per cent rated quite to very useful).

Comments received by participants were more focused on the support offered by staff (DHS and other) supporting the Framework.

> *Overall the Local Government Partnerships Team is the face of Environments for Health and I am very pleased with the service and input they provide*

> *The most useful resource I had was contact with the Leading the Way consultant who was practical, and gave me really good advice and ideas.*

3.3.4 Level of Influence and Integration of *Environments for Health*

Level of influence

Participants were asked to indicate the level of influence the *Environments for Health* Framework had on various other plans and strategies. As Figure 11 shows, the *Environments for Health* Framework had a moderate to substantial influence on councils' MPHPs for approximately two-thirds of participants.

Many participants commented that the Framework had provided a sound basis for plan development and that it legitimised a model for councils:

> *Our council was already working on an integrated framework but the Environments for Health provided a significant clarity and legitimacy for taking that approach with our council.*

Over the past four years councilors and council officers have been educated around the social model of health via the use of Leading the Way and Environments for Health.
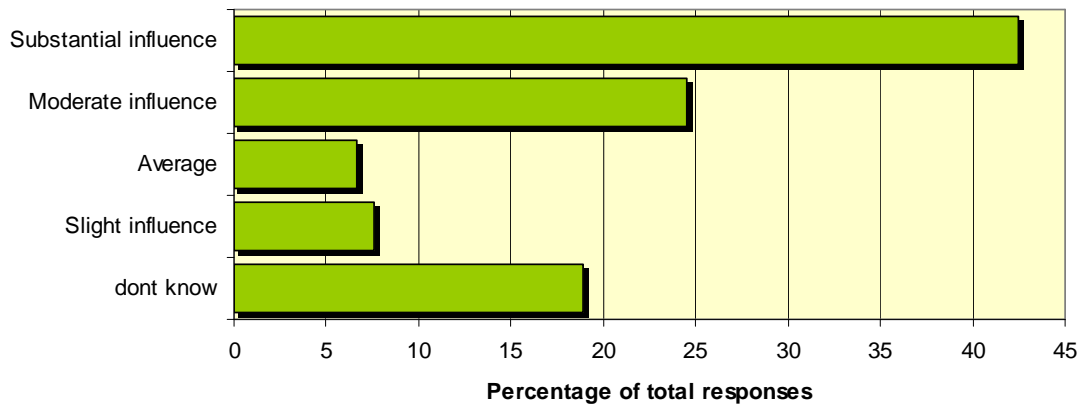

Figure 11 Level of influence on councils' MPHP in the Local Government Area

Many participants who were not council staff were not able to assess the influence of the Framework. Comments received suggested that some service providers and community members were less informed about the development of their local municipality's MPHP.

There was less agreement about *Environments for Health*'s influence on other plans, especially those unrelated to 'health' in the traditional sense. Figure 12 shows the proportion of participants who considered that *Environments for Health* had a moderate to substantial influence on other plans within councils.
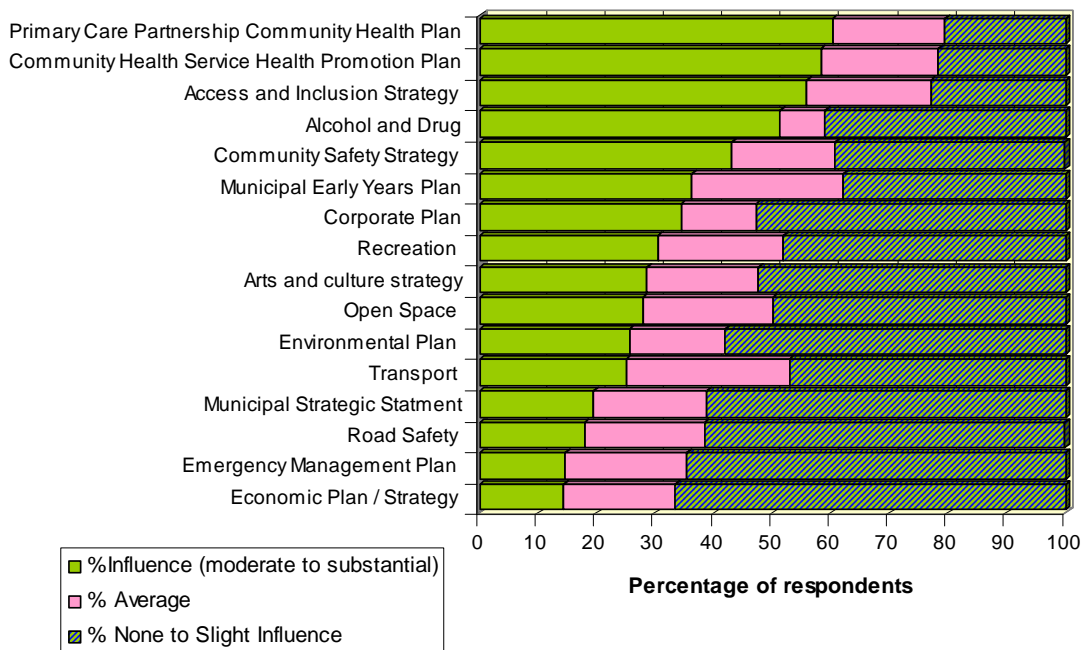
Figure 12 Level of influence of *Environments for Health* on other council Plans

Over 60 per cent of participants agreed that *Environments for Health* had a moderate to substantial influence on the PCP Community Health Plan. Slightly less agreed that *Environments for Health* had a moderate to substantial influence on their Community Health Service Health Promotion Plan, Access and Inclusion, and Alcohol and Drug Strategy. This result might be expected as these plans cover areas traditionally associated with primary health. Under 50 per cent believed that the Community Safety Strategy and Municipal Early

Years Plan were influenced by the framework, and less believed that there was a more than average influence on the other plans indicated in Figure 12.

Only around 25 per cent of participants believed that *Environments for Health* had a moderate to substantial influence on the Transport, Recreation, Environment and Open Space Plans, and Arts and Culture Strategy. Fewer participants believed that the Framework had influenced the Road Safety (under 18 per cent), Emergency Plan (15 per cent) and Economic Plan (14 per cent).

In relation to the Corporate Plan, only 34 per cent of participants believed that *Environments for Health* had had a moderate to substantial influence. Even fewer participants indicated that the Framework had influenced their MSS (19 per cent).

One participant suggested that influence across plans was a determinant of structural alignment of units within council:

> *Where there has been influence this is because the areas are closely aligned internally. Where there has been little or no influence, it is because there has been insufficient information sharing across high levels.*

Some participants felt that commenting on the level of influence over this multitude of council plans was difficult as they lacked the overview of the planning scheme within each respective council required to answer this question.

Level of integration

Levels of influence of the *Environments for Health* Framework on LGAs' planning schemes in general were reported to be relatively low or unknown (see Figure 13). These results suggest that there may be a lack of mainstreaming of the MPHP planning initiatives in the main planning schemes of council.

There was also a perceived lack of integration between MPHPs and Corporate Plans. Just over 37 per cent of participants suggested that their MPHP was moderately or substantially integrated with their Corporate Plan (16 per cent of respondents indicated 'don't know'). Integration with the Municipal Strategic Statement was less common with only 21 per cent of participants indicating that the MPHP was moderately to substantially integrated (30 per cent of respondents indicated 'don't know' or 'not applicable').
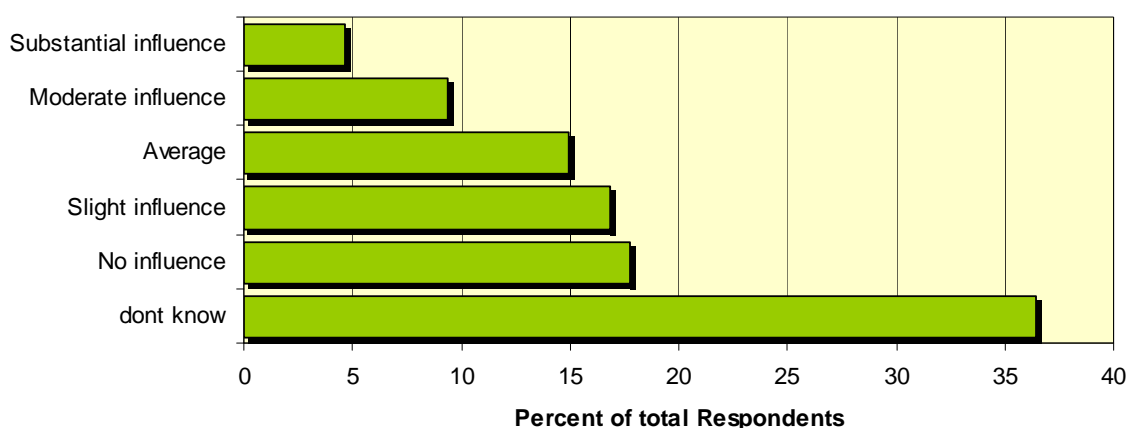

Figure 13 Level of influence of the Framework on councils' planning scheme generally

Comments by participants indicated that currently there was more cross-referencing of plans rather than actual joint activity or actions as an outcome of truly integrated planning processes. One participant was optimistic about a bottom up process for integrating their MPHP:

> *Currently there is no integration, but the aim is to develop the new plan in such a way as to increase its stature, influence and capacity for integration into the corporate plan and the MSS over time.*

Other participants suggested that statutory requirements of the MSS were presenting a barrier and therefore suggested that local government commitment to integration was required.

Some participants alluded to the need for further training of planners in councils:

> *I feel that there could be training attached to using the Framework and orienting/stepping new workers to the field to the resource. At the moment it is there as a resource with very little training to back-up its use as a framework for health planners and more broadly within councils. This needs to be ongoing as there is always staff turnover and changes in councillors.*

Some participants had overcome these barriers and were satisfied with the level of integration of health planning in their general planning scheme:

> *We have an integrated planning unit responsible for MSS and health planning so we ensure integration.*

> *I believe the Plan has provided cohesion to a variety of health considerations which, previously, were considered as separate and not considered as a whole-of-community situation.*

3.3.5 Outcomes of the Framework

Figure 14 displays the level of agreement ratings from participants to various questions about outcomes of the *Environments for Health* Framework. Participants mostly agreed that *Environments for Health* had:

- increased the level of understanding of the impact of the four domains on health and wellbeing (over 70 per cent agreed that the Framework had made an average or above contribution);
- contributed to improving public health policy (66 per cent indicated they agreed);
- contributed to policies and plans that impacted on the four domains (65 per cent agreed that the Framework had made an average or above contribution); and
- helped create supportive environments in the LGA (over 63 per cent indicated they agreed).
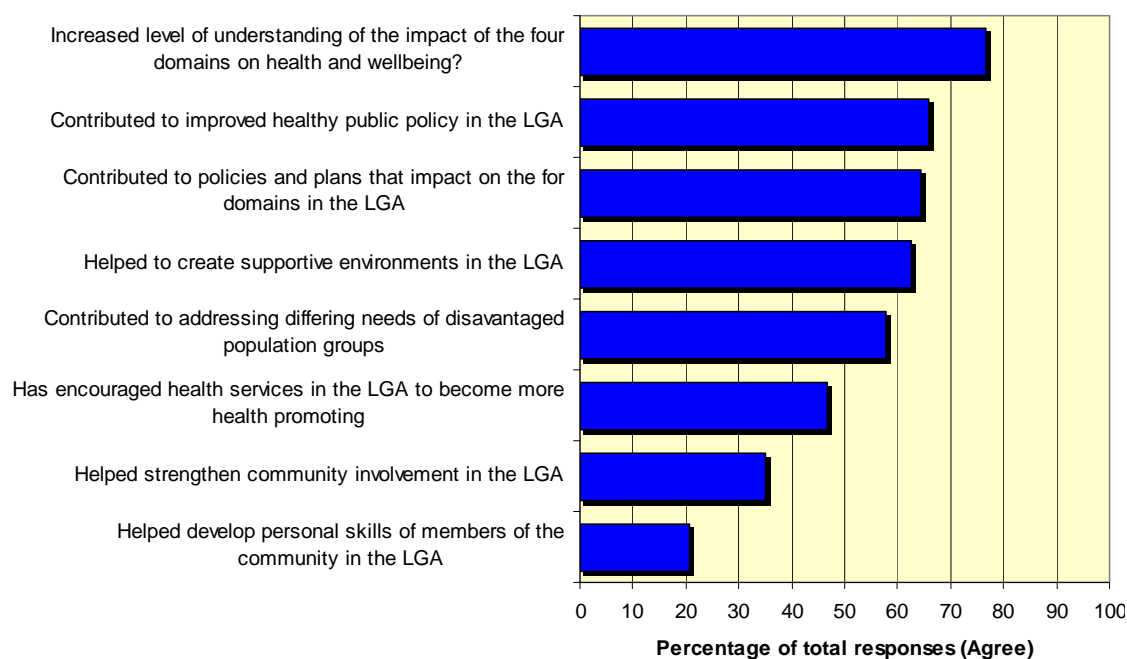
Figure 14 Outcomes of *Environments for Health* [8]

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[8] Note: the following items were scaled on a five point Likert scale from largely contributed to not at all contributed:

There was less agreement that the Framework had: contributed to addressing different needs in the LGA (58 per cent indicated that the Framework had made an average or above contribution); encouraged services to be more health promoting (47 per cent indicated they agreed); strengthened community involvement (35 per cent indicated they agreed); and lastly, fewer participants agreed that the Framework had developed personal skills of members of the community (only 21 per cent indicated they agreed).

One participant suggested that the impacts of *Environments for Health* could be better achieved if it were targeted more at the PCP level:

> *The Environments for Health could be broadened out to more support for PCPs. I have found the Framework rather than the MPHP process more useful to encourage collaboration around new and emerging issues amongst a broad range of agencies. I have found the Environments for Health Framework is a more dynamic process than that of Municipal Public Health Planning. MPH Planning is a more strategic approach, whereas the Environments for Health Framework we have used to problem solve emerging issues.*

One participant suggested that outcomes of *Environments for Health* might be difficult to source directly due to its nature as a set of guiding principles:

> *The application of the Environments for Health Framework is more subtle rather than overt - it occurs when the health planner works with other areas and disciplines within council.*

Another participant suggested that it was difficult to attribute outcomes to the Framework in light of other tools and resources used in the same context:

> *The Environments for Health Framework has not been the only tool used by the PCP to assist in making decisions of planning around priority groups. It has however, assisted with considering strategies and establishing partnerships outside the PCP sector.*

Other participants were able to clearly articulate the impact of *Environments for Health*:

> *The critical change seems to be to have parts of the organisation which are not overtly associated with health (such as the Planners Group) endorse the Environments for Health approach.*

3.3.6 Factors that affect outcomes of *Environments for Health*

The survey was designed to investigate whether organisational factors in particular provided variances in relation to the successful implementation and achievement of outcomes of *Environments for Health*. Organisational factors that were of particular interest here were: geographic locations, job role and type of organisation, and organisational capacity dimensions.

Multivariate analyses of variance were conducted to investigate mean differences on influence and outcomes variables related to the Framework according to whether participants worked in differing regions in Victoria. Results suggested that there were no significant differences according to geographic locations, or job role (management versus staff and community) in mean scores for responses to:

- familiarity with *Environments for Health*;
- familiarity with *Leading the Way*;
- integration of MPHP with the Corporate Plan;
- integration of MPHP with the Municipal Strategy Statement;

- Increased level of understanding of the impact of the four domains on health and wellbeing
- Contributed to policies and plans that impact on the for domains in the LGA
- Contributed to addressing differing needs of disadvantaged population groups

The remaining items were scaled on a 5 point Likert scale from strongly agree to strongly disagree. Both scales had a mid-point called 'average' and are therefore presented here together with percentages inclusive of the mid-point of the scale.

- influence of *Environments for Health* on the general planning scheme; and
- participants' perceptions of outcomes relating to the *Environments for Health* Framework.

Multivariate analyses of variance were conducted to investigate mean differences between participants employed in councils (75 per cent of respondents) versus non-council participants. Results did suggest there were significant differences between organisational type in mean scores for responses to:

- familiarity with *Environments for Health*[9]
- familiarity with *Leading the Way*[10]
- participants' perceptions of some of the outcomes related to the *Environments for Health* Framework
- increased level of understanding of the impact of the social, economic, natural and built environments on health and wellbeing[11]
- contributed to policies and plans that impact on the social, economic, natural and built environments in LGAs[12]
- contributed to addressing the differing needs of disadvantaged population groups in you LGAs[13].
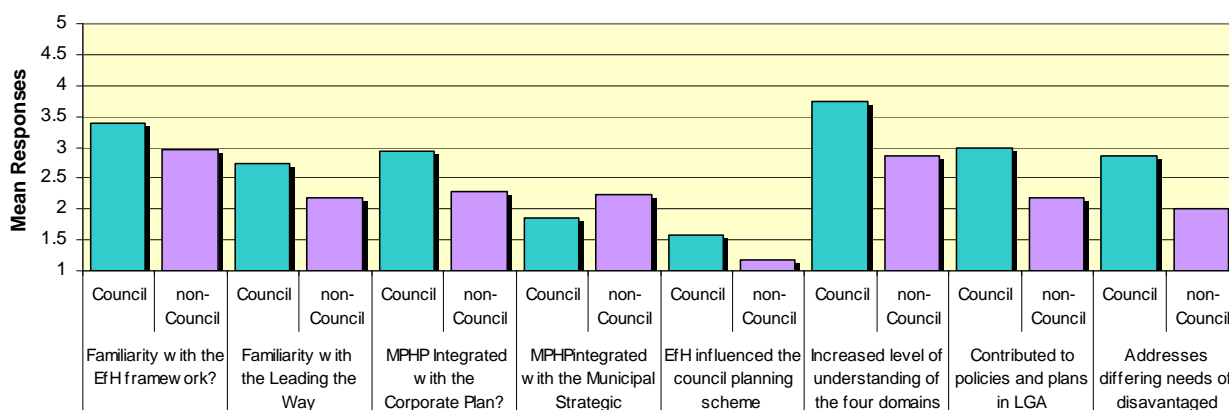
Figure 15 Mean responses of familiarity with and outcomes of *Environments for Health* by council and non-council employees

Mean responses showed that council employees were more likely to be familiar with the Framework and attribute outcomes related to increased level of understanding, contribution to planning and addressing the needs of disadvantaged population groups to the Framework (see Figure 15).

Having ascertained that neither geographic location, job type nor organisation type largely affected average perceptions of participations in relation to outcomes of the Framework, what is the relationship of these variables to organisational capacity? Bivariate correlations were produced between organisational capacity, familiarity and outcome dimensions. These are displayed in Table 4 (see Appendix 5). Results showed that there were significant positive relationships between integration of plans and organisational capacity; and outcomes and organisational capacity. Each of these results will be discussed in turn.

Relationships between integrated planning and organisational capacity

There were moderate positive correlations between integration of plans and most of the organisational capacity dimensions, except for Resources in relation to Corporate Plan

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[9] $F(1,91) = 4.10$, MSE = 1.30, p<.05.
[10] $F(1,91) = 4.10$, MSE = 1.30, p<.05.
[11] $F(1,94) = 6.39$, MSE = 2.07, p<.05.
[12] $F(1,94) = 5.02$, MSE = 2.37, p<.05.
[13] $F(1,94) = 4.10$, MSE = 5.31, p<.05.

integration. Interestingly, however, organisational capacity was not significantly related to familiarity of the *Environments for Health* Framework. This indicates that whilst organisational capacity is not a necessary condition for gaining information about the Framework, it was more important in the implementation of principles of the Framework into mainstream plans and strategies. Higher correlation coefficients between leadership and integration of plans also suggest that Leadership was the most critical dimension here. This was reinforced by one participant's comments:

> *The senior council staff support within Local governments I have dealt [with] really depends on the CEO of the day's commitment to health planning. Even in places where there is commitment, it is difficult to identify whether there is adequate financial resources allocated to planning for health and wellbeing.*

Relationships between outcomes and organisational capacity

Increased understanding of the impact of the social, economic, natural and built environments on health and wellbeing was not associated with any of the organisational capacity dimensions. However achieving successful outcomes related to development of plans and policies related to these multiple impacts appeared to be significantly associated to increased organisational capacity in relation to Partnerships.

The extent to which *Environments for Health* contributed to the needs of disadvantaged groups appeared to be significantly related to increased organisational capacity along the dimensions of Workforce Development, Knowledge Transfer and Partnerships. Knowledge Transfer and Workforce Development were also significantly correlated with the extent to which the Framework helped create supportive environments. The remaining outcomes were all significantly related to increases in organisational capacity dimensions: Workforce Development, Knowledge Transfer, Partnerships and Resources. Interestingly, the leadership dimension was not an important factor in relation to outcomes associated with *Environments for Health*.

Barriers and suggestions

Participants consistently commented on the lack of resources required for implementation of the *Environments for Health* and health planning in general. They also suggested the ongoing need for more resources and government support:

> *Council does not have resource capacity to take advantage of documents such as Environments for Health and other MPHP support opportunities.*

> *[There is an] ongoing need for resources in terms of information, research, advice and direct grant funding.*

> *Local government in rural areas do not have the resources necessary to develop and implement truly excellent plans. They lack both financial and human resources (skilled professionals with appropriate training).*

> *There is inadequate funding by state government to deliver MPHP and health promotion initiatives within local government. More work is needed to get greater buy-in from senior managers to the Environments for Health Framework, this needs to be supported and encouraged by state government.*

> *These leadership and integration functions are our goal, not the current reality.*

These findings suggest that whilst leadership may be a critical success factor for the integration of health into general planning schemes across councils, other organisational capacities in relation to information, human and financial resources are key to successful implementation of plans.

Some participants offered recommendations in relation to improving the Framework and its implementation. These included:

> *There needs to be recognition that the MPHP does not and should not be stand alone plans. The requirements should be able to be incorporated into council plans etc*
>
> *It's a great framework; but not that practical. Could be more succinct; have specific resources for key audiences (e.g. councillors, town and stat planners). Some case examples could be useful.*
>
> *Provide a simple conceptual framework and examples of integration of council Plan, MSS and MPHPs.*
>
> *I think that it is a useful framework. What I thinks needs to take place is general updating of the Framework, elevating the status of the Framework and incentives for this to take place, [provision of] resources / demonstrations projects (more than just what is available in GPP) to implement projects that demonstrate the usefulness of the Framework. More resources for research and evaluation.*
>
> *DHS should provide funding for all councils to make the Health Planner role more consistent across the state to strengthen the role of local government in planning. The role is growing in importance and will only continue to do so if policies such as 'Care in your Community' and the planning models proposed prevail. Local government needs to somehow standardize the way it does health planning and should do so in partnership with DHS through funds matching to ensure the position is at the right level in each council.*
>
> *Critical to have a clear and flexible framework based on research and good practice. There is a growing need to link with state-wide developments in Community planning and the role of local government in whole of community planning...stronger outcomes of the discussions with DVC and the Office of Local Government in relation to the overall planning framework for local communities. Reduce focus on PCP's to a stronger LGA base for planning. State government to provide better resourcing for health and wellbeing planning at the local level.*

3.3.7 Discussion

Results suggested that there was adequate familiarity with *Environments for Health* Framework amongst participants.

The structure of *Environments for Health* as a resource was understood by participants who felt that it had met its objectives in relation to identifying useful resources and providing a sound theoretical basis.

Findings suggested that there may be a lack of integration of the MPHP planning initiatives in the main planning schemes of council. This finding contradicts statements about integrated planning in the MPHPs themselves. Recalling document analysis results presented in Section 3.1, 79 per cent of MPHPs indicated links with the Corporate Plan, 61 per cent indicated links with the MSS and 31 per cent indicated links with both. However participants' perceptions of real linkages were less positive, with only 37 per cent of the survey participants believing that their MPHP was linked to the Corporate Plan and only 21 per cent believing that it was linked with the MSS. Perhaps rhetoric or intention has not been realised in the implementation of these plans in the context of the overall planning scheme within local government. More focussed initiatives to encourage integrated planning might be required backed by the commitment of senior management within councils. Correlations with levels of the successful implementation of the Framework into mainstream plans and strategies as perceived by participants were significantly related to organisational capacity. In particular leadership is a critical factor as it was identified as a critical component of successful implementation of the *Environments for Health* Framework in the 2000 survey.

Results suggested that *Environments for Health* contributed largely in creating supportive environments in the LGA improving public health policy. However it may not have achieved its objectives fully in relation to contributing to the strengthening of community involvement

developing personal skills of members of the community. The 2000 survey report had made recommendations in relation to community focus in health planning, and in particular to more inclusive community participation in the development of the MPHP. However results of this study suggest that five years on, after the initial introduction of *Environments for Health* this recommendation has not achieved outcomes in relation to increasing capability in the community.

In relation to organisational capacity of health planning, results showed that councils are richer in partnerships than in resources and professional development related to planning for health. Findings from the 2000 survey report had identified the need to develop state-based skill development processes in relation to sharing information and good practices. It had also recommended improved access to resources in the way of local data and research, funding and local reference groups. Whilst some of these resources and training have been provided (as evidenced in an analysis of MPHPs) it equally is apparent that these resources need to be more precisely targeted. Recommendations in the 2000 survey had identified the following resource requirements: increase qualifications in health planning for staff involved in health planning; full time worker to develop, implement and monitor the plan; add to resource allocations to impact on inter-departmental and inter-organisational planning within the community.

Summary of findings

- A majority of respondents indicated that they were familiar with the *Environments for Health* Framework.
- Most participants commented positively about the *Environments for Health* Framework.
- Most participants indicated that activities/resources had some use. The highest ratings were related to the following support activities: Good Practice Program with over 35 per cent of respondents rating it as 'very useful' ; support from participants' own organisations, other stakeholders (69 per cent rating quite to very useful), and the *Healthy by Design* framework by the National Heart Foundation with around 58 per cent rating it as quite to very useful ; and participation in MPHP steering group (65 per cent rating as quite to very useful) and other funding resources provided by DHS Regional Public Health staff as rated by just under 58 per cent of respondents as quite to very useful.
- As a group, initiatives from peak bodies and other sources were judged useful by more participants than those provided by DHS, with the exception of the Health Promotion Short Course and the Local Government Partnerships Team. However the suite of services provided by DHS regional offices achieved good ratings. This was particularly true for participation in MPHP steering committee and regional network meetings, funding programs, Good Practice Program, provision of data, and Training Programs.
- In relation to the Corporate Plan, only 34 per cent of participants believed that *Environments for Health* had had average to substantial influence. Even fewer participants indicated that the Framework had influenced their MSS (19 per cent).
- Just over two-thirds of participants indicated the Framework had a moderate to substantial influence on councils' MPHPs.
- Over 37 per cent of participants suggested that their MPHP was integrated with their Corporate Plan.
- Only 21 per cent of participants indicating that the MPHP was integrated with the MSS.
- Comments by participants indicated that currently there was more cross-referencing of plans rather than actual joint activity or actions as an outcome of truly integrated planning processes.

3.4   Council and Stakeholder Forums

Five council and stakeholders forums were conducted state-wide in September and October 2006. Locations were identified through consultation with the Project Advisory Group and DHS Regional Public Health Managers across Victoria. Details of the forums, and the numbers of people attending, as provided in Table 3 below. A single case-study forum, which was to have involved staff from one inner-city council, was cancelled due to low registrations.

Table 6 Details of council and stakeholder forums

Host Organisation and Location	Attendance
Hume City Council – Broadmeadows	16
Wellington Shire Council – Sale	6
City of Melbourne - Melbourne	12
Barwon South West Region – Colac	19
Goulburn Valley Primary Care Partnership - Shepparton	16
TOTAL	**69**

Council and stakeholder forums aimed to elicit perceptions on *Environments for Health* and planning for health more generally, and to gather stories of change across the five dimensions of community capacity (Kegler et al, 2003). Participants were invited to describe at which level/s of the community capacity framework the most change had occurred (individual, civic participation, organisational, inter-organisational, community), and at which level/s the biggest challenges had been experienced. Refer to section 2.4.4 for a full description of these levels. The Forums also provided an opportunity for the evaluation team to gain immediate feedback on the preliminary findings.

3.4.1 Main areas of change

Across all forums, participants identified that the main areas of change had occurred at the organisational and inter-organisational levels of analysis.

Organisational level

At the organisational level, the social model of health has become increasingly embedded across council planning, with greater linkages observable in many councils between health planning and urban planning. 'Health' and wellbeing are becoming seen much more as core council business, with implications for work portfolios across council. For example, one workshop participant described a 'slow creep of *Environments for Health* into other planning spheres', with the uptake of the Framework by corporate planners and now embedded in the Community Plan (Sale forum). In other councils, decision-making around health and well-being had also shifted to a higher strategic level, for example with senior managers now participating in committees, thus enabling decisions to be reached more quickly. The most commonly-cited examples of integrated planning were the increasing connectivity between the MPHP and MSS, and often the Community Plan.

> *Increased understanding of what constitutes health and wellbeing in particular built environment implications – both individual and organisational (Melbourne forum).*

> *Now reflected in the Council Plan. Not sure if this is a direct result of the Environment for Health Framework or the understanding of the Environment for Health. (Colac)*

Inter-organisational level

Change was also seen to have occurred widely at the inter-organisational level. The development and implementation of *Environments for Health* had helped to engage local government more effectively in Primary Care Partnerships, although some participants acknowledged that the conceptual and logistical overlapping of Community Health Plans and MPHPs was still a source of confusion. *Environments for Health* was seen as part of a broad trend within government for 'joined up' thinking and practice, with many initiatives across government departments embracing a social model of health and forging intersectoral alliances. For example, Neighbourhood Renewal in the Office for Housing within DHS, and much of the agenda of Department for Victorian Communities, were seen by some participants to have embraced a social model of health. The Minister for Planning's new Sustainable Neighbourhoods package, to be administered by the Department of Sustainability and Environment, was also mentioned as an initiative with intersectoral impact and implications for health planning. Clause 56 has been developed to ensure implementation of the State Planning Policy Framework and the Local Planning Policy Framework (including the MSS; see DSE, 2006). The various sub-clauses aim to promote compact and walkable neighbourhoods, mixed-use activity centres, appropriate planning and provision of community facilities, and urban places with identity and character throughout Victoria. The work of the PIA (such as through the recent Year of the Built Environment) and VicHealth was also seen as integral to helping achieve this general sea-change.

A sense of community capacity was created by the adoption of the *Environments for Health* Framework. This was achieved by engaging with local government and other sectors and through workforce development initiatives. Good Practice Program funding and *Leading the Way*, contributed substantially to the climate supporting integration and partnership. Whilst not the only framework in use, some participants identified that the *Environments for Health* document had become a resource used by other agencies and departments.

> *MPHP helped to lever for funding/resources from a regional level, best start, DVC funding and VicHealth. (Goulburn Valley PCP forum)*

> *Overlapping of services and priorities – Environments for Health and other frameworks provide an approach/blueprint for how to go about partnership approaches. (Colac forum)*

> *Engagement of local government from the PCP is easier because there was a framework. We are starting to talk the same language. It is a way for PCPs to engage and approach the council. The overlapping of the PCP plan and MPHP can be confusing however. (Melbourne forum)*

Individual level

Contributing to - and deriving from – these changes at the organisational and inter-organisational levels were changes identified at the individual, civic participation and community levels of analysis. At the individual level, *Environments for Health* was seen as having enhanced the skills, understanding and work practices of many people in the local and state government sectors. For example, at one forum, participants stated that they had discerned *an increasing interest in people from different departments in integrated health promotion and their role in wider processes that impact on health*.

> *[There is] better knowledge of other organisations and their role in health planning. (PCP forum)*

> *Differing understanding – but there is an increasing interest in people from different departments in Integrated Health Promotion and their role in wider processes that impact on health. (Melbourne forum)*

> *Individual understanding – reflected in organisations (Sale forum)*

> *Shifts in the notion of mental illness – community notion is now around 'mental wellbeing'. (Colac forum)*

> *More awareness of integration of health, lifestyle, economic and physical environments. (PCP forum)*

Community participation

In terms of *Environments for Health*, changes at the level of civic participation were seen as part of a general trend towards encouraging greater community engagement in planning and governance. For example, neighbourhood renewal was described as a place-based approach that embedded place management in a community development and community engagement framework. Understanding the impacts of all four environments on health and wellbeing was seen as having led to community participation in certain areas. This has also come with a broader understanding of council agendas, inside and outside the promotion of health and wellbeing.

3.4.2 Main areas of challenge

> *The MPHP gives a tool for communication but there are still barriers to changing understanding at an individual and organisational level. (Melbourne forum)*

As described above, participants across the five forums identified evidence of systemic change resulting from – and/or coinciding with – the introduction of *Environments for Health*. However, many challenges have been experienced to achieving greater implementation of the Framework. Interestingly, while the bulk of positive changes had been identified at the organisational and inter-organisation levels, the biggest challenges were also identified at these levels.

Organisational level

Challenges identified at the organisational level included: turnover of staff; limitations in provision of workforce development and induction; and the broader issue of resourcing - time, money, and staffing. These reflections supported the concerns raised by the Planning Institute of Australia about the shortage and turnover of planners working in local government, and the huge workloads of those who remain (Holliday, 2005). Despite the regular provision of *Leading the Way*, MAV training and other initiatives, the loss of knowledge, awareness and support associated with the turnover of councillors was identified as a key organisational barrier. Of the four environments for health, economic planning and health planning were seen as still largely unconnected, suggesting that more work was needed within councils to integrate these areas of planning. Forums also identified issues regarding the MSS and status of MPHP in relation to other planning processes.

> *The MPHP [does not have] the status of the MSS or the corporate plan. So we need to review [whether] the MPHP needs the same status. If so, how? If not, [we need to] amend the Framework, amend the health act or local government act to reflect this decision. (Hume forum).*

> *Safer Cities and Shires [a three-year project] fell apart when the dollars ran out. Needs positions to pull it together because people are all busy. Relying on existing dollars within departments and organisation. (Hume forum.)*

> *DHS needs to put more resources e.g. success of rural access was dedicated funded resources. (Colac forum)*

> *[A] number of partnerships both within and outside of local government have not seen Environments for Health, so [there has been] some failure in the system to promote the Framework. (PCP forum).*

> *Interface between plans is complicated; language can be the cause of difficulty. It is most difficult at the service planning level. (Hume forum).*

Environments for Health is being done by sections of council but not the whole. (Colac Forum)

Inter-organisational level

The gap between economic and health planners at the council level suggests a broader inter-organisational gap between these disciplines. Many delegates identified that despite a greater general awareness of social model of health, the term 'health' still presents a barrier to stakeholders from outside the health sector. This is to be expected, considering that even within the broad health sector, there are different theoretical positions held about what 'health' means, and priorities for action. It was suggested that many of the non-health sector respondents targeted for the *Environments for Health* survey and stakeholder forums may well have not identified that this evaluation was germane to their work. (This also relates to the organisation barriers discussed above of staff turnover and limited induction/professional development. Many of the early inter-sectoral champions of *Environments for Health* may have moved on, creating a professional vacuum in their wake.)

Participants at the Melbourne forum felt that the broad argument for integrated planning and intersectoral collaboration outlined in *Environments for Health* does not address the structural or sub-cultural barriers that may hinder the collaboration and shared understanding between different agencies (such as local government, police, and the wider community). Different sectors were seen as having different perspectives, strengths and limitations.

> *The challenge is in shifting the individual's understanding - particularly in relation to those who have been in council for a long time and spent that time in a regulatory role. They don't see their role as being linked to the social model of health. Therefore, promotion of the 'value' of the social model of health and environments that are supportive of promoting 'new ways of thinking' are important. (Melbourne forum)*

> *Need for partnership approaches in which LG leads but others need to participate eg 'Municipal Community Plan' – shared ownership not just LG – links to Local Safety Plans and Early Years Plan. How can LG take on that leadership role effectively? PCP scale compared to LG scale priorities… where the common ground is and how can they work from that? (PCP forum)*

> *Some people have not seen the Environments for Health document – therefore there may be a systemic failure in the document's promotion. (PCP forum)*

Individual level

At the individual level of analysis, participants identified the need for additional practical examples of how to use *Environments for Health*. It was suggested that the practitioners need to be offered suggestions for measuring less tangible outcomes such as political engagement and social change. It appeared from discussions that many informants were unaware of the resources developed to date and available on the DHS website. Clearly, workforce development must occur within individual councils. However, it would seem that many of the existing resources remain under-utilised and under-promoted.

> *… influence of the Environments for Health Framework on the MPHP depends on the champion (Colac forum).*

> *Limited to individual change/understanding with local government employees dependent on their proximity to Environments for Health/MPHP processes. (PCP forum).*

Civic participation

Barriers to meaningful civic participation were also identified. Some council advisory committees were seen as lacking adequate participation of individual community members. In particular, it was considered beholden on councils to provide background training to community members to enable their effective participation in decision making. It was suggested that councils could identify civic engagement as a council priority, and that this priority be expressed in the MPHP, MSS and other planning activity.

> *Lack of educated people around public health, council/community interface is weak – needs ongoing support (Melbourne).*

> *Community needs to know when and how to engage with local government [to] lobby and enact change (Melbourne).*

3.4.3 Responses to the Preliminary Evaluation Findings

Each forum was given a brief presentation on the preliminary findings based on the data collected at that time from the MPHP document analysis, key informant interviews and online survey results. There was strong agreement with the findings presented.

Opportunities to improve *Environments for Health*

After reviewing the impact of *Environments for Health* and discussing the preliminary findings, participants suggested a range of practical strategies for DHS to consider when revising the *Environments for Health* guidelines and supporting resources.

> *Needs case studies (Melbourne)*

> *Needs to be more prescriptive, rather than a "theoretical document" (Colac)*

> *Feedback that the Environments for Health document is quite dated and needs to be more of a ' living document', (i.e. perceived value was seen as a reference resource and not an action document) (Colac)*

> *More links to NGO's and the ways in which they can value add to local government health planning (Colac)*

> *Resources should be packaged and presented better, move on from Part A. (Colac)*

> *Part B of Environments for Health could be updated to include electronic links to new and local resources. (Colac)*

> *Good overview for planning but not reflecting local Government operation/implementation (Colac)*

> *Good resources already there on the web – link to create a portal (Melbourne)*

> *Environments for Health states that the Corporate plan/MSS/MPHP are equal status – maybe the MPHP should be promoted to that level, (pg 17 of the Environments for Health document). (Hume)*

> *Tendency towards fluffiness - Says lots of good things but does not have measurable – political issues social change is difficult to measure (Melbourne)*

The broad themes that emerged from the participants' discussion of possible improvements can be categorised as the need for:

- practical tools or examples for implementing environments for health;
- greater prescription of process;
- adaptability to local needs;
- incorporation into the planning process;
- connection to other plans and organisations;
- attachment to LGA core activity;
- update to include links to new material and resources.

Workforce Development

The forums identified workforce development as a major opportunity for extending the reach and impact of *Environments for Health*. Suggested developments are summarised below.

- The Planning Institute of Australia, MAV, VicHealth and other agencies could find ways to expand the frequency of training and development for planners, councillors and senior management. One participant suggested that *Leading the Way* training could be tailored for specific council roles

- The DHS Public Health Group could develop the Good Practice project findings and tools developed by practitioners into training and development materials for the whole sector. Presently, project findings are accessible via the Local Government website, however these materials could be developed into active training and resource material.

- *Healthy by Design* by the National Heart Foundation could be developed into training material.

- Training in Health Impact Assessment be extended to link specifically to MPHP, MSS. The British National Health Service's 'Watch Out for Health' HIA checklist, developed for use with the London Plan, could also be adapted for training and development, and use as a checklist tool in *Environments for Health*.

- Some participants argued that *Environments for Health* could include some 'template' tools to encourage some consistency across council planning.

3.4.4 Discussion

The results suggested that the social model of health has become increasingly evident in councils, and that health is perceived more often as core council business. Integrated planning was also more evident, as was the adoption of health as an issue at strategic levels by senior council personnel.

Change was evident to participants at organisational and inter-organisational levels. Numerous other governmental plans and policies were seen as connected to *Environments for Health*. Participants perceived enhanced skills and work practices at the personal level, and increased community participation.

Challenges to increasing systemic change experienced at the organisational level included staff turnover and limitations in training and resources. It was felt by participants that the loss of language, awareness and support associated with the turnover of councillors was a significant problem, and that raising the status of the MPHP to that of the MSS or Corporate Plan would promote the Framework more effectively. Inter-organisational barriers were seen as those resulting from a narrow definition of health in other sectors, and a lack of recognition of other sectors' role in health.

Individual participants put forward a number of challenges to extending and enhancing *Environments for Health*. These included workforce development, raising awareness of resources, and the lack of 'hands-on' examples of how to use the Framework. Training to maximise the benefits of community participation was also seen suggested by participants.

Participants expressed particularly the need for practical examples: case studies, methods of measuring community participation, specific examples applying to rural/regional councils; and action plans that correspond to core council operations.

In general it was felt that Part B of *Environments for Health* needed to be made more prescriptive to enable further used of the Framework. It was also noted that Part B needed to include links to new resources at departmental and local levels.

Summary of Findings

- A second edition of *Environments for Health* is needed to move on from Part A and focus more attention on Part B which should be revised and updated to include more practical and measurable tools, case studies, practical examples and prescriptive methods of connecting *Environments for Health* to core council operations, and updated electronic links to relevant resources.

- Challenges identified at the organisational level included: turnover of staff; limitations in provision of workforce development and induction; and the broader issue of resourcing - time, money, and staffing.

- *Environments for Health* requires parity with other plans - elevate its position to the same status as the MSS and CP.

- Practitioners need to be offered suggestions for measuring less tangible outcomes such as political engagement and social change. Many informants were unaware of the resources developed to date and available on the DHS website. Clearly, workforce development must occur within individual councils. However, it would seem that many of the existing resources remain under-utilised and under-promoted.

- Identify civic engagement as a council priority, and to give clear links to the MPHP, MSS and other planning activity.

PART D – DISCUSSION AND RECOMMENDATIONS

4.1   Discussion

This evaluation study has demonstrated that to some extent, *Environments for Health* has both shaped, and been part of, an emerging approach to health and wellbeing that integrates thinking and practice across policy domains. Attributions of causality can not be made uniformly to *Environments for Health*. However, there is evidence that for local government staff and other stakeholders, the development and implementation of *Environments for Health* has been significant in their immediate setting, as follows.

- There has been an increase in the level of understanding and the impact of the four environmental domains.
- This understanding has been recognised in the documentation of MPHPs and other council plans.
- Partnerships and inter-organisational networks have been strengthened.
- Planning capacity in general has been enhanced across the broader local government sector.

In sections 1.4 and 1.5 the international context for local health planning was described. As mentioned, the few evaluations of programs similar in context to the Municipal Public Health Plans indicate very limited, if any, success for the development of local health plans elsewhere. Findings of this evaluation, in that context, can be regarded as extremely positive. Every local government in Victoria has developed a MPHP and the vast majority report that they are in the implementation phase of the planning cycle.

The *Environments for Health* Framework is generally appreciated as having been highly instrumental in this accomplishment. Differing from similar international programs this evaluation suggests that *Environments for Health* may well be superior in its effectiveness as a conceptual and planning framework for the formulation of health policy. This of course must be considered in the context of the relatively short time frame in which this policy development in Victoria has occurred. In general, however, we have seen that 'brand recognition' of *Environments for Health* is high. Therefore any change should not depart radically from the current conceptual Framework.

The structure of *Environments for Health* as a theoretical and practical resource was strongly supported by research participants, who found it useful and easy to understand.

In relation to the level of influence that *Environments for Health* has had, participants indicated that the Framework had made significant impacts on council's MPHPs and other heath plans and strategies. Participants agreed that *Environments for Health* had:

- increased the level of understanding of the impact of the four environmental domains on health and wellbeing;
- contributed to improving public health policy in their LGA;
- contributed to policies and plans that impacted on the four environmental domains; and
- helped create supportive environments in the LGA.

However participants felt there was little evidence of influence on other traditionally non-health plans, suggesting a lack of integrated planning in most councils. The same finding was true in relation to a lack of impact of the Framework on the strengthening of community involvement.

This may explain why some participants judged MPHPs to be tokenistic within their council planning schemes. Some suggested that the formulation of plans did not necessarily eventuate in their action in real terms, and there was considerable variation in the understanding and sustainability of the Framework.

Strategies for improving the impact of *Environments for Health* identified by participants included the need for:

- enhanced state government (DHS) resourcing to support implementation and workforce development;
- refinement of resources and materials to target the traditionally non-health related environmental domains within councils and the community;
- ongoing monitoring of the Framework's implementation, including the possibility of developing greater incentives for councils to implement plans with consequences for not meeting targets;
- systematic and ongoing training to raise capability within the workforce and to address loss of knowledge due to high staff turnover; and
- more consistent approaches from state and federal governments that assist with the integration of plans and reduce planning complexity.

This section of the report will discuss these issues in depth, and in Section 4.2 offer conclusions and recommendations.

4.1.1 The four environmental domains

In this study, the document review of MPHPs, findings from the online questionnaire, stakeholder interviews and the validation exercise through the stakeholder forums have all demonstrated that the *Environments for Health* Framework has effectively changed perceptions of the determinants of health. This has been achieved in the context of a current intellectual and cultural climate that advocated similar comprehensive and social planning frameworks. This evidence has also suggested that the four environmental domains have been successfully integrated in municipal public health plans. However, concern has been expressed consistently that neither state nor local governments should be complacent. A continued advocacy strategy for the four environmental domains as pillars for planning for health should be pursued.

Environments for Health should continue to aim to provide guidance that raises the standard of planning and subsequent action across the four environments. Whilst acknowledging the enormous success of *Environments for Health* in the communication of the determinants for health, our findings suggest that more could be done to broaden people's understanding, especially in relation to the economic and social domains. Fleshing out the specifics of the domains could do this. Such inter-domain connection could include, for example, evidence and guidance about how to include culture in the social domain, and how learning links to the economic domain and the social domain. This could be achieved through sharing of good practice where this has been achieved, and in the development of tools that assist with the explication of these relationships.

There is an evident need for more effective communication with other sectors – a need to learn how other sectors talk, think, what their priorities are. *Environments for Health* could provide guidelines for how such communication can be most effective. Practical examples that explore how to develop appropriate communication strategies are needed. Similarly, guidelines related to alternatives to health promotion jargon could be developed. Participants indicated that the stakeholder matrix tool was most useful in relation to reviewing stakeholders and 'looking at whom you are not working with'. A similar tool related to communication could add significant benefit to planning and review activities.

Discussion among key stakeholders indicated that there was a need to establish an evidence base across the four environmental domains in Victoria. This was particularly pertinent in relation to increased access to the evidence base for the economic, natural and social environments. Despite the significant work that has taken place within the built environment, the investment in the built environment has not been modelled for the remaining environments. In the past resources have been available for work relating to the built environment. Tools are now needed like *Healthy by Design* for the economic sector and its audience.

An emphasis could also be placed upon the natural environment with Parks Victoria, the People and Parks Foundation and the EPA. Support and funding for research and practical implementation of local government strategies for local parks and open spaces also would be appropriate.

4.1.2 Variations in understandings of health and wellbeing

Our evaluation has demonstrated that, at a general level in Victoria, the understanding of health and wellbeing and their determinants has changed significantly since the 2000 evaluation study. However, there is still considerable variation among local governments and professionals operating at local and state level in terms of their understanding and subsequent implementation of related measures. Respondents stressed that a consistent and continued push for a social model of health remains important.

The presentation and demonstration of specific tools, in addition to workforce and capacity development endeavours (below) would be instrumental in maintaining and driving the current comprehensive perspectives.

We believe that a second stage in framework development should comprise the development of key performance indicators, and processes for reviewing performance against these measures over time. The measures could include: a standard set that include input data and determinants to be considered in developing MPHPs, as well as outcome measures and guidelines for reporting. In addition, the evidence base for Health Impact Assessment and Social Impact Assessment has advanced dramatically in recent years. These tools could be communicated and supported for application in council decision-making towards comprehensive local health planning. Development will also need to be sensitive to the differing population and physical sizes of LGAs.

Key performance indicators that are more social rather than illness-related have been developed in the Victorian Community Indicators Project (CIV). This project could be considered in the development of indicators for the four environments of health and wellbeing.

4.1.3 Local cultural and organisational context

The degree of development and implementation of local health planning is, in spite of the overall success of *Environments for Health*, highly diverse. This may be in part a consequence of the diverse range of planning requirements at the local government level.

Participants appeared to be overwhelmed by the multitude of plans and strategies that were in various stages of development, implementation, evaluation and integration. Specific guidance on the next level of integration of local government and community planning would have to be an essential part of the further development of *Environments for Health.* The variation in councils (significance of size and location of the council in terms of available funding and the pressures/demands linked to the implementation of the MPHP) must be taken into account. Development of *Environments for Heath* could include specific tools to assist councils in integrated planning with the use of business planning models. Perhaps planning departments could participate in the development of these tools, rather than health promotion professionals alone. This could serve a dual purpose in adapting tools from the planning literature that have been successfully implemented in other industry sectors, and to also engage planning departments in councils who are responsible for the overall planning scheme. Furthermore, this kind of interdisciplinary collaboration is what is required to help colleagues across various departments learn each others' language and worldview.

A significant number of respondents highlighted the problematic nature of the use of the word 'health' in the application of *Environments for Health* in local contexts. 'Health' sometimes leads to an attribution of responsibility for local health planning to more traditional health sectors and professionals, which is inconsistent with the broad social determinants model that is being advocated. Removal of the word, however, would violate the integrity and 'brand recognition' of *Environments for Health* and the MPHP. A refinement and complementary designation (such as *Environments for Health* and *Wellbeing*) seems to be most appropriate. From what is currently understood about the development of the new Health Act (2006) such a designation would be commensurate with future legislative phrasings.

There is potential for MAV to promote the *Environments for Health* Framework as a vehicle or model for MAV's vision for local councils. This could be done through documentation in MAV policy statements and training programs.

4.1.4 Capacity building and workforce development

The participants in this study emphasised the importance of leadership and organisational capacity for the successful implementation of *Environments for Health*.

Much of the effort involved in helping to reach a 'tipping point' of people and agencies embracing new concepts and systems lies in 'social entrepreneurs'. These are people with the vision and skills needed to help introduce new ways of thinking into an organisation, and the tactical skills needed to build up alliances of support across and between organisations, Successful social entrepreneurs need knowledge, skills and confidence to analyse, envision, communicate, empathise, mediate, enable and empower across individuals and organisations; to think holistically, proactively, reflectively; to seize opportunities to broker more effective political relations; to act as 'boundary spanners'; and to help ensure innovative policy (Catford, 1997; de Leeuw, 1999; Duhl, 2000).

Catford (1998) noted 'social entrepreneurs are vital for health promotion - but they need supportive environments too' (p. 95). They need to find an employing organisation that embraces an empowering organisational culture, or at the very least find and join networks within or outside the organisation that can enable the social entrepreneur to flourish and effect systems change.

Empowered outcomes for organisations can be obtained through better access to resources, network development and lobbying power. Empowering organisations encourage staff to develop and share their strengths through collective action and reflection, and to view themselves and their involvement as part of a broader mission (Maton & Salem, 1995). Much of this encouragement is provided by leaders, who act as inspirational role models. Leaders are talented in working with others, and in sustaining the organisation. They are also committed to sharing their leadership widely, to encourage the development of new leadership opportunities. Finally, support systems ensure that members can obtain a wide range of support from many sources, including their peers. This enables staff to develop a sense of community: not only within the organisation, but also beyond it, as they extend their supportive relations to other life settings (Maton & Salem, 1995).

These are the supports sought by participants when implementing *Environments for Health*. Many experienced support in certain contexts; others suggested that for local governments to achieve this level of functioning, they need additional resources from the state government. Alternatively or additionally, they may need entrepreneurial staff with the political skills and time to find better ways to leverage funds and resources. Certainly, evaluation of 20 Californian Healthy Cities and Communities initiatives identified an eight-fold return on investment among entrepreneurial leaders who used funding as leverage for enhanced economic development (Kegler et al., 2003).

Many participants in this evaluation study have called for enhancements to State government leadership, backed by resources, in order to help make holistic integrated local area planning the norm. For this reason, we suggest strongly that local government be afforded greater prominence within DHS. We note with some concern that the Local Government Partnerships Team no longer exists as a discrete entity within the Public Health Branch. The LGPT offered visibility and credibility to the local government sector.

We propose that DHS consider not only reinstating local government as a visible priority area, but elevating it to a key policy area within DHS. At the very least, it could have a coordinating role that integrates all work being done between the DHS and local government sector; ideally it would have key responsibilities for integrating the DHS work with that of DVC and DSE.

4.1.5 Partnerships and integration at the state level

Barriers to meaningful civic participation were also identified in this study. Whilst analysis of MPHPs found that the community was consulted extensively in the development of MPHPs (90 per cent of plans documented wide range of consultation mechanisms and 57 per cent indicated they had established consultative committees), perceptions of participants in this study suggested that community members had not benefitted from the planning process. They suggested that community was not adequately represented in committees related to planning,

and may not have benefitted from resources and tools provided for health planning, such as *Environments for Health*. In particular, it was considered incumbent upon councils to provide specific training to community members to enable their effective participation in decision making.

Consistently, respondents in this study have shared their notions that a precondition for effective joined-up or whole-of-government approach at the local level must be similar to operations at the state level. The pre-existing Inter-Governmental Agreement (IGA) on local government could provide an opportunity to promote the *Environments for Health* Framework was as an overarching framework across portfolios at a state government level. The IGA adopted in April 2006.

4.2   Conclusions and recommendations

This evaluation study aimed to determine the extent to which *Environments for Health* had:

- Been incorporated by local governments in their policies and practices.
- Increased the level of understanding among appropriate local government staff of the impact of the social, economic, natural and built environments (four domains) on health and wellbeing.
- Contributed to greater consistency and quality in the scope and approach of municipal public health planning across the state.
- Led to the integration of municipal public health plans (MPHP) with other council plans.
- Created additional opportunities for health gain through strengthened intersectoral partnerships address the social determinants of health.
- Been supported effectively by the Department of Human Services and other stakeholders.

It also aimed to provide direction for future development in supporting Municipal Public Health Plans.

Conclusions in relation to these aims will be briefly discussed in turn with recommendations to this end.

4.2.1 Incorporation by local governments in their policies and practices

The findings of this study demonstrated that *Environments for Health* had had a significant influence on local government policy and practice. This was evident from participants' perceptions about the impact of the Framework on improved and 'healthier' public health policy, and its contribution to improvements in plans that impact on the four environmental domains.

In spite of the relative success of *Environments for Health*, this study also revealed barriers and factors blocking its further effective dissemination. These factors are not intrinsic to the current format of the Framework: rather, this evaluation has found future work should focus on enhancements in communication, and on the provision of further support mechanisms for the dissemination and sustainability of current achievements.

The following recommendations could encourage the further incorporation and implementation of the Framework by local government:

a. Revise, re-badge and re-issue as *Environments for Health and Wellbeing*.

b. Consolidate *Leading the Way* with *Environments for Health* - linking the two more consistently through, for instance, co-branding of already available and newly developed resources and nomenclature.

c. Communicate sector-specific messages about the four domains to groups traditionally outside the health field via practical examples and guides for developing communication strategies. Develop guidelines that avoid health promotion industry-related language.

   d.   Develop funding incentives and opportunities for implementing *Environments for Health* including more specific support for rural regions.

4.2.2   Increased the level of understanding about the four environmental domains

Environments for Health has had a significant impact on the change in understanding of the many determinants of health. The social model of health is now being used widely in the formulation of Municipal Public Health Plans in Victoria. This change has taken place alongside other initiatives supporting the social model of health.

Despite the significant achievement in relation to changing understandings, this study demonstrated that there may have been less reach of these understandings in areas not traditionally associated with health. In particular the economic and social domains may still require targeting in relation to raising awareness and understanding of their inter-relationships with other environmental domains. Findings suggested that community representatives and councillors were often less likely to realise the benefits of resources that support the Framework. The following recommendations address these gaps:

   e.   Develop tools like *Healthy by Design* for the economic environment with economic development sector as the audience.

   f.   Encourage better use of existing resources. For example, consider ongoing *Leading the Way* training in councillor orientation programs and consolidate MAV councillor/senior officer *Leading the Way* training module as a permanent offering in local government training.

   g.   Develop links with Health and Social Impact Assessment tools and resources.

   h.   Compile a community participation guide containing lists of resources and examples for local governments with multiple access points.

4.2.3   Consistency and quality in the scope of MPHPs

The document analysis conducted as part of this study showed a wide variation in the content of MPHPs, which in itself may be most appropriate for a local government areas dealing with diverse populations and geographies. All councils had a MPHP. This represents a 15 per cent improvement on the 2000 evaluation survey where 11 councils did not have a plan. The majority of plans in 2006 mentioned *Environments for Health* and referenced the four environmental domains and social determinants for health model in their introductory sections.

Despite this improvement, a consistent theme that emerged from interviews and survey results was the variability of capability and capacity for planning in general within councils. Future work should focus on disseminating best practice models in relation to planning, rather than health planning specifically. There was little information in plans about how these plans would be implemented, monitored and reviewed, and many participants indicated confusion about whether the MPHP was a strategic statement or an operational plan.

Many participants suggested the need for training and specific tools in relation to planning, and in particular, how to integrate plans. Recommendations specific to addressing this gap include:

   i.   Confirm the status of the MPHP as a high-level strategic document within the broader planning arena and across local government areas.

   j.   Develop tools and resources focused on implementation that are sourced from general planning literature and practice. For example, provide models of linked or cascaded plans and guidelines to implement the social model of health that include access to data, including key performance indicators that are not just illness and disease measures, best practice examples and intervention points under each environmental domain.

   k.   University training of planners needs to be multidisciplinary to equip planners with intersectoral skills and understandings. This may develop the ability to work across sectors and divisions, use the language of other disciplines, and the ability to describe 'health' from multiple perspectives.

4.2.4 Integration of MPHPs and other plans

Contradictory findings across different levels of data collection in this study suggested that while many MPHPs refer to their links to other plans, this may not reflect actual practice. The document analysis suggested that a majority of MPHPs were linked to the council's corporate plan, and to a lesser degree the MSS. However, overwhelmingly, participants' perceptions about the level of integration suggested that these links were not evident, or at the most weakly constructed. Only 29 per cent of respondents to the online survey indicated that *Environments for Health* had an average to substantial influence on the council's planning scheme in general with only 5 per cent suggesting there was substantial influence. Whilst 37 per cent of participants believed the MPHP to be linked to the Corporate Plan, only 21 per cent believed the MPHP to be linked to the Municipal Strategic Statement. Participants expressed strong intentions to practice integrated planning, however appeared frustrated with barriers faced including lack of capability in relation to how to achieve this, as well as some technical barriers, particularly in relation to statutory requirements of the MSS.

The interviews with key stakeholders confirmed this finding, with themes emerging around barriers to integrated planning: silo mentality, language issues, workforce capability and capacity and the complexity of planning requirements within councils.

Future work should focus on the establishment of conceptual consistency between *Environments for Health* and other planning parameters. This could also involve the establishment and maintenance of an inter- and intra-governmental policy perspective on whole-of-government approaches at all levels of governance.

It is recommended that a program of work be conducted to simplify planning requirements for councils:

l.   Use the findings of the recent mapping exercise, the Joint State/Local Government Planning Review led by the Department of Victorian Communities (DVC), to clarify and help integrate the range of statutory and other planning requirements relevant to MPHPs and the *Environments for Health* Framework.

m. Develop guidelines for integrated planning that could be developed along with practical tools and templates. This work could utilise the expertise of planners, ensuring that plans contain links to business plans and the budget process.

n.   Strengthen the strategic and operational links between PCP Community Health Plans and MPHPs.

o.   Develop and disseminate specific examples of how the Corporate Plan, the MSS, MPHPs and other local government plans can be integrated.

p.   Consider a benchmarking project in relation to integrating planning. Benchmark partners may not necessarily be in health or government, and could include other industries that need to address the needs of a range of stakeholders.

The following strategies may provide a way forward to a more integrated approach at the state level:

q.   Promote the MPHP as the strategic higher-order health plan from which other health and wellbeing plans would cascade down across regional and sub-regional settings.

r.   Investigate linking the key local government plans at the legislative level including MPHPs.

s.   Build on existing partnerships and understandings between DHS, DVC, Department of Sustainability and Environment (DSE), VLGA and VicHealth where appropriate and possible. University partnerships with DHS and all relevant local government stakeholders could be to be explored and extended to facilitate mutual teaching and learning.

t.   Develop a state-integrated local government policy statement based on *Environments for Health* for government departments and state partners to adopt.

u. Promote the use the *Environments for Health* Framework across DHS and other state government departments in developing policies and any funding programs for local government, and in conceptualising the MPHPs.

v. Raise the profile and leadership role of the Public Health Branch of DHS in strategic health planning not just service delivery. Encourage regional offices to promote, market and resource local government as the key strategic planning level. Ensure entry points and contact details for the local government resources located within the Public Health Branch of DHS are highly visible and accessible.

4.2.5 Created additional opportunities for health gain

Although it is difficult to attribute outcomes to *Environments for Health* alone, findings of this study suggested that *Environments for Health* had significantly:

- increased the level of understanding of the impact of the four environmental domains on health and wellbeing;
- contributed to improving public health policy;
- contributed to policies and plans that impacted on the four domains; and
- helped create supportive environments in local government.

There was less agreement that the Framework had: contributed to addressing different needs in local government; encouraged services to be more health promoting; strengthened community involvement; or developed personal skills of members of the community.

An analysis of different group responses to these outcome measures suggests that there were no differences according to geographic locations, or job role (management versus staff and community). However there were some differences between council and non-council staff in their perceptions. As expected, council employees tended to be more familiar with the Framework and attribute outcomes related to increased level of understanding, contribution to planning and addressing the needs of disadvantaged population groups to the Framework. This finding may suggest that future opportunities for health gain in relation to *Environments for Health* should focus on community needs and strengthening partnership involvement.

Strategies in relation to strengthening community and partner involvement in the Framework could include:

w. Tools and resources to identify the benefits of engagement, and help increase the level of engagement

x. Extending the understanding of the social model of health to identify and address health inequalities through a recognition of the social determinants of health

4.2.6 Levels of support provided to the Framework

Participants appeared to be satisfied with many of the supplementary initiatives that support the implementation of *Environments for Health*, especially *Leading the Way* and the Good Practice Program, as well as *Healthy by Design* (Heart Foundation) and Planning for Health (PIA). However, findings in this study clearly showed that barriers to implementation of the Framework included gaps in workforce capability and resources. Participants strongly supported ongoing training for a range of stakeholders including councillors.

Confirming conclusions of the evaluation report for the 2002-2004 Good Practice Program, this study also found that organisational culture and leadership were key to acceptance of the social determinants of health model and the level of intra and inter organisational collaboration. In particular, correlations with outcome measures in the online survey showed that organisational capacity, and in particular leadership, was a significant factor for successful integration of the MPHP with other plans.

However it also found that, rather than leadership, other organisational capacities were more likely to impact on the achievement of demonstrated health gain in relation to *Environments for Health*. These include workforce development (in relation to professional development for staff); knowledge transfer (in relation to evidence based planning and meaningful stakeholder consultation); partnerships (in relation to proactively working in a cooperative and inclusive

manner and having available networks); and resources (in relation to appropriate human and financial resources).

The following recommendations address the need to raise the capability of various sectors.

    y. Provide an integrated training and workforce development program which operates regularly and involves planning partners as well as other resources and expertise.

    z. Revisit and revitalise existing training models and resources for new health planners with appropriate peer-learning and support mechanisms along the lines of the Good Practice Program. This might require:

- inclusion of materials and guidance in councillor training handbooks;

- use and strengthening of existing forums and networks, such as local government networks, regional management forum, Fairer Victoria regional forum, Health Promotion Short Course;

- training using *Environments for Health* with regional public health teams;

- provision of state government incentives for senior level demonstrated commitment; and

- development of information and learning exchanges with universities and other relevant research bodies.

4.2.7 Directions for the future development of Municipal Public Health Plans

As described above, the findings of the study have been positive for all the study objectives evaluated. The *Environments for Health* Framework has been implemented successfully in terms of the installation of a broad social model of health in local government health plans. This is reflected in the incorporation of the Framework into local government planning and in the achievement of additional opportunities for health gain. These achievements should be applauded.

Five years on, the Framework itself requires revision. A new edition is needed to incorporate new developments in the field, to address the shortcomings identified in this study, and to permit a more sophisticated use of the social model of health at the local government level. Tools, templates and resources require revision and updating, and new materials included.

A series of practical, 'on the ground' recommendations has been proposed above to further the implementation achieved to date. However in order to truly sustain this accomplishment, three strategic recommendations must be added.

    1. Respondents in the different elements of the evaluation have expressed a concern that, if local authorities are to adopt a **whole-of-government approach**, this should be modelled and exemplified at the state level. The need to align and integrate the local government planning roles of DHS and DVC, in particular, was identified as an immediate priority. It is therefore recommended that the existing initiatives and processes in train that provide a consistent whole-of-government approach be strengthened and extended. These initiatives need to be more visible, have a strong local government planning focus and an accessible point of contact. The local government field needs to be well-informed of the deliverables expected and their achievement so that the planning benefits may be experienced immediately.

    2. The second strategic recommendation is to implement the outcomes of the above whole-of-government initiatives, such as the findings of the recently completed Joint State/Local Government Planning Review, led by DVC. The need to map and review the different local government planning requirements in terms of governance, decision-making, organisational collaboration, capacity development, legal context, and resourcing has been well recognised. This process will allow for the identification of opportunities for **coordination, integration and streamlining** of health planning requirements. The strategic development of integrated planning mechanisms and processes at state, regional and local level has already occurred to

some extent. The Department for Victorian Communities' role in this area should be actively supported across government departments and state partners.

3. Taking full advantage of these opportunities hinges heavily on further **capacity and resource development**. Such development calls for visible and high level commitment in the Victorian Government to the role of local government in promoting health and wellbeing. Capacity and resource development must be structured and benchmarked with long-term objectives in mind. The NSW capacity-building framework and California Community Capacity Building framework may guide this effort in the following areas:

   ▪ *Community capacity building*. This was perhaps is the weakest area identified in the study. Intersectoral efforts are required to sustain and build further community development.

   ▪ *Workforce and organisational capacity building*. From the highest level, the need to embed awareness, implementation processes and resource allocations is required to be put high on social and political agendas. Priority areas include targeting training for different audiences i.e. councillors, planners, community developers etc, ensuring training resources are ongoing (due to high staff turnover) and make better use of existing resources.

   ▪ *Review mechanisms*. Increase requirements for review, evaluation and accountability compliance measures which are needed not just for developing MPHPs but for implementing and reporting on the achievements or outcomes of these plans.

   ▪ *Appropriate resourcing*. This evaluation showed that respondents appreciate the existing tools and support mechanisms, but that they are not always experienced as accessible, transparent, or appropriate. The continued review, marketing and redevelopment of these should be a prime priority. Any review should also include an economic evaluation of the first stage of the Framework, and recommend resource requirements for the subsequent planning and implementation cycles. Finally, it is recommended that funding in the second stage needs to equal or exceed the investment already made to develop and implement the Framework. This funding would best be used in conjunction with direct grants and the creation of opportunities for local government to generate additional resources in partnership with key players in the four environments for health.

References

Alpine Shire (2004). Alpine Shire Community Wellbeing Plan (Municipal Public Health Plan): 2004-2006. 1-79.

Ashton. J (1992). The origins of healthy cities. Healthy cities. J. A. (Ed.). Milton Keynes, UK:, Open University Press.: 1-12.

Bass Coast Shire Council (2005). "Health and Wellbeing in Bass Coast." 1-49.

Bauld, L., K. Judge, M. Barnes, M. Benzeval, M. Mackenzie & H. Sullivan (2005) Promoting Social Change: The Experience of Health Action Zones in England. Journal of Social Policy (2005), 34: 427-445

Baum. F (1998). *New Public Health*. Melbourne, Oxford University Press.

Baw Baw Shire Council (2003). *Municipal Public Health Plan*: 2003-2006. 1-26.

Banyule City Council (2004), Health Plan: 2004 - 2007.

Bayside City Council (2004). *Municipal Public Health Plan*: 2004-2008. 1-20.

Blau. G and Mahoney. M (2005). *The Positioning of Health Impact Assessment in Local* Government in Victoria. Melbourne, Deakin University: 35.

Bethell C, Fiorillo J, Lansky D, Hendryx M, Knickman J. (2004) Online consumer surveys as a methodology for assessing the quality of the United States Health care System. Journal of Medical Internet Research, 6(1): e2.

Brimbank City Council (2004). *Municipal Public Health Plan*: 2004-2006. 1-26.

Burdge, Rabel J. (1995) *A Community Guide to Social Impact Assessment*. Middleton: Social Ecology Press.

Cardinia (2005). *Cardinia Municipal Public Health Plan: 2005-2008*. 1-51.

Catford, J. (1997). Social entrepreneurs are vital for health promotion - but they need supportive environments too. Health Promotion International, 12, pp 1 - 4.

Catford, J. (1998). Developing leadership for health: our biggest blind spot. Health Promotion International, 13, pp. 95 - 98.

City of Boroondara (2003). *Boroondara Municipal Public Health Plan: 2003-2006*.1-71.

City of Casey (2002). *a healthy Casey . . . a healthy future.* 1-38.

City of Darebin (2005). *Community Health and Safety Framework: 2005-2009*. 1-16.

City of Greater Bendigo (2003). *Bendigo Health Wellbeing Framework*. 1-46.

City of Kingston (2002). *The City of Kingston Strategic Public Health Plan: 2002-2005*. 1-25.

City of Melbourne (2005). Municipal Public Health Plan - Cityhealth: 2005-2009.1-51.

City of Monash (2004). *Municipal Public Health Plan: 2004-2006.* 1-24.

City of Port Phillip (1999). *Creating a Healthy and Safer Port Phillip*. 1-41.

City of Stonnington (2002). *City of Stonnington Municipal Public Health Plan: 202-2005*. 1-30.

City of Whitehorse (2004). *Our Well-being, Our Community: Whitehorse Municipal Public Health Plan*: 2004-2006. 1-42.

City of Whittlesea (2004). *City of Whittlesea Municipal Public Health Plan: 2004-2007.* 1-43.

City of Yarra (2005). "City of Yarra Municipal Public Health Plan: 2005-2008." 1-53.

Clark Phillips Pty Ltd (2004). "Central Goldfields Shire Council." 1-48.

Clark Phillips Pty Ltd (2005). "Hepburn Shire Healthy Communities: 2005-2008." 1-34.

Corangamite Shire (2006). "Municipal Public Health Plan: 2006-2009." 1-39.

de Leeuw, E. (1999) Healthy Cities: Urban Social Entrepreneurship for Health. Health Promotion International, 14 (3) 261-269

Department of Human Services (2001). Environments for Health, Promoting Health and Wellbeing through the Built, Social, Economic and Natural Environments, Municipal Public Health Planning Framework.

Department of Human Services (2000). Municipal Public Health Plan Questionnaire Draft Report Unpublished document.

Department of Human Services (2004). Municipal Public Health Planning Update November 2004. 1-2.Available:
http://www.health.vic.gov.au/localgov/downloads/lg_partner_newsletter_nov04.pdf

East Gippsland Shire Council (2005). "East Gippsland Community Wellbeing Plan: 2005-2008." 1-48.

Frankston City (2002). "Health and Wellbeing Plan: 2002-2007." 1-10.

Garrard. J, Hawe. P, & Graham, C. (1995a). Acting locally to promote health: An evaluation of the Victorian Healthy Localities Project. Executive Summary. Australia: Melbourne, Municipal Association of Victoria.

Garrard. J, Hawe. P, & Graham, C. (1995b). Acting locally to promote health: An evaluation of the Victorian Healthy Localities Project. Volume 1: Evaluation Overview. Melbourne, Australia:, Municipal Association of Victoria.

Glen Eira City Council (2005). "Municipal Public Health Plan: 2005-08." 1-28.

Goumans, M. and J. Springett (1997). "From projects to policy: 'Healthy Cities' as a mechanism for policy change of health?" Health Promotion International 12(4): 311-322.

Goumans, M. (1998) Innovations in a Fuzzy Domain. Healthy Cities and (Health) Policy Development in the Netherlands and the United Kingdom. PhD Thesis Universiteit Maastricht, Maastricht

Greater Dandenong Council (2003). "Greater Dandenong Municipal Public Health Plan: 2003-2006." 1-36.

Greater Shepparton City Council (2002). "Greater Shepparton Public Health Plan: 2002-2004." 1-27.

Gusfield, J. (1981) The Culture of Public Problems: Drinking-Driving and the Symbolic Order. University of Chicago Press, Chicago

Gusfield, J. (1996) Contested Meanings. The Construction of Alcohol Problems. University of Wisconsin Press, Madison

Harris. E and Wills. J (1997). "Developing healthy local communities at local government level: lessons from the past decade." Australian and New Zealand Journal of Public Health 21(4): 403-412.

Hindmarsh Shire Council (2004) Municipal Public Health Plan: 2004-2007. 1-17

Hobson Bay City Council (2003). "Hobson Bay City Council: Municipal Public Health Plan: Strategic Action Plan." 1-68.

Hoeijmakers. M (2005). Local health policy development processes. Health promotion and network perspectives on local health policy-making in The Netherlands. Maastricht, Maastricht University.

Holliday. S (2005). Planners for tomorrow: challenges and the way ahead. Keynote presentation at the Planning Institute of Australia National Congress, Melbourne.

Horsham Rural City Council (2005). "Municipal Public Health Plan: 2005-2007." 1-9.

Hume City (2001). "Hume Health Action Plan: 2001-2004." 1-21.

Kegler. M. C, Norton. B. L, et al. (2003). Evaluation of the five-year expansion program of Californian Healthy Cities and Communities (1998-2003): Final report. Sacramento CA, Centre for Civic Partnerships.

Knox City Council (2003). "Community health & wellbeing strategy: summary: 2003-2006." 1-14.

Koch NS, Emrey JA. (2001) The internet and opinion measurement: surveying marginalised populations. Social Science Quarterly, 82(1): 131-38.

Latrobe City Council (2004). "Community Plan: Nindedhana Njinde Community Health and Wellbeing: 2004-2008." 1-68.

Macedon Ranges Shire Council (2004). "Health and Wellbeing Plan: 2004-2006." 1-41.

Manningham City Council (2005). "Healthy Living in Manningham: Manningham Municipal Public Health Plan: 2005-2008." 1-51.

Mansfield Shire (2005). "Health Now and Into the Future: 2005-2008." 1-29.

Maribyrnong City Council (2003). "Maribyrnong Municipal Public Health Plan: 2003-2006." 1-76.

Maroondah City Council (2003). "Maroondah 2025: A Community Planning Together." 1-54.

Maton, K. I., & Salem, D. A. (1995). Organizational characteristics of empowering community settings: A multiple case study approach. American Journal
of Community Psychology, 23, 631-656.

Moira Shire Council (2004). Moira Shire Municipal Public Health Plan 2004 – 2007. 1-26

Moonee Valley City Council (2003). "Building Partnerships: Building Communities." 1-48.

Moorabool Shire Council (2003). "Moorabool Health and Wellbeing Strategy: 2003-2006." 1-31.

Moreland City Council (2003). "Health, Safety and Well-being in Moreland." 1-51.

Mornington Peninsula Shire (2003). "Mornington Peninsula Health Hope & Happiness Action Plan: 2003-2006." 1-36.

Mornington Peninsula Shire (2003). "Mornington Peninsula Health Hope & Happiness Summary Report: 2003." 1-16.

Mount Alexander Shire (2004). "Mount Alexander Shire Municipal Public Health Plan: Action Plan: 2004-2007." 1-16.

Murrindindi Shire Council (2004). Municipal Public Health Plan: 2004-2007. 1-96.

National Civic League (1998). "A dialogue on healthy communities: past, present and future. (Building Healthier Communities: Ten Years of Learning) (Panel Discussion)." National Civic Review 87(4): 283-288.

Neverauskas, D& Mollison W (2004) Shire of Campaspe Municipal Public Health Plan Global Human Services Consultancy.

Nillumbik Shire Council (2004). "Healthy Living in Nillumbik: Municipal Public Health Plan: 2002-2005: Third Edition 2004-2005." 1-83.

NSW Health Department (2001). A Framework for Building Capacity to Improve Health, http://www.health.nsw.gov.au/pubs/f/pdf/frwk_improve.pdf, Accessed 31st October, 2005.

Shire of Loddon (2004). "Municipal Public Health Plan: 2004-2006." 1-39.

Shire of Melton (2004). "Municipal Public Health Plan: 2004-2007: Quality of Life for All." 1-8.

Shire of Yarra Ranges (2002). "Shire of Yarra Ranges Community Well-Being Plan: 2002-2005." 1-40.

Smith, J. (1995) Planning for Health in Local Government: A review of the implementation of MPHP and discussion of the future health role of Local Government in Victoria, School of health Systems Sciences, Faculty of Health Sciences La Trobe University, South Gippsland Shire Council (2001). Municipal Public Health Plan 2001 – 2004. 1-16

Southern Grampians Shire Council (2006). "Municipal Public Health Plan: March 2006." 1-28.

Southern Mallee Primary Care Partnership (2003). "Living and Working Together in Southern Mallee." 1-41.

Strathbogie Shire Council (2003). "Municipal Public Health Plan: 2003-2005." 1-15.

Success Works (2005). "Ararat Rural City Healthy Communities Plan: 2005-2008." 1-62.

Success Works (2005). "Northern Grampians Shire Council Municipal Health Action Plan: 2005-2008." 1-57.

Success Works (2005). Pyrenees Health Action Plan: 2005. 1-19

Pyrenees Shire (2006). Pyrenees Community Wellbeing Action Plan 06-07. 1-14

Tacticos, T. & Jordan, H. (2005) Final Evaluation Report of the Municipal Public Health Planning Framework, Good Practice Program, Program Evaluation Unit, The University of Melbourne, available at http://www.health.vic.gov.au/localgov/downloads/goodpractice/gpp_eval.pdf.

Tsouros. A (1995). "The WHO Healthy Cities Project: State of the art and future plans." Health Promotion International 10: 133-141.

Upper Hume Primary Care Partnership (2004). "Upper Hume: Health Communities Plan: 2004-2006." 1-49.

Victorian Department of Human Services (2003). Integrated health promotion resource kit. Melbourne, Primary and Community Health Branch.

Victorian Department of Human Services (2004). "Review of the Health Act 1958: A new legislative framework for public health in Victoria." 1-94.

Warrnambool City Council (2006). Warrnambool City Council Municipal Public Health Plan 2006. 1-33.

Wellington Shire Council (2006). "Healthy Living Plan: 2006-2009." 1-28.

WHO (1986). Ottawa Charter for Health Promotion. WHO,Geneva

WHO, (1997). Twenty Steps for Developing a Healthy Cities Project (3rd Ed.). Copenhagen, Denmark: World Health Organization Regional Office for Europe. Available on-line: http://www.who.dk/document/E56270.pdf

WHO, (1999), Community participation in local health and sustainable development: a working document on approaches and techniques, Geneva, p.9.

Wilkinson. R & Marmot. M. (Eds.) (2003). Social determinants of health: The solid facts (2nd Ed.). Copenhagen: World Health Organization Regional Office for Europe.

Wolff, T. (2003). The Healthy Communities movement: A time for transformation. National Civic Review, 92, (2, Summer), 95-111.

Wyndham City Council (2003). "Wyndham City Council: Municipal Public Health Plan: 2003-2005." 1-29.

Yarriambiack Shire Council (2005). "Community Health and Well-being in Yarriambiack." 1-24.

Glossary of Terms

Civic participation
A process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change (WHO, 1999).

Community capacity building
Development work – involving training and providing resources – that strengthens the ability of community organisations and groups to build structures, systems and skills that enable them to participate and *take* community action (*Environments for Health Municipal Public Health Planning Framework*, 2001).

Community Health Plan
PCP community health plans are annual plans that encompass locally identified health issues and report each PCP's strategies and achievements.

Corporate Plan
Corporate Plans (also referred to as Council Plans) are a requirement of the local government strategic planning process as specified in the Local Government Act (1989). The plan must include:

- the strategic objectives of the Council;
- strategies for achieving the objectives for at least the next 4 years;
- strategic indicators for monitoring the achievement of the objectives;
- a Strategic Resource Plan containing the matters specified in section 126;
- any other matters

Health gain
Improved health outcomes.

Health impact assessment
HIA is a combination of procedures, methods and tools by which a policy, program or project may be assessed and judged for its potential, and often unanticipated, effects on the health of the population, and the distribution of those effects within the population (Blau & Mahoney, 2005).

Health promotion
Health promotion is the process of enabling people to increase control over and to improve their health. A comprehensive social and political process that embraces actions to strengthen the skills and capabilities of individuals and actions directed towards changing social, environmental and economic conditions to alleviate their impact on public and individual health. Participation is essential to sustain health promotion action (*Environments for Health* Municipal Public Health Planning Framework, 2001).

Integrated planning
Linking of different planning processes and plans.

Municipal Public Health Plans
Municipal Public Health Plans (MPHPs) are a requirement of the local government strategic planning process as specified in the Health Act (1958). The plans outline action to prevent or minimize public health dangers, as well as to enable people living in the municipality to achieve maximum health and wellbeing.

Municipal Strategic Statement
Municipal strategic statements are a requirement of the local government strategic planning process as specified in the Planning and Environment (Planning Schemes) Act 1996. Municipal Strategic Statements must contain:

- the strategic planning, land use and development objectives of the planning authority;
- the strategies for achieving the objectives;
- a general explanation of the relationship between those objectives and strategies and the controls on the use and development of land in the planning scheme;
- any other provision or matter which the Minister directs to be included in the municipal strategic statement;
- a municipal strategic statement must be consistent with the current corporate plan prepared under section 153A of the Local Government Act 1989 for the municipal district;
- a municipal council must review its municipal strategic statement at least once in every three years after it is prepared.

A municipal council must also review its municipal strategic statement at any other time that the Minister directs.

New Public Health
Emphasises strategies outlined in the Ottawa Charter, such as strengthening community action, developing health-promoting environments and public health policy (Harris & Wills, 1997).

Primary Care Partnerships
Primary Care Partnerships are voluntary alliances between service providers. Since April 2000 over 800 service providers across Victoria have established 32 catchments. The aim of PCP is to address the issue of fragmentation of the primary health service delivery.

Social determinants of health
According to the World Health Organisation, the social determinants of health comprise:

1. The need for policies to prevent people from falling into long-term disadvantage;

2. How the social and psychological environment affects health;

3. The importance of ensuring a good environment in early childhood;

4. The impact of work on health;

5. The problems of unemployment and job insecurity;

6. The role of friendship and social cohesion;

7. The dangers of social exclusion;

8. The effects of alcohol and other drugs;

9. The need to ensure access to supplies of healthy food for everyone; and

10.The need for healthier transport systems, (WHO, 2000).

Social impact assessment
Systematic analysis in advance of the likely impacts a development event (or project) will have on the day-to-day life (environmental) of persons and communities (Burdge, 1995).

Social model of health
A social view of health implies that we must intervene to change those aspects of the environment which are promoting ill health, rather than continue to simply deal with illness after it appears, or continue to exhort individuals to change their attitudes and lifestyles when, in fact, the environment in which they live and work gives then little or no choice or support for making those changes (*Environments for Health Municipal Public Health Planning Framework,* 2001).

References:

Burdge, Rabel J. (1995) *A Community Guide to Social Impact Assessment*. Middleton: Social Ecology Press.

Harris, E. and Wills, J. 1997, 'Developing healthy communities at local government level:

Lessons from the past decade' *Australian and New Zealand Journal of Public Health,* 21, 403-412.
WHO, 1999, *Community participation in local health and sustainable development: a working document on approaches and techniques*, Geneva, p.9.

WHO *(2000) Social Determinants of Health: The Solid Facts Available:*
http://www.who.dk/document/e59555.pdf

Appendices

Appendix 1 - *Environments for Health* Evaluation Project Advisory Group

Members, Terms of Reference and Meetings

Name	Role/Organisation
Clare Hargreaves	Senior Policy Advisor, MAV
Shauna Jones	Team Leader, Local Government Partnerships, DHS
Ron Frew	Senior Project Officer, Local Government Partnerships, DHS
Kellie Horton	Project Officer, Local Government Partnerships, DHS
Monica Kelly	Manager Health Promotion & Chronic Disease Prevention, DHS
Prof Evelyne de Leeuw	Head, School of Health & Social Development, Deakin University
Dr Josephine Palermo	Research Fellow, Centre for Health through Action on Social Exclusion, Deakin Univ
Dr Jan Garrard	Senior Lecturer, School of Health & Social Development, Deakin University
Dr Iain Butterworth	Senior Lecturer, School of Health & Social Development, Deakin University
Tara Godbold	Research Assistant, School of Health & Social Development, Deakin University
Theonie Tacticos	Research Fellow, Program Evaluation Unit, University of Melbourne
Holly Piontek-Walker	Manager Public Health Development, Southern Region, DHS
Harvey Ballantyne	Public Health, Hume Region, DHS
Sally Rose	Senior Project Officer, Integrated Health Promotion, DHS
Jared Osborne	Policy Development Officer, Sustainable Communities, VLGA
Peter Boyle	Principal Urban Designer, Urban Design Unit, DSE
Yvonne Robinson	Director, Cardiovascular Health Programs, National Heart Foundation (Vic Divison)
Kellie-Ann Jolly	Director, Physical Activity Unit, VicHealth
Morris Bellamy	Manager, Arts & Culture, City of Melbourne
Tracy VanderZalm	Coordinator Community Strengthening, Greater Shepparton City Council.
John Dixon	Community Services & Municipal Recovery Manager, Pyrenees Shire
David Baker	Team Leader, Community Safety, City of Casey
Anne McLennan	Director, Community Services, Macedon Ranges Shire Council
Rachel Carlisle (replaced Yvonne Robinson)	Physical Activity Manager National Heart Foundation
John Bivano (replaced Monica Kelly)	Senior Manager Health Promotion and Chronic Disease
Therese Robinson (replaced Holly Piontek-Walker whom remained on the PAG but in a new role)	Regional representative from Eastern Metro region
Rita Butera	Senior Project Officer, VicHealth

Terms of Reference

Purpose
To guide the process of assessing the introduction of the *Environments for Health* framework in municipal public health planning (and related implementation activities such as *Leading the Way*), and provide direction for future developments in supporting local government public health planning.

Objectives
To inform and design the data collection framework to be applied to a wide range of stakeholders by the Project Team (Deakin/Melbourne Univ).

To develop and implement a broad communication strategy which provides timely information regarding the evaluation process to all Local Governments, as well as other key stakeholders over the life of the project.

To work collaboratively with the Project Team to produce a comprehensive project report and disseminate the findings widely.

To contribute to the recommendations for DHS regarding development of a new policy framework to support municipal public health planning in the future.

To act in dual roles of project advisor and participant by also contributing to the evaluation project as key informants.

Membership
• Membership of the group will comprise, where possible, the initial members of the *Environments for Health* Steering Group
• Local Government will be represented by 4-6 councils covering:
  o inner metropolitan councils
  o interface councils
  o rural cities
  o rural shires
• Other key stakeholders with an interest and role in local government planning for wellbeing will also be invited to participate in the group

Meetings
• The Advisory Group will meet at key stages of the evaluation process linked to key project review points and deliverables.
• A meeting schedule will be determined at the initial meeting of the Advisory Group based on the project plan proposed by the Project Team.

Chairperson
• The Advisory Group will be co-chaired by Shauna Jones (DHS) and Clare Hargreaves (MAV).
• The chairperson (or appointed proxy) will distribute the meeting agenda and any written reports at least one week prior to the meeting.

Secretariat/Minutes
Meeting minutes will be taken through a shared arrangement between the Local Government Partnerships Team and the Project Team who will:

Distribute the minutes to each member no more that 21 days from the meeting date.

Ensure that the minutes will follow an agreed format and feature actions required by members

Meetings Dates and Locations

Thursday, 20th April 2006	2-4pm	Department of Human Services, 50 Lonsdale St Melbourne
Thursday, 4th May 2006	2-4pm	Department of Human Services, 50 Lonsdale St Melbourne
Thursday, 15th June 2006	2-4pm	Department of Human Services, 50 Lonsdale St Melbourne
Thursday, 27th July 2006	2-4pm	Department of Human Services, 50 Lonsdale St Melbourne
Thursday, 12th October 2006	2-4pm	Department of Human Services, 50 Lonsdale St Melbourne
Friday, 17th November 2006	2-4pm	Department of Human Services, 50 Lonsdale St Melbourne

Appendix 2 - Key Informant Interview Questions

1. Impacts of *Environments for Health*

1.1   Over the past five years what changes have occurred in the way the terms 'health' and 'wellbeing' are defined or conceptualised within councils (both within the health departments of the council and more broadly across council)?

1.2   To what extent do councils (a) understand and (b) translate into action the social- environmental determinants of health approach to achieving health gains that underpins the *Environments for Health* strategy?

1.3   To what extent do you think that *Environments for Health* and initiatives linked to MPH Planning have contributed to these changes?

1.4   Has the *Environments for Health* Framework had any impact on the *capacity* of local government, DHS regions and divisions, and other key stakeholders to promote effective MPH planning? (Prompt: what impact do they feel that *Environments for Health* has had on issues related to organisational / community capacity such as leadership support, systems in place for planning, reporting and evaluating outcomes etc)

2. Barriers and enablers

2.1   To the extent that councils have adopted the *Environments for Health* approach, what do you think have been the main supporting factors?

2.2   What have been the main barriers? (Are there different barriers for councils at different stages of incorporating the *Environments for Health* approach?)

3. Health gain and sustainability

3.1 What is needed to sustain and/or further develop the sorts of changes in health planning within local government that we've been talking about? (i.e. where to from here, and how?)

3.2 Do you think that implementation of *Environments for Health* has contributed to additional opportunities for health gain?

Appendix 3 - Online survey

Evaluation of *Environments for Health* Municipal Public Health Planning Framework

Questionnaire

Please note that your participation in this survey is part of a larger study that aims to review the *Environments for Health* Municipal Public Health Planning Framework (including *Leading the Way*). The aims of this survey are to investigate the extent to which the *Environments for Health* Framework has been incorporated in policies and practices of local government stakeholders. We also aim to explore any barriers and enablers to the implementation of this framework. Your participation is voluntary and confidential, and will assist in the development of the next phase of assistance for municipal public health planning. The survey will take about 10-15 minutes to complete.

Please complete the questions below by filling in a circle or selecting an appropriate number or response.

Please note: This questionnaire will be completed by Local Government staff and staff of other organisations that work with Local Government. If you work with, or are associated with <u>more than one council</u>, please base your responses on the council with which you are most familiar. Also as we are seeking a wide range of responses not every respondent is going to have the ability to respond to every question. Therefore please complete as many questions as you can.

Municipal Public Health Plans

1. Are you familiar with the *Environments for Health* Municipal Public Health Planning Framework?
   - ❐ Very familiar
   - ❐ Somewhat familiar
   - ❐ Not very familiar
   - ❐ Not at all familiar

2. Are you familiar with the *Leading the Way* resource and associated training?
   - ❐ Very familiar
   - ❐ Somewhat familiar
   - ❐ Not very familiar
   - ❐ Not at all familiar

3. What is the current status of the Municipal Public Health Plan (MPHP) in your Local Government Area (LGA)?
   - ❐ Currently being developed but not formally adopted by council
   - ❐ Adopted, but not yet implemented
   - ❐ Implementation phase, with annual review
   - ❐ Plan is due for renewal
   - ❐ Plan is overdue for renewal
   - ❐ Don't know

4. Please indicate the level of influence that the *Environments for Health* Municipal Public Health Planning Framework has had on the Council's Municipal Public Health Plan in your Local Government Area.

   - ❐ Substantial influence
   - ❐ Moderate influence
   - ❐ Average
   - ❐ Slight influence
   - ❐ No influence
   - ❐ Don't know

5. Please indicate the level of influence that the *Environments for Health* Municipal Public Health Planning Framework has had on any of the following plans in your Local Government Area.

Type of Plan	Substantial influence	Moderate influence	Average	Slight influence	No influence	Don't know	Not applicable
1. Corporate Plan	❒	❒	❒	❒	❒	❒	❒
2. Municipal Strategic Statement	❒	❒	❒	❒	❒	❒	❒
3. Municipal Early Years Plan	❒	❒	❒	❒	❒	❒	❒
4. Environmental Plan	❒	❒	❒	❒	❒	❒	❒
5. Economic Plan/Strategy	❒	❒	❒	❒	❒	❒	❒
6. Emergency management Plan	❒	❒	❒	❒	❒	❒	❒
7. Access and inclusion Strategy	❒	❒	❒	❒	❒	❒	❒
8. Alcohol and drug strategy	❒	❒	❒	❒	❒	❒	❒
9. Community safety	❒	❒	❒	❒	❒	❒	❒
10. Transport strategy	❒	❒	❒	❒	❒	❒	❒
11. Road safety strategy	❒	❒	❒	❒	❒	❒	❒
12. Recreation strategy	❒	❒	❒	❒	❒	❒	❒
13. Open space strategy	❒	❒	❒	❒	❒	❒	❒
14. Arts and Culture strategy	❒	❒	❒	❒	❒	❒	❒
15. Primary Care Partnership - Community Health Plan	❒	❒	❒	❒	❒	❒	❒
16. Community Health Service – integrated health promotion plan	❒	❒	❒	❒	❒	❒	❒
17. Other- please specify below	❒	❒	❒	❒	❒	❒	❒

6. To what extent is the Municipal Public Health Plan of the council in your Local Government Area integrated with the following plans.

	Substantially integrated	Moderately integrated	Average	Slightly integrated	Not integrated	Don't know	Not applicable
1. Corporate Plan	❒	❒	❒	❒	❒	❒	❒
2. Municipal Strategic Statement	❒	❒	❒	❒	❒	❒	❒

7. To what extent has the *Environments for Health* Municipal Public Health Planning Framework influenced your Local Government Area **Planning Scheme** more generally?
   ❒ Substantial influence
   ❒ Moderate influence
   ❒ Average
   ❒ Slight influence
   ❒ No influence
   ❒ Don't know
   ❒ Not applicable

The *Environments for Health* Municipal Public Health Planning Framework

8. To what extent has the *Environments for Health* Municipal Public Health Planning Framework;

	Largely contributed	Moderately contributed	Average	Slightly contributed	Not at all contributed	Don't know
1. Increased your **level of understanding** of the impact of the social, economic, natural and built environments on health and wellbeing.	❐	❐	❐	❐	❐	❐
2. Contributed to **policies and plans** that impact on the social, economic, natural and built environments in your Local Government Area.	❐	❐	❐	❐	❐	❐
3. Contributed to **addressing the differing needs of disadvantaged population groups** in your Local Government Area.	❐	❐	❐	❐	❐	❐

8a. Would you like to make any general comments about this question?

_____

_____

9. Please indicate your agreement/disagreement with the following statements. The *Environments for Health* Municipal Public Health Planning Framework has;

	Strongly Agree	Agree	*Neither Agree nor Disagree*	Disagree	Strongly Disagree	Don't know
1. Contributed to improved healthy public policy in the LGA	❐	❐	❐	❐	❐	❐
2. Helped to create supportive environments in the LGA	❐	❐	❐	❐	❐	❐
3. Helped strengthen community involvement in the LGA	❐	❐	❐	❐	❐	❐
4. Helped develop personal skills of members of the community in the LGA	❐	❐	❐	❐	❐	❐
5. Has encouraged health services in the LGA to become more health promoting	❐	❐	❐	❐	❐	❐

10. This question is about the *Environments for Health* document. If you are not familiar with the *Environments for Health* document, please go straight to question 11, otherwise please indicate your agreement/disagreement with the following statements.

	Strongly Agree	Agree	*Neither Agree nor Disagree*	Disagree	Strongly Disagree	Don't know
1. It is presented in a way that makes it easy to understand	❏	❏	❏	❏	❏	❏
2. The links to supporting documents, research and websites help to identify relevant references and related models	❏	❏	❏	❏	❏	❏
3. Part A of the Framework 'a new approach to Municipal Public Health Planning' provides a sound theoretical base	❏	❏	❏	❏	❏	❏
4. Part B of the Framework 'a practical guide to planning' provides practical planning tools	❏	❏	❏	❏	❏	❏

11.. The following activities and resources were designed to complement and support the *Environments for Health* Municipal Public Health Planning Framework. Please indicate how useful they were.

	Very useful	Quite useful	Average	Slightly useful	Useless	Not applicable
1. *Leading the Way* (VicHealth)	❏	❏	❏	❏	❏	❏
2. Municipal Public Health Planning Conference 2003	❏	❏	❏	❏	❏	❏
3. Municipal Public Health Planning Conference 2004	❏	❏	❏	❏	❏	❏
4. Good Practice Program (Local Government Partnerships Team DHS Central Office)	❏	❏	❏	❏	❏	❏
5. Municipal Public Health Planning Newsletters (Local Government Partnerships Team DHS Central Office)	❏	❏	❏	❏	❏	❏
6. Local Government Planning for Health and Wellbeing web site (Local Government Partnerships Team DHS Central Office)	❏	❏	❏	❏	❏	❏

12. This question seeks some further information about the range of support and activities provided by DHS regions. How useful were the following activities in providing support for Municipal Public Health Planning.

	Very useful	Quite useful	Average	Slightly useful	Useless	Not applicable
1. Telephone support and visits	❏	❏	❏	❏	❏	❏
2. Participation in MPHP Steering Committee/Reference Committee	❏	❏	❏	❏	❏	❏
3. Individual meetings and support	❏	❏	❏	❏	❏	❏
4. Regional local government network meetings	❏	❏	❏	❏	❏	❏
5. Other regional meetings	❏	❏	❏	❏	❏	❏
6. Good Practice Program	❏	❏	❏	❏	❏	❏
7. Provision of data/information/evidence						
8. Training program (eg evaluation skills training)	❏	❏	❏	❏	❏	❏
9. Other funding/resources	❏	❏	❏	❏	❏	❏
10. Other - please specify below						

13. What other initiatives have been useful in supporting the implementation of the *Environments for Health* Municipal Public Health Planning Framework?

	Very useful	Quite useful	Average	Slightly useful	Useless	Not applicable
DHS Regional Office						
1. Public health team	❐	❐	❐	❐	❐	❐
2. Other program areas	❐	❐	❐	❐	❐	❐
DHS Central Office						
3. Local Government Partnerships team	❐	❐	❐	❐	❐	❐
4. Health Promotion and Capacity Building section	❐	❐	❐	❐	❐	❐
5. Evidence based reviews	❐	❐	❐	❐	❐	❐
6. Health Promotion Short Course	❐	❐	❐	❐	❐	❐
7. Public Health Awards	❐	❐	❐	❐	❐	❐
8. Public Health Branch	❐	❐	❐	❐	❐	❐
9. Municipal Early Years Plan (Office of Children, DHS)	❐	❐	❐	❐	❐	❐
10. Other DHS Central Office Support (Please specify below)	❐	❐	❐	❐	❐	❐
Peak Organisations						
11. Kids – 'Go for you life' (Victorian Government)	❐	❐	❐	❐	❐	❐
12. Metro – active (VicHealth)	❐	❐	❐	❐	❐	❐
13. Food for all (VicHealth)	❐	❐	❐	❐	❐	❐
14. *Healthy by design* (National Heart Foundation)	❐	❐	❐	❐	❐	❐
15. Planning for Health (Planning Institute of Australia)	❐	❐	❐	❐	❐	❐
Other supports						
16. Primary Care Partnerships	❐	❐	❐	❐	❐	❐
17. Support from other stakeholders (please specify below)	❐	❐	❐	❐	❐	❐
18. Support within my organisation (please specify below)	❐	❐	❐	❐	❐	❐
19. Other - please specify below	❐	❐	❐	❐	❐	❐

Council organisational capacity

14. 'Organisational capacity' can impact on effective Municipal Public Health Planning. Please indicate your agreement or disagreement with the following characteristics of the council in which you work (or for non-council respondents the council you are most involved with).

Partnerships	Strongly Agree	Agree	*Neither Agree nor Disagree*	Disagree	Strongly Disagree	Don't know
1. Council works in a cooperative and inclusive way	❐	❐	❐	❐	❐	❐
2. Council initiates and sustains effective involvement with other partners to implement/ sustain the MPHP	❐	❐	❐	❐	❐	❐
3. There is a capacity to deliver the MPHP through a network of organisations and groups	❐	❐	❐	❐	❐	❐

Workforce Development	Strongly Agree	Agree	*Neither Agree nor Disagree*	Disagree	Strongly Disagree	Don't know
4. Council provides professional development for staff in skills related to planning for health and wellbeing	❐	❐	❐	❐	❐	❐
5. Planning for health and wellbeing is integrated across departments/divisions in Council	❐	❐	❐	❐	❐	❐

Knowledge Transfer	Strongly Agree	Agree	*Neither Agree nor Disagree*	Disagree	Strongly Disagree	Don't know
6. MPHP planning in council is informed by evidence	❐	❐	❐	❐	❐	❐
7. Council disseminates information about the MPHP within relevant networks	❐	❐	❐	❐	❐	❐
8. Council has meaningful consultation with stakeholders about their needs in relation to MPHP planning	❐	❐	❐	❐	❐	❐

Leadership	Strongly Agree	Agree	*Neither Agree nor Disagree*	Disagree	Strongly Disagree	Don't know
9. Council is committed to planning for health and wellbeing at all levels	❐	❐	❐	❐	❐	❐
10. Senior council staff support a multi-disciplinary approach to improving health and wellbeing.	❐	❐	❐	❐	❐	❐
11. Different departments incorporate health and wellbeing as a planning priority, to the extent that I feel like we all speak the same language	❐	❐	❐	❐	❐	❐

Resources	Strongly Agree	Agree	*Neither Agree nor Disagree*	Disagree	Strongly Disagree	Don't know
12. Appropriate human resources are allocated to planning for health and wellbeing	❐	❐	❐	❐	❐	❐
13. Adequate financial resources are allocated to planning for health and wellbeing	❐	❐	❐	❐	❐	❐

The next questions are about the further development of the *Environments for Health* Municipal Public Health Planning Framework.

15. What parts of the *Environments for Health* Municipal Public Health Planning Framework do you think are essential to retain?

_____

_____

16. What parts of the *Environments for Health* Municipal Public Health Planning Framework need updating and revising for future   planning needs?

_____
_____

17. Are there any gaps in the *Environments for Health* Municipal Public Health Planning Framework that need to be addressed?

_____
_____

18. What future assistance would enhance the implementation of the *Environments for Health* Municipal Public Health Planning Framework?

_____
_____

19. Would you like to give a brief example of how the *Environments for Health* Municipal Public Health Planning Framework has impacted on the work of the council in your Local Government Area?

_____
_____

20. Would you like to make any other comments about *Environments for Health* Municipal Public Health Planning Framework??

_____
_____

Some final questions

The following questions will give us some useful information about the demographic characteristics of survey respondents. It will not be used to identify individuals or organisations. Please remember that all information you provide is confidential and no potentially identifiable information will be presented. Individual respondents, councils and regions will not be identified in the final report.

21. Where do you work (can be in a voluntary capacity)? That is, which council or other organisation.

22. Please indicate the location of workplace.
❑ Inner metro
❑ Interface/city fringe
❑ Rural
❑ Regional

23. What is your role in this council or other organisation?

24. Is your organisation a member of a Primary Care Partnership (PCP)?
❑Yes   ❑No

25. What is your age range (in years)?
❑ <20
❑ 20-29
❑ 30-39
❑ 40-49
❑ 50-59
❑ 60-69

❑ 70-79
❑ 80+

26. Are you?
❑ Female ❑ Male

Appendix 4 – Local Planning for Health Forum Agenda

10.30 am	**Registration, morning tea and coffee**
11.00am	**PLENARY**
	- Welcome - Overview - Goals - Agenda - Procedures – consent forms and confidentiality
11.30am	*Data Collection 1 – Group discussions*
	'Planning for health – council and stakeholder reflections'
	- Across these dimensions: - Individual - Civic participation - Organisational - Inter – organisational - Community - Where has the biggest change occurred? - What are the most difficult areas?
12.15am	**LUNCH**
12.30am	**PLENARY**
	Presentation of evaluation findings to date
1pm	**Questions, points of clarification**
1.15pm	*Data collection 2 – Group discussions*
	'Reflections on findings'
	- What is ringing true for you? - Anything that is different? - Anything that is missing?
2pm	**PLENARY**
2.30pm	**End**

Appendix 5 - Statistical Tables

Table 7 Bivariate correlations between organisational capacity dimensions, familiarity, integrated planning and health gain Familiarity with the Framework, Integration with other Plans and Outcomes of the *Environments for Health* Framework

	Workforce Develop - ment	Knowledge Transfer	Leadership	Partnerships	Resources
Familiarity					
Familiarity with *Environments for Health*	0.13	0.22	-0.03	0.05	0.10
Familiarity with *Leading the Way*	0.02	0.19	-0.03	0.03	0.14
Integration with other Plans and Strategies					
MPHP integrated with the Corporate Plan	0.19	**0.27**	**0.34**	0.19	0.23
MPHP integrated with the Municipal Strategic Statement	0.21	**0.29**	**0.40**	**0.31**	0.25
Influence of EfH on LGA Planning Scheme generally	0.22	0.20	0.22	0.22	0.16
Health Gain outcomes					
Increased level of understanding of the impact of the social, economic, natural and built environments on health and wellbeing	0.09	0.18	-0.04	0.10	-0.02
Contributed to policies and plans that impact on the social, economic, natural and built environments in your LGA	**0.27**	0.23	0.15	**0.34**	0.05
Contributed to addressing the differing needs of disadvantaged population groups in you LGA	**0.31**	**0.33**	0.18	**0.31**	0.16
Contributed to improved healthy public policy in the LGA	**0.33**	**0.28**	0.19	**0.27**	**0.27**
Helped to create supportive environments in the LGA	**0.29**	**0.32**	0.08	0.16	**0.26**
Helped strengthen community involvement in the LGA	**0.42**	**0.32**	0.21	**0.38**	**0.31**
Helped develop personal skills of members of the community in the LGA	**0.44**	**0.30**	0.24	**0.36**	**0.36**
Has encouraged health services in the LGA to become more health promoting	**0.39**	**0.30**	0.23	**0.43**	**0.30**

Note: Significant correlation coefficients are in bold